



## *Performance Standards*

# **Individualized Residential Treatment Community Rehabilitation Residential Host Home**

Performance Standards are intended to provide a foundation and serve as a tool to promote continuous quality improvement and progression toward best practice performances, to increase the consistency of service delivery and to improve outcomes for members

**Disclaimer:** These Performance Standards should not be interpreted as regulations. Entities providing services as part of the HealthChoices program must first be enrolled in the Pennsylvania Medical Assistance program as the appropriate provider type. Providers must then comply with all applicable Pennsylvania laws, including Title 55, General Provisions 1101, licensing program requirements and any contractual agreements made with Community Care Behavioral Health Organization in order to be eligible for payment for services.

**PERFORMANCE STANDARDS**  
**Individualized Residential Treatment/Community**  
**Rehabilitation Residential Host Home**

Final 7/06

## **INTRODUCTION**

Individualized Residential Treatment (IRT)/Community Rehabilitation Residential (CRR) Host Home Treatment Programs are part of the comprehensive mental health system of care for children, adolescents and their families approved by Congress in 1984 for the Child and Adolescent Service System Program (CASSP). This children's system of care is based on a well-defined set of principles for mental health services for children and adolescents with or at risk of developing severe emotional disorders and their families. These principles are summarized in six core statements also known as the CASSP Principles:

- **Child-centered:** Services meet the individual needs of the child, consider the child's family and community contexts, and are developmentally appropriate, strengths-based and child-specific.
- **Family-focused:** Services recognize that the family is the primary support system for the child and participates as a full partner in all stages of the decision-making and treatment planning process.
- **Community-based:** Whenever possible, services are delivered in the child's home community, drawing on formal and informal resources to promote the child's successful participation in the community.
- **Multi-system:** Services are planned in collaboration with all the child-serving systems involved in the child's life.
- **Culturally competent:** Services recognize and respect the behavior, ideas, attitudes, values, beliefs, customs, language, rituals, ceremonies and practices characteristic of the child's and family's ethnic group.
- **Least restrictive/least intrusive:** Services take place in settings that are the most appropriate and natural for the child and family and are the least restrictive and intrusive available to meet the needs of the child and family.

An IRT/CRR HOST HOME provides individualized “out-of-the-home” community-based behavioral health treatment, which includes a 24 hours/day structured therapeutic environment for the child in a host home. The IRT/CRR Performance Standards are the result of a series of meetings facilitated by Community Care Behavioral Health, with representatives from network IRT/CRR Host Home providers, county representatives, and representatives from oversight entities. The goal of these meetings was to develop standards to expand upon the current regulations. Input from other stakeholder groups, including family and member representatives was also sought prior to the finalization of this document. These standards are intended to clearly articulate

Community Care's expectations of IRT/CRR Host Home providers and define the parameters of reasonable standards of practice for the provision of these services. The standards are intended to provide a foundation and serve as a tool to promote continuous quality improvement and progression toward best practice performance, to increase the consistency of service delivery, and to improve outcomes for children, adolescents, and their families. In some instances, the standards set the bar higher than baseline performance standards. Overall, this is reflective of the current level of quality within the network and the commitment of all involved stakeholders to continually strive to improve the quality of care for children and adolescents.

These standards should not be interpreted as regulations, but rather a progression towards a better standard of performance. These standards will not be utilized as a means of requiring or prohibiting specific interventions for specific individuals. Each child or adolescent receiving IRT/CRR Host Home services will have a uniquely developed treatment plan, which identifies strengths and addresses needs.

IRT/CRR Host Home providers are expected to monitor adherence to the standards and to take corrective actions where indicated to assure compliance with the standards. Community Care will assess compliance to these performance standards during medical chart reviews conducted by our Quality Department and will include feedback in provider benchmarking efforts. As Community Care and its providers implement monitoring activities to assess compliance with the standards and establish baseline measures, Community Care may move to pilot less intense utilization review processes or alternative reimbursement methodologies with high quality IRT/CRR Host Home providers.

### *Differentiating IRT/CRR Host Home from Other Types of Out-of-home Care:*

Throughout the various types of service systems for children and adolescents, i.e., mental health, mental retardation, children and youth and juvenile probation, there exists numerous forms of out of home care. The following definitions are intended to assist the reader in differentiating these.

IRT/CRR Host Home is a State Office of Medical Assistance Programs (OMAP) approved behavioral health treatment program for children and adolescents. Treatment includes individualized "out-of-the-home" community-based behavioral health treatment while living with a trained host family. The child must have a mental health diagnosis and meet medical necessity for this level of care. IRT/CRR Host Home treatment is funded by Mental Health, i.e., Fee For Services or HealthChoices. Room and board is funded by one of the following; SSI; the County MH/MR, Children, Youth and Family Services (CYS); Juvenile Probation; Parents; or HealthChoices as the last resort.

CYS Therapeutic Foster Home is a court ordered placement funded by CYS. Children in a therapeutic foster home placement have been adjudicated dependent by the court and are legally in the custody of CYS. CYS is responsible for training the foster parents. A child in therapeutic foster care may or may not have mental health diagnosis. Behavioral health services may be in place from a behavioral health provider.

Foster Home is a CYS placement utilized for children and adolescents with no place to live. Children in foster care may or may not have a mental health diagnosis. Some children in foster care have no behavioral health treatment, while others may have clinic or community based behavioral health treatment.

CYS Group Home is a CYS funded and court ordered placement. Children in a CYS group home have either no place to live, have no foster home available, or no foster home will take the child due to a specific circumstances such as the child's age, significant behavioral problems, running away, truancy, parent-child conflicts or sexual acting out for example. Some children in CYS group homes are waiting for an opening in a Residential Treatment Facility (RTF), but he/she does not meet medical necessity criteria for an inpatient admission or continued inpatient stay.

CYS Shelter is a temporary CYS placement which is crisis oriented. Typically children in CYS shelter are waiting for placement elsewhere, i.e., CYS, JPO; or MH placement.

Respite Care is temporary relief care lasting between 24 hours and 4 weeks in the child's own home, a respite family's home, or an approved medical facility. Respite care is utilized to give the caretakers and family short term relief from caring for the identified child with the overall goal of the child returning home after this break. Respite care is funded by MH/MR base funds.

Community Living Arrangement (CLA) also referred to as MR Group Home provides housing and care for persons with mental retardation. CLA's are funded by the MR system. MR children with no place to live or no available foster placements may reside in a CLA. Typically there is a long waiting list for someone to get into a CLA because this usually becomes the MR child or adult's permanent living arrangement.

JPO Residential Placement is court ordered and funded by juvenile probation. Children in a JPO residential placement have been adjudicated delinquent by the court due to unlawful behavior. These treatment programs provide rehabilitation, education, medical and vocational training to help the child better function in the community once they are discharged. Since some of these children have committed violent and or sexually related offenses, some of the facilities are secure. Behavioral health treatment is provided to these children by staff at the facility.

Detention is a temporary JPO funded placement used for children charged with a criminal offense while the child is waiting for a hearing or waiting for placement in JPO Residential or Residential Treatment Facility (RTF).



## **SERVICE DESCRIPTION**

### **Core Services**

IRT/CRR Host Home Treatment is a voluntary mental health treatment program for children and their families. An IRT/CRR Host Home provides individualized “out-of-the-home” community-based behavioral health treatment, which includes a 24 hours/day structured therapeutic environment for the child in a host home. Host home parents are extensively trained and supervised and receive regular clinical oversight regarding behavioral health issues including diagnosis, medications, behavioral interventions, crisis intervention, incident reporting, verbal de-escalation and passive restraint techniques. Additional treatment services including, but not limited to, individual therapy, family therapy, medication management, crisis intervention, and case management are incorporated into the host home environment as well. IRT/CRR Host Home treatment is less restrictive than treatment in a RTF, but clinically intense enough to meet the child’s behavioral health needs.

IRT/CRR Host Home may be an alternative for:

- Very young children recommended for RTF treatment
- As an alternative for adolescents with mental health disorders needing this amount of structure while preparing for independence.
- Children whose symptoms would be expected to improve better in a structured family environment that provides one to one attention rather than a structured therapeutic group environment such as a RTF
- Children with specific behavioral health disabilities for which no RTF exists.
- A step-down from RTF or step-up from intensive community based services where these services have not made much impact on the child/family’s symptom stability

The ultimate goal of IRT/CRR Host Home is to stabilize the child/family’s symptoms enough for the child to return home to his/her natural family, foster care or independent living facility.

### **Average Length of Stay**

The anticipated length of stay in an IRT/CRR Host Home is 6 – 9 months.

### **Relationship of IRT/CRR Host Home to Continuum of Behavioral Health Care**

IRT/CRR Host Home is a bundled treatment service that fits into the continuum of care between RTF and Community Based Services (FBMHS and BHRHS).

Exclusionary criteria would be extreme dangerousness including: recurrent suicidal behavior, active psychosis, extreme homicidally, and active fire-setting behavior.

### *IRT/CRR Host Home Staffing Requirements, i.e., Qualifications, Training and Supervision*

The staffing requirements in an IRT/CRR Host Home include host home parents, a host home therapist, a case manager and supportive staff. Additional behavioral health services are also available as needed, and may include psychiatric services, psychological services and respite care.

#### Host Home Parents

##### **Qualifications for Host Home Parents**

A host home may consist of a one or two parent family. Host home parents must be at least 21 years of age and must, at minimum be a high school graduate or have earned a General Educational Development (GED). One or both host home parents are permitted to work outside of the home; however, appropriate coverage must be provided to supervise the child when the parent(s) are not home. To apply for host home parent status, the individual(s) must complete an initial interview, have at least 3 personal/professional references, obtain act 33/34 clearances, and obtain FBI clearances if he/she resided out of the state as an adult. A home study is also conducted to check the home environment and meet the state regulations of the CRR. All family members residing in the home must take part in an annual physical examination and be free of significant health problems. The household cannot exceed 6 children in the home including natural children. Only 1 - 3 children in the home can be in “out of home placement or treatment”, and only 1 of these 3 children may be in IRT/CRR care at any given time, unless otherwise approved by CCBH utilization review.

##### *Training for Host Home Parents*

Host home parents are required to participate in 24 hours of pre-service training including topics such as first aid, CPR, medication management, fire safety, psychiatric diagnosis, crisis management, documentation, and behavioral management training. Host home parents are also required to have ongoing training including 24 hours/year of continuing education for the primary parent and 12 hours/year for the secondary parent. Continued education includes training topics such as CASSP principles, cultural competency, updates on pre-service training, nutrition, dietary, and training specific to the needs of the client and natural family.

### *Supervision of Host Home Parents*

Both clinical and service supervision is conducted with the host home parents. The host home family meets with the IRT/CRR Host Home therapist on a weekly basis to review treatment plans. The IRT/CRR Host Home Case manager meets with the host family at least twice a month to review and collect documentation and check the physical structure of the home. In addition, a health and safety assessment is completed quarterly and a full home study is conducted annually by the provider agency.

### ***IRT/CRR Host Home Therapist***

#### *Qualifications for Host Home Therapist*

The host home therapist must meet one of the following qualifications:

- He/she must be a licensed mental health professional; with Act 33/34 clearances; FBI clearance if he/she has been an out of state resident; 3 professional references; and a physical exam *or*;
- An individual with a graduate degree in the human service field (may include education, juvenile justice, pastoral counseling, human services); a clinical practicum in a mental health field; 12 graduate credits in counseling; at least 1-year paid experience providing clinical supervised treatment to children with mental illness or serious emotional disturbance in a CASSP system (employed by or under contract to CYF/S/S/F, Juvenile Justice, Behavioral Health provider, Special Education, or D & A working with children); Act 33/34 clearances; FBI clearance if had residency out of state; have 3 professional references; and a physical exam, *or*;
- An individual with a graduate mental health degree (psychology, social work, community mental health, counseling education); act 33/34 clearances; FBI clearance if had residency out of state; 3 professional references, and a physical exam, *and*; a clinical practicum in a mental health field *or*; 2-years paid experience providing clinical supervised treatment to children with mental illness or serious emotional disturbance if no practicum or credits in counseling.

#### *Training for Host Home Therapist*

Host home therapists are required to take part in a 3-day pre-service training program, which focuses on clinical issues, treatment planning, and documentation. They must also attain 40 credit hours of training annually, with no more than 20 of these hours being provided by his/her direct supervisor.

Annual training may include monthly phone conferences with other clinical coordinators and training topics specific to the host home/client.

### *Supervision of Host Home Therapist*

The host home therapist must receive weekly supervision with a MA or PhD level supervisor. The supervisor of a host home therapist must have at least 1-year supervisory experience.

### ***IRT/CRR Host Home Case Manager***

#### *Qualifications for Host Home Case Manager*

The host home case manager must have the minimum of a Bachelor's Degree with at least 2 years experience working with children with behavioral health disorders. He/she must also have act 33/34 clearance; FBI clearance if he/she has been an out of state resident; a physical exam, and 3 professional references.

#### *Training for Host Home Case Manager*

The host home case manager is required to have a minimum of 40 credit hours of training annually; however, no more than 20 of these hours can be provided by the case manager's direct supervisor. Annual training may include any topics specific to the case manager's host home/clients.

#### *Supervision of Host Home Case Manager*

The host home case manager must receive weekly supervision with a MA or PhD level supervisor. The supervisor of a host home case manager must have at least 1-year supervisory experience.

### ***IRT/CRR Host Home Supportive Staff***

#### *Qualifications for Host Home Supportive Staff*

The host home supportive staff must be a high school graduate or have earned a General Educational Development (GED). Experience in a social service setting is preferred. The supportive staff must also have act 33/34 clearance; FBI clearance if he/she has been an out of state resident; a physical exam, and 3 professional references.

#### *Training for Host Home Supportive Staff*

The host home supportive staff is required to have a minimum of 15 hours of training prior to working alone with a child or adolescent and an additional twenty-four hours of training within the first six months of working with children and adolescents. The overall training curriculum must include at least the following topics:

- Professional ethics, conduct, and legal issues, including child protective services and mandated reporting, and confidentiality;
- Understanding CASSP principles and implementing and supporting those principles in actual clinical practice;
- The role of the TSS worker in the home, school, and community, including the use of community resources to support the child/adolescent/family;
- Crisis intervention, behavior management, and safety;
- Overview of serious emotional disturbance and other behavioral needs in children and adolescents (with particular emphasis on the specific diagnoses of the children/adolescents with whom the TSS staff may be working);
- Collaboration with families;
- Normal child/adolescent development;
- Behavior management skills;
- CPR, first aid, universal precautions and safety;
- Documentation skills;
- Psychotropic medications, including common side effects.

#### *Supervision of Host Home Supportive Staff*

The host home supportive staff must receive weekly supervision with a BA level case manager or MA level therapist.

## *IRT/CRR Host Home Respite Services*

#### *Definition of Respite Services*

A respite home is an individual family home (other than host family) that is trained by the IRT/CRR Host Home Program that may be utilized up to a maximum of 2 days/month.

#### *Qualifications for Respite Services*

A respite home may consist of a one or two parent family. Respite parents must be at least 21 years of age, and must, at minimum be a high school graduate or have earned a GED equivalent. One or both parents are permitted to work outside of the home. In this instance, appropriate coverage must be provided to supervise the child when the parent(s) are not home. To qualify for a respite status, the respite family must take part in an initial interview, have at least 3 personal/professional references, obtain act 33/34 clearances, and obtain FBI clearances if either of the parents has resided out of the state. A home study must also be conducted to assure that the respite home environment meets CRR regulations. All members of the respite family must complete physical

examinations prior to obtaining respite status and annually thereafter. The number of children in a respite home cannot exceed 6 including natural children and only 1 - 3 children may be in substitute care at any given time.

#### *Training for Host Home Respite Services*

Respite parents are required to participate in 24 hours of pre-service training including topics such as first aid, CPR, medication management, fire safety, psychiatric diagnosis, crisis management, documentation, and behavioral management training. Respite parents are also required to have ongoing training including 24 hours/year of continuing education for the primary parent and 12 hours/year for the secondary parent. Continued education includes training topics such as CASSP principles, cultural competency, updates on pre-service training, nutrition, dietary, and training specific to the needs of the client and natural family.

#### *Supervision of Host Home Respite Services*

Both clinical and service supervision is conducted with respite parents. The respite family meets with the IRT/CRR Host Home parents prior to and at the conclusion of the respite stay to review specialized treatment plans and outcomes of the respite stay. The IRT/CRR Host Home Case manager meets with the respite to check the physical structure of the home and conduct a quarterly health and safety assessment and an annual home study.

## **REFERRAL PROCESS**

### **Access Standards**

#### *Best Practice Evaluations*

Prior to admission in an IRT/CRR Host Home, each child must receive an initial Best Practice evaluation conducted by a licensed psychiatrist or psychologist recommending IRT/CRR as the least restrictive, least intrusive treatment necessary to meet the behavioral health needs of the child. Best Practice re-evaluations must be conducted every 4 months to continue treatment in this level of care. The initial Best Practice evaluation expires after 60 days and re-evaluations after 45 days. The outline for the Best Practice evaluation following the Life Domain Format for Psychiatric/Psychological Evaluations, 2<sup>nd</sup>

edition, as defined by Dr. Hodas in the Guidelines for Best Practice in Child and Adolescent Mental Health Services, Copyright 2001, can be seen in Appendix I.

### *Psychiatric Services*

An initial psychiatric evaluation is completed within the first 30 days of treatment for each child in an IRT/CRR Host Home. If a child is on psychotropic medications, he/she is seen by the psychiatrist on a monthly basis for medication management. If a child is not prescribed any psychotropic medication, he/she must be seen at least annually by a psychiatrist.

## **Intake/Admission Procedures**

Prior to admission in an IRT/CRR Host Home, each child must receive an initial Best Practice evaluation conducted by a licensed psychiatrist or psychologist recommending IRT/CRR as the least restrictive, least intrusive treatment necessary to meet the behavioral health needs of the child. The referral entity (typically case manager or the RTF Group in Allegheny County) will contact the family within 48 hours after learning of the IRT/CRR Host Home referral. They will schedule an interagency service planning team (ISPT) based on the parent's availability. The family is educated about the admission process, which includes their rights, timelines for admission and paperwork, parents' choice of provider, attendance at the ISPT meeting, the ISPT process, physical health requirements, and financial abilities. The referring entity recognizes a verbal request from a psychiatrist or psychologist as the beginning of their processing for obtaining IRT/CRR Host Home treatment. The ISPT meeting will occur within 7 to 14 days from the date of the referral. If the child is in a psychiatric hospital, they are noted as priority and a meeting on the inpatient unit is scheduled immediately by the case manager or RTF group.

After the Best Practice evaluation has been completed, an Interagency Service Planning Team Meeting (ISPT) is held. The main goal of the ISPT is to gather input from all entities involved with the child including: the child, his/her legal guardian, community affiliates as defined by the child/family, a school representative, all behavioral health service providers involved with the child, the Community Care Behavioral Health Care Manager and the County MH/MR representative, to develop a comprehensive treatment plan. The ISPT provides a forum in which the child's unique needs can be addressed and the family and child's voice heard. By drawing on the contributions of individuals with multiple perspectives who best know the child, the ISPT can enable a unified approach, with a single plan and offer a structure for the potential attainment of unity among all involved stakeholders.

Once the ISPT members agree on IRT/CRR host home as the least restrictive/intrusive level of care that can meet the child/family's needs and treatment goals are defined, the treatment plan is written by the referral source, i.e., typically CYS or County MH/MR representative. The next several activities occur simultaneously to assure that the child enters treatment as soon as possible. The referral source sends the referral information to IRT/CRR Host Home providers and informs the child and natural family of possible host families/providers. The family chooses a provider. The referral source sends the IRT/CRR Host Home Packet to Community Care Behavioral Health to request an authorization for this level of care. Community Care reviews the IRT/CRR Host Home request and a decision is made based on Medical Necessity Criteria (MNC). If MNC is met, Community Care notifies the referral source/provider that the packet is approved. The IRT/CRR Host Home provider coordinates a face-to-face assessment by the IRT/CRR Host Home Intake Worker with child and natural family and determines if there is a match between a host home family and the child/family needing treatment. Some determining factors may include:

- Family requests
- Preferences – one or two parent home; race; religion;
- County of origin to ensure appropriate access to family treatment
- Other – gender of natural/foster kids in home; pets; educational system in host home community.

Once a Host Home family is identified, the IRT/CRR Host Home provider develops a transitional plan including the following steps:

- Member/family information is reviewed with the host home family.
- The natural family and host family meet.
- The member has an overnight visit at the host home, and subsequent overnight visits if necessary.
- Treatment goals are reviewed with the member, natural family and host home parent(s).
- Transition is based on child and natural family's needs.
- Funding sources are secured.
- The client moves to the host home.

## **MISA Screen**

In 1999, the report of the MISA Consortium emphasized the fact that early identification of the existence of co-occurring disorders is crucial to ensuring that individuals receive appropriate behavioral health services. The report of the MISA Consortium recommended an initial screening process and identified essential components of a MISA assessment, to be conducted at the point of entry into either the mental health or the drug and alcohol service delivery system.

Community Care is committed to furthering the implementation of the recommendations outlined in the MISA Consortium Report. Therefore, it is the expectation of Community Care that all members 12 years of age and older be screened for the presence of symptoms of mental health issues and issues related to alcohol and other drug usage. Within the first seven days of contact with a member or no later than the first continuing stay review, providers are expected to screen for the presence of mental health and substance abuse issues. The purpose of the screening process is to assess the member's immediate needs and whether emergency services are warranted. It is also our goal to ensure that all members are screened and then referred for an assessment for co-occurring disorders when indicated. Consistent with the 1999 MISA Consortium Report, the MISA screening process is to be conducted by appropriately trained individuals and is to identify:

- 1) Alcohol and other drug issues
  - a) Substances used and intensity of use
  - b) Likelihood and severity of withdrawal
  - c) Medical and behavioral risk secondary to intoxication
- 2) Mental health issues
  - a) Suicidal, homicidal ideation/intentions/plans/history
  - b) Impairment of function and/or judgment
- 3) Medical issues
  - a) Pregnancy
  - b) Conditions posing an immediate risk of harm to self or others
  - c) Current medications and recent ingestions of any non-prescribed drugs or alcohol
- 4) Special needs
  - a) Barriers to access
  - b) Environmental risks

When contacting Community Care to request an initial authorization for services for a member, the care manager will ask if a MISA screening has been conducted for the member in question. All providers are expected to screen for the need for mental health services **and** drug and alcohol services for each individual that approaches them for treatment and to assist the member in accessing necessary services. Providers are also expected to re-assess for the existence of co-occurring disorders all those individuals that continue to receive services on at least an annual basis. When conducting routine medical chart audits, Community Care will determine provider compliance with this expectation for all levels of care. In addition, at site visits by our Credentialing Department, Community Care will ask for verification that providers have a policy and procedure in place that demonstrates the provider's commitment to assess all of the individuals they serve for mental health and substance abuse issues.

## **ADMISSION PROCESS**

## Targeted Member/Client Population

Children and adolescents under the age of 21 with an Axis I Diagnosis (MR or D&A cannot stand alone) are eligible for IRT/CRR Host Home treatment. Members targeted for this level of care need a 24-hr/day structured environment to support his/her efforts to meet basic needs, utilize appropriate judgment, coping skills and comply with treatment due to severe mental/emotional illness and/or a behavioral disorder; however, the risk of safety to self and others is manageable in the community. Treatment needs for these children cannot be appropriately met in their current living environment, i.e., at home, even if services were delivered in the home/community, and/or in a RTF or inpatient unit because a less intensive/restrictive setting is needed for a step-down or transition. The child/adolescent must be able to function and participate safely in age-appropriate, community-based activities for limited periods of time with appropriate supervision and support. The child/adolescent must be involved in individual treatment and case management as identified in the treatment plan and provided by the IRT/CRR Host Home as well as other treatment services recommended by the team, which may include a psychiatric evaluation, medication management, group therapy, or other therapies as indicated in the treatment plan. In addition, the parent/guardian and child must be involved in the treatment planning process and agreeable to participate in face-to-face sessions with IRT/CRR Host Home provider on at least a weekly basis.

## Medical Necessity Criteria

The IRT/CRR Host Home MNC can be reviewed in Attachment 1.

## TREATMENT PLANNING PROCESS

### Treatment Planning Standards

The IRT/CRR Host Home Treatment Plan must follow the Life Domain format which is comprised of the following components:

1. *Child and Family Strengths*: including interests, abilities, activities, competencies, and past progress in treatment

2. *Needs, Concerns and Problems*: including a specific description of symptoms and behaviors as described in the best practice evaluation or ISPT. Both symptoms and behaviors must be operationally defined, i.e., what does the symptom/behavior look like or consist of for the specific child, including current rates, i.e., frequency, intensity, and domain in which the symptom or behavior is occurring. Problems identified in the treatment plan should also be prioritized making it easy for the child, family, and all other ISPT members to identify the problems being targeted during the current treatment period vs. those that will be targeted at a later date.
3. *Statement of Goals and Measurable Objectives*: A goal is a global statement that reflects a positive resolution to the identified need or problem and indicates the specific area of functioning to be addressed, including an expected outcome. The objective is directly related to a specified goal, but is highly specific and identifies measurable steps toward achievement of the goal. Each problem targeted in the current treatment period must have a corresponding goal with measurable objectives, or steps leading to the attainment of the goal.
4. *Methods/Interventions*: answering who, what, where, how, and how often, i.e.,
  - Who is responsible for implementing each objective, i.e., the Host Home parent, child, parent, babysitter, teacher, or Boy Scout leader?
  - What is each person responsible for?
  - Where, or in what setting or circumstance is this to occur?
  - How – what is the specific method of intervention to address the concern (the behavior plan, the skill being taught).
  - How often – identify the expected rate of intervention.
5. *Target Date*: identify the date each objective is expected to be complete/attained.
6. *Completion Date*: identify the date each objective was actually completed/attained.
7. *Signatures*: Each participant should sign the treatment plan to indicate that they agree with the treatment goals, interventions and their role in the treatment process. In addition, each participant should be clearly identified by name and role within the treatment plan as well as in the signature section.
8. *Comments Section (Update on Progress or Lack of Progress)*: This section includes the following information:
  - Describe actual rates of target behaviors
  - Skill acquisition by child and family

- Child/family's response to treatment
- Obstacles to treatment
- Special Circumstances

In addition to the components defined via the Life Domain format, the following *Domains* must be addressed in the IRT/CRR Host Home Treatment Plan:

1. *Family Legal Guardians* includes goals related to the family and the identified patient as part of the family unit and building natural (family) supports. The family domain identifies goals for both the host home and the biological family. Therapeutic leaves are documented in this section. Family strengths, needs and goals are identified as well as any progress that is made. The reintegration progress is specifically defined in the treatment plan, i.e., discharge resources/caretakers are discussed in this section as well.
2. *Educational/Vocational* includes goals related to the child's school or job. The school domain addresses the child's home school as well as the school the child is attending in the host home. Both school districts have input into the school goals in this domain.
3. *Peer* includes all goals related to peers in school and in the community, i.e., social skills development, development or maintenance of positive peer relationships.
4. *Physical/Environment/Structure* includes safety concerns in the child's living environment, i.e., elopement when it is a safety risk, unsafe neighborhood, when the child's basic needs are not being met.
5. *Leisure/Recreation* includes leisure/recreation needs of the child i.e., building community resources, identifying hobbies, special interests. The leisure/recreation domain includes community resources in the child's host home neighborhood as well as in his/her natural community.
6. *Psychiatric/Psychological* identifies behavioral health needs of the child up and above BHR services, i.e., medication evaluation/management, specialized therapeutic needs, groups, crisis services. Medications and medication visits are updated monthly in the psychiatric/psychological domain.
7. *Referral/Consultation* identifies any referrals that need to be made in any service system, i.e., referral for a psychiatric evaluation, ICM, Social skills group, evaluation for special education, physical exam, neurology consult, sex abuse counseling.

8. *Special Considerations* identifies any other need to make treatment successful that is not outlined in any other domain, i.e., transportation needs, need for interpreters, need for use of adaptive equipment for communication, CYS/juvenile justice involvement, D & A needs, ...
9. A *crisis plan* individualized for the child/family is developed and included in each child's treatment plan.
10. *Individualized behavioral plans* are developed as needed and attached to the child's treatment plan.
11. *Progress is reviewed* for all domains on a monthly basis and written into the existing plan at least every 60 days.

## **Timelines for Initial Treatment Plans and Treatment Plan Reviews**

Treatment plan timelines for CCBH authorizations and funding purposes include the following:

- An initial ISPT meeting takes place, with the referral source as lead, within 7 to 14 days from the referral. The ISPT meeting identifies treatment goals for IRT/CRR Host Home treatment prior to the identification of a provider;
- The initial treatment plan is submitted with the packet to request IRT/CRR Host Home treatment via the referral source
- The initial treatment plan is further developed by the provider within the first 30 days of treatment via an ISPT;
- An ISPT is held 45 days after treatment begins to develop treatment goals and review progress for the re-authorization;
- An ISPT treatment plan review is due every 90 days thereafter for reauthorization

Treatment plan timelines for treatment plan reviews for clinical purposes (as defined in CRR regulations) include the following:

- The initial tx plan is developed by referring agency
- The IRT/CRR provider further develops the initial tx plan within 30 days of the child residing in the host home
- Treatment plans are reviewed and adjusted on a monthly basis with the child, family (host home and biological family) and treatment team
- A written treatment plan update is completed every 60 days via an ISPT

## **Interagency Service Planning Team Meetings (ISPT's)**

The interagency team, through its formal meetings and its follow-up activities, is expected to play a key role in planning, implementing, and monitoring the child's treatment. The interagency team (ITM) has more than regulatory relevance, however. It embodies CASSP Principles in action. For example, the ITM provides a forum in which the child's unique needs can be addressed and the family's and child's voice heard (CASSP Principles #1 and 2: child-centered and family-focused). By drawing on the contributions of individuals with multiple perspectives who know the child, the ITM can enable different mandates and interests to be reconciled and a unified approach, with a single plan, developed (CASSP Principles #4: multi-system). In addition, the team draws upon natural supports and community resource persons (CASSP Principles #3 and 5: community-based and cultural competence). The clinical focus of the team plan is to help the child remain at home and in the community whenever possible, and to promote self-sufficiency as part of treatment (CASSP Principles #6: least restrictive/least intrusive).

An effective ITM has two principal goals that set into motion an ongoing process to address the unique needs of the child and family. These goals are: a) to create a context for restoring hope to the child and family and b) to promote constructive, collaborative treatment planning to benefit the child and family.

In Pennsylvania, the ITM occurs after a formal evaluation has already occurred, basic information has been gathered, and IRT/CRR Host Home has been recommended as the least restrictive level of behavioral health treatment necessary to adequately meet the child and family's mental health needs. The initial ISPT meeting takes place prior to the child's admission to the IRT/CRR Host Home. At minimum, the following individuals should be present at this meeting, the child's legal guardian; a representative from the child's school; the child's current behavioral health service provider; the Care Manager from the MCO, and the County MH/MH representative. An exception may involve the participation of school representatives if the parents object and the child is not expected to receive mental health services in the school. Another possibility is that the family desires limited participation by a particular system representative. This situation may arise when the family wants the school to participate but prefers that school staff not have extensive information about home events. In this situation, it may be appropriate, through a prior-arranged process, to invite the school representative(s) to "visit" with the rest of the team to provide information about the child in the school setting sometime at the beginning of the meeting and then leave. In addition, every effort should be made to obtain the participation of the prescriber at this meeting. Ideally, this occurs face-to-face, however, if this is not feasible, then telephone participation is preferable to none at all. If the ISPT agrees that IRT/CRR Host Home is the most appropriate treatment option, the case manager or RTF group sends the referral to IRT/CRR Host Home providers and develops the initial treatment plan. The ISPT also develops an interim and safety plan so that active treatment is occurring on some level while the child is waiting for admission the IRT/CRR Host Home. This is completed to support the child and maintain him in the community setting that will secure his safety and reduce the possibilities of behavior deterioration. If the ISPT determines that IRT/CRR Host Home services do not appear

appropriate for the child and family, the case manager/RTF group makes a referral to another level of care and/or support services deemed more appropriate.

Additional ISPT's take place during specific time increments to further develop the treatment plan at different stages in treatment. The 30-day ISPT functions to develop the initial treatment plan. A third ISPT is held within 45 days of admission to update the treatment plan for the second waiver period. ISPT's are then held every 90-days to further develop and update the treatment and disposition plans. A discharge ISPT is conducted with the treatment team, discharge provider(s), discharge caregivers, and other discharge resources to review the child and family's progress, disposition plan, status of referrals, and to identify treatment and service start dates and the dates of community resources that have been initiated during disposition planning.

In order to avoid being "just one more meeting" that exacerbates feelings of futility, the ITM should not begin with another recitation of "what's wrong" with the child or family or a litany of the most pressing problems. Similarly, the meeting need not elaborate on every past service failure. It is also important to be realistic about time expectations. In most instances, an ITM cannot be completed in a single hour. It is also appropriate to guarantee that the appropriate stakeholders are present at the ISPT meeting because informed and meaningful decisions cannot be made until the right people are at the table. The child's parents should be encouraged to invite anyone to the ISPT that will provide support to the family and child. Professionals should take into consideration that families will not automatically understand that they can invite community support persons to an ITM unless they are informed of this option and encouraged to do so before hand.

To be effective, an ITM needs to be guided by established ground-rules and stages. Such structure helps set a constructive tone to the process, ensure that key issues are addressed, and promote effective use of time. Since there is more than one effective meeting protocol, the primary issues are a) that there be a protocol and b) that an individual familiar with it be designated as the meeting facilitator. When this occurs, the meeting is likely to flow smoothly. The meeting facilitator may be the same individual who invites and recruits participants, or a different individual. The identification of this individual is best made prior to the start of the actual meeting. The meeting facilitator may be the case manager, a therapist or other mental health professional, a wraparound coordinator, a school counselor, or a family member. It is the responsibility of the meeting facilitator to start the meeting, explain the protocol, initiate introductions, and make other initial comments, as indicated.

Most ITM protocols share eight core elements:

A. Early discussion of strengths

Following the initial team building stage of the ITM, substantive discussion of the child and family should begin with strengths, not with problems, concerns, limitations, or

failures. A meeting that begins with a focus on pathology is likely to activate feelings of pessimism.

#### B. Concern with child in multiple life domains:

Regardless of the child's specific presenting concerns, the interagency team is interested in the whole child, understood in multiple life contexts (also known as life domains) and also within a developmental framework. Therefore, a treatment plan that only addresses specific problematic behaviors of the child without also promoting the child's attainment of age-appropriate functioning is not consistent with a wraparound approach. Life domains may include: Spiritual; Family; Community; Friends/Social; Health; Emotional; Legal; Work; Educational; Safety; Cultural; and Others.

The key point is that an appropriate group of life domains be addressed, to ensure that each child is considered comprehensively, not just in terms of behaviors, symptoms, and disorders. When a child is considered comprehensively, information comes directly from the child and family through the psychiatric or psychological interview and the ITM, not solely through written information and the judgment of professionals.

#### C. Avoidance of premature discussion of services:

Service decisions, when appropriately determined, are made near the end of the meeting, not at the outset. It is only after identifying strengths, goals, barriers, and available resources at hand that a team is ready to consider professional services. Premature discussion of services, even if well intentioned, bypasses the important information gathering and team building processes.

#### D. Active participation by family:

An effective ITM is one in which family members offer their points of view early in the process. Active and early family participation is important not only because of the family's valuable perspectives offered but also as a way to signal to child and family that this meeting is for them and that they are equal participants in the process. If the parents and child do not offer their ideas spontaneously, it is the responsibility of the meeting facilitator to enlist their participation in a non-threatening manner.

#### E. Inclusion of a group envisioning process:

The reason for the formation of the interagency team and the convening of the ITM is the presence of a child, functioning unsuccessfully in the current setting, who is at risk of endangerment and/or more restrictive placement and more intrusive treatment. For an ITM to be effective and for wraparound to be successful, there needs to be a collective capacity of team members to move beyond the present in an imaginative manner, in order to envision desired outcomes.

F. There is delineation of tasks and responsibilities prior to the end of the meeting:

Since the goal of the ITM is to identify a plan to help the child and the family, it is essential that there be clarity about the tasks and responsibilities of various team members, including the child and parent themselves.

G. Other interagency tasks prior to ending the meeting include identifying the following:

1. Identify the individual responsible for completing the treatment plan with the child and family.
2. Identify the individual responsible for completing the necessary paper work and submitting the formal request.
3. Identify the individual responsible for completing the meeting notes and distributing them to all team members.
4. Identify the individual responsible for contacting team members absent from the meeting, to keep them in the loop.
5. Identify the individual(s) responsible for contacting community agencies and natural supports identified during the meeting.
6. Identify the individuals responsible during a crisis, and the nature of their specific roles.
7. Identify the individuals who will follow through with other identified tasks and interfaces.
8. Determine the mechanism for communication between meetings, and clarity as to the next meeting.

### **Linkages to Natural and Community Supports**

Natural supports are those resources being used, or potentially available for use, by the child and family within the community, which do not involve formal behavioral health services, and which are consistent with the cultural beliefs and practices of the child and family. Natural supports may involve activities, community institutions, key resource individuals outside the immediate family, community beliefs, and a variety of informal supports found in the neighborhood or larger community. Natural resources are external to the child and family and, once accessed through active affiliation, become part of the child's and family's strengths.

Natural supports help to normalize the child's life. As the child's life becomes more normalized and more "typical" of that of others, the child becomes less isolated and lonely. Participation in appropriately-chosen activities-such as a summer reading program, Scouts, a YMCA/YWCA program-enables the child to expand interests and experience competence and spontaneity.

Natural supports also can also help the child's parents. Self-help groups for parents can be invaluable in sharing information and offering support. Neighbors and extended kin can help during times of crisis, and also offer the parents some time alone, by staying with the child in question or all of the children.

Finally, it should be appreciated that natural supports are important not just for children with mental health issues, but for all children. It is through use of natural supports that the child develops friendships, community ties, and competence in the real world.

Although the use of natural resources is often limited during a time of crisis, or when services are initiated, consideration of available or potentially available community supports should occur so that the treatment offered is holistic. Over time as symptoms and behaviors stabilize there is additional opportunity to explore those individualized natural supports suitable to the child and family. The balance between professional services and natural supports shifts over time as the child and family symptoms get better. This shift in balance enables services to be tapered and eventually discontinued. When there is total or primary reliance on behavioral health services, it may never seem like the right time to discontinue services, and the transition, when it does occur, may be difficult.

The first authority on community resources is always the family itself. In addition, it takes professionals who are knowledgeable about communities in general and the child's community in particular to assist in the identification process. The case manager can play an indispensable role here. In general, the training of many mental health professionals tends to overlook the need to identify and incorporate community resources into the treatment process.

Natural support and community linkages are a vital part of IRT/CRR Host Home treatment. To begin the process of identifying areas of potential interest, an interest inventory is conducted with the child during the intake process. An initial assessment of the home and community resources for both the host home and natural home environments is conducted within the first 30 days of treatment. The treatment team then assists the child and family to develop goals to incorporate natural and community resources in the host home community (and natural community if possible) into the treatment plan. To prepare the child and family for discharge to home, the home and community resources for the natural community should be updated and individualized within 6 months prior to discharge. Prior to the child's discharge home, the resources of interest to the child and family in the natural community are identified and connections made for the child and family to be an active participant in these activities prior to discharge from the IRT/CRR Host Home. These activities should be well documented in the child's discharge plan to allow the follow up level of care to pick right up where the IRT/CRR Host Home left off.

### **Coordination of Care w/Other BH Service Providers and Service Systems**

As thoroughly discussed above, the interagency team meetings, which are held at a least every 4 months, serve as a unique structure in which coordination of care with other behavioral service providers and service systems can be accomplished. The interagency team includes a variety of individuals with expertise from other behavioral health service providers as well as other service systems. In addition, this team also

includes the child, family and community participants in an effort to provide a unique mechanism in which the child's needs can be met in a holistic way.

### **Service Systems**

All service systems currently involved with the child prior to treatment in an IRT-CRR Host home are included as a member of the Interagency Team. In addition, any service system becoming involved with the child during treatment is added as an Interagency Team member. The Interagency Team Meetings are held at least every 4 months encourage the coordination of care of all service systems as well as the child, family and community participants.

### **Assuring Cultural Competency**

According to CASSP principles, mental health professionals are required to address the cultural strengths and needs of each child and the child's family and recognize the impact of these strengths and needs on service delivery. Cultural competence has a direct impact on service delivery, and requires planning that incorporates the family as equal partners in the process. Culture has an impact on how the family defines itself, on who should be included in the assessment process, the language to be used in providing services, and the appropriateness of particular service modalities.

The fifth CASSP principle requires that multiple cultural factors be included in the formulation of services and treatment plans. Since few professionals are trained to address these factors, initial and ongoing training is required to assure that multiple dimensions of culture are being explored and appropriately documented for each child and family.

Within a "wraparound perspective", the concept of relevant information includes; the child's strengths and interests, the family's religious and cultural beliefs, community resources, and the child and family's ideas about treatment. The assumption by wraparound staff is that each family and each constellation of family resources are unique and must be discovered. As the child and family are asked about and given the opportunity to discuss strengths, accomplishments, cultural needs and goals, the stigma associated with receiving help often decreases and the process becomes safer and more productive. In taking cultural competency into consideration during any level of behavioral health treatment, goals should be set by considering the functioning of a typical student from the same cultural background as the child in treatment who is doing well (Hodas, 1996).

## **DISCHARGE PLANNING PROCESS**

### **Disposition Planning**

Discharge planning from IRT/CRR Host Home Treatment should begin on the day of admission. The child, family and treatment team should identify measurable goals and objectives for treatment which are individualized for the child and family. These goals should clearly define measurable discharge expectations for the child and family, i.e. what he/she/they will look like at discharge. This way the child and family will know exactly what they must accomplish to be discharged from this level of care. Disposition plans must be individualized to meet the child's needs and may include; returning to a family member's home, permanent foster care/group home placement or independent living.

Within 30 – 60 days of discharge the IRT/CRR host home team should conduct an assessment of the community resources specific to the child's discharge community. This way specific home and community resources can be identified and the referral process and/or involvement in these resources completed prior to the child's discharge. ISPT discharge meetings should also begin within this time frame and be scheduled as often as necessary to complete all tasks, referrals, and treatment transitions prior to the day of discharge. These ISPT's should be conducted with the treatment team, discharge provider(s), and other discharge resources and review the IRT/CRR treatment progress, disposition plan, status of referrals, and identify treatment start dates.

Referrals to all professional services (mental health, D & A, education, CYS, JPO, ...) must be made and appointment dates secured prior to discharge. If agreed upon by the ISPT, some services may begin 30 days prior to discharge from the IRT/CRR host home to ensure continuity of care and a smooth transitional period. On the day of discharge all appointments, contact names and phone numbers must be given to the child/family/discharge caretaker and discharge resources to assure continuity of care.

A written discharge summary must be completed by the provider and submitted to Community Care within 14 days of discharge from the IRT/CRR host home. Appropriate releases should also be completed so the discharge summary can be given to the treatment team, discharge resources and discharge providers by the providing agency.

A Community Care care manager will provide follow-up to the child/family within 1 week of receipt of the discharge summary to assure that follow-up treatment is occurring as planned.

## **Transition of Services**

### Therapeutic Leave Process

A therapeutic leave is a period of overnight absence from the IRT/CRR Host home setting directly related to the child's treatment. The therapeutic leave is part of the child's individual treatment program which gives the child and his/her parents/guardians/discharge caregivers the ability to stay together and practice the skills they are acquiring via the IRT/CRR Host home treatment. The IRT/CRR Host home

where the child is currently receiving treatment is responsible both clinically and fiscally for mental health services the recipient may require while on leave.

Therapeutic leaves should begin as soon as the child, his/her parent/guardian/discharge caregiver, and the IRT/CRR Host Home clinicians have indicated that they are ready to begin. Treatment goals are developed for therapeutic leaves. Specific objectives are defined for the child and family for each therapeutic leave and reviewed with them by the clinical staff prior to the leave beginning. Upon return from each therapeutic leave, the objectives are discussed to determine if they have been met. This information is documented via the clinical notes by the host home parent.

Prior to a child going on a therapeutic leave he/she may begin to have day visits with his/her family. Specific objectives are also defined for day visits. The child and family's success in meeting these objectives are reviewed and documented upon the child's return to the IRT/CRR Host home. Once successful day visits have taken place, therapeutic leaves should follow.

Day visits and therapeutic leaves are a crucial part of IRT/CRR Host home treatment and are aimed at encouraging the child's discharge from the IRT/CRR Host home and return to the home community at the earliest possible time. Day visits and therapeutic leaves should, therefore, not be used as a reward for behavioral contingencies. There is no limit to the number of day visits and therapeutic leave days a child can have. Inpatient stays are not considered therapeutic leaves.

Most providers pay the host parent a percentage of the daily rate when the child is in the hospital or on a therapeutic leave, however, this is not required. IRT/CRR's do not get reimbursed from the MCO for inpatient days.

### Inpatient Treatment

According to the Medical Assistance Bulletin, when a recipient is admitted for a continuous 24-hour period to an acute care general hospital, rehabilitation hospital or rehabilitation unit of an acute care general hospital, psychiatric hospital or psychiatric unit of an acute care general hospital and the child is expected to return to the IRT/CRR Host home, Community Care will make a payment to the IRT/CRR Host home to reserve the bed for the child's return to the IRT/CRR Host home. Either the same or a comparable bed must be available for the recipient upon return to the facility. Payment for a hospital reserved bed day is one-third of the facility's per diem payment rate and is limited to 15 days per child per calendar year. This 15-day per calendar year limit is cumulative and applies regardless of whether the child received continuous or intermittent treatment at one or more RTF's and/or IRT/CRR Host homes or was admitted to one or more hospitals or units during the calendar year. Hospital reserved bed days in excess of 15 days per calendar year are a non-compensable service, and as such may be billed to the recipient under the conditions to Chapter 1101.63(a). If the reserved bed days paid for the Department are exhausted and return to the IRT/CRR Host home is medically necessary

but the recipient did not pay to reserve the bed, the child will be returned to the IRT/CRR Host Home's first available comparable bed.

## **Diversion Planning**

IRT/CRR Host home treatment is sometimes used as a diversion from an inpatient or RTF stay; however, it may also be used as a step-down from these levels of care.

# **QUALITY IMPROVEMENT/DOCUMENTATION STANDARDS**

## **Documentation Prior to Referral**

Prior to referral to IRT/CRR Host Home the following tasks must be completed and documented:

1. A Best Practice evaluation is completed referring the child to the IRT/CRR Host Home
2. County CASSP meeting or ISPT is held
3. The child's IEP or school records are requested and received by the referral source and/or treatment provider
4. The child must undergo a physical examination
5. If applicable, court records are requested and received by the referral source and/or treatment provider

## **Packet for MCO Authorization**

The packet submitted to Community Care for authorization for this level of care must include:

1. The completed Best Practice evaluation
2. The ISPT signature page
3. A Confidentiality Statement
4. The Family Choice Notification Form
5. The IRT/CRR Treatment Plan
6. The Plan Of Care Summary
7. A mini home study if more than one child is being considered for IRT/CRR Host Home treatment in the same host home

## **Intake Packet**

The Intake packet includes the following documentation and is housed at the treating facility:

1. Child's demographics
2. A Social History
3. Releases of information

4. Treatment consent forms
5. Patient Rights
6. The Service Agreement
7. The Grievance policy
8. Individualized Residential service plan (IRSP) – includes outcomes/baseline data in some capacity, i.e., self-made scale or standardized measure
9. Demographics of the host home family
10. A visitation plan
11. A proactive safety plan
12. An Emergency Plan – part of IRSP (Individual Residential Service Plan) which includes step by step instructions on how to handle the child's problem behaviors
13. Parental signatures indicating that they have reviewed the IRT/CRR HOST HOME policies and procedures
14. The compensation agreement for host home family
15. The authorization from county for room and board

### **Treatment Documentation**

The following information must be documented accordingly by the provider in the child's chart:

1. Daily progress notes must be completed by the host home parents
2. Monthly treatment summaries must be completed by the masters (MA) level clinician or program coordinator
3. The clinical treatment plan is completed by the lead MA level clinician
4. Clinical progress notes are written by the MA level staff for every contact
5. The program coordinator writes a progress notes for each contact
6. IRSP review is completed every 60 days by program coordinator, including review of the visitation plan
7. A safety assessment is completed by the MA level clinician or Program coordinator following every visit
8. Incident reports are completed for any unusual incident as per the State policy
9. A visitation report is completed by the host home family upon return from each day visit or therapeutic leave
10. A review of the host home is completed annually
11. The host home parents receive monthly supervision from the IRT/CRR HOST HOME provider
12. IRT/CRR HOST HOME staff and host home parents receive a minimum of 24 hours of documented training

### **Discharge Documentation**

The following documentation must be completed for each child upon discharge from the IRT/CRR Host home:

1. A discharge summary is prepared by the MA level clinician or program coordinator within 2 weeks of discharge. The summary must include the disposition plan. The facility should also obtain the appropriate releases such that the MCO, county, parent, new service provider, and others as needed, receive the discharge summary.
2. All referrals for behavioral health services and to other service systems for continued care must be made by the IRT/CRR HOST HOME provider.
3. After the child is discharged from the IRT/CRR Host home, the Community Care care manager will follow up to assure that appointments have been attended.

# **APPENDICES**

**APPENDIX I**  
**LIFE DOMAIN FORMAT FOR**  
**PSYCHIATRIC/PSYCHOLOGICAL EVALUATIONS:**  
**INITIAL AND CONTINUED CARE**

2<sup>nd</sup> Edition

Note: This format is applicable to both initial and continued care evaluations. However, when writing an evaluation for continued care, it is recommended that Section III, Relevant Information, begin with an additional subheading called Brief Update that identifies and briefly summarizes the key events and changes during the most recent service period. The remainder of Relevant Information then follows the usual format (e.g., Strengths, Concerns, Etc).

**I. Identifying Information:**

- A. Places the child in individual, family, cultural, residential, and educational/vocational contexts (e.g., age, date of birth, gender, race, ethnicity, cultural/religious beliefs, name and grade in school, type of class setting).
- B. Identifies family and household members, including each biological parent, stepparents, siblings/half-siblings. Identifies marital status of parents, and nature of child's contact with a non-custodial parent. Identifies employment status of current parental caregivers.
- C. Identifies custody of the child, and child's legal status (e.g., adjudicated or not). Identifies other team members, including involved professional agencies/systems (e.g., MH/MR, C&Y, juvenile justice, case management, child psychiatrist, special education, etc.) and community supports.

**II. Reason for Referral:**

- A. Determine medical necessity for initial care or continued care service request.
- B. Identify additional purposes, as relevant (e.g., monitor medication, respond to crisis).

**III. Relevant Information** (begin with *Brief Update*, if a continued care request):

*A. Strengths:*

- Child/adolescent strengths, in multiple domains.
- Special attention to motivation and ability to form relationships and use support.
- Areas of greatest competence and independence.
- Family and community strengths.

*B. Concerns:*

- Clinical basis for current service request and recommended treatment.
- Nature, frequency, severity, and history of the child's behaviors/symptoms/ serious emotional disturbance (SED) of concern.

- Identification of both externalized behaviors and internalized symptoms, comparing present to past.
- Other identified needs and concerns.

C. *Family:*

- Family composition (including relevant extended family), family relationships, strengths/concerns.
- For child in substitute care, foster family and natural family included.
- Family cultural and spiritual beliefs and practices, as relevant.
- Family history of psychiatric disorder, as relevant.

D. *School/Vocational:*

- The child's academic, social, and behavioral adaptations, including relationships with school peers and with teachers and/or level of functioning in vocational programming.
- Efforts to date of school to address current problems. Characteristics of current class setting.
- Current or past use of school-based services, if relevant.
- Current or past educational testing, CER, and IEF. • Prior school placements.

E. *Community:*

- Place of residence-family home or apartment, group home, RTF, etc.
- Community activities and attachments.
- Use of leisure time.
- Community employment, current and in past.
- Degree of church or spiritual involvement.
- Nature of neighborhood, in terms of resources and culture, safety, specific conditions.
- Specific stressors, as relevant.

F. *Peer Relationships:*

- Patterns of peer relationships in the neighborhood and in school, including similarities and differences between the two settings.
- Predominant age of peers-same-aged, older, or younger-and gender of relationships.
- Predominant activities with peers, formal and informal. Nature of peer culture.

G. *Drug and Alcohol:*

- Child's current use/abuse of drugs and alcohol-type, frequency, severity.
- Child's past history of use.
- Child's past drug and alcohol treatment, response to treatment, involvement in self- help groups.
- Family substance abuse history, where relevant, including nature of use, type and effectiveness of treatment.

H. *Medical/Developmental:*

- Medical illness, acute or chronic infection, physical limitation, brain or other injury, past surgery.
- Lead or other toxicity.
- Medication allergies as relevant.
- Developmental history: pregnancy, delivery, neonatal period, developmental milestones.
- Mental retardation, atypical development, autism/PDD.
- Trauma history: neglect, physical abuse, or sexual abuse.
- Gender preference, when relevant and with consent of the child, and other issues of sexuality. Past pregnancy, when relevant.

I. *Legal:*

- Custody.
- Adjudication as delinquent or dependent.
- Other delinquent status indicators: probation, placement in juvenile facility, incarceration.
- Outstanding legal issues: pending charges, community service requirement, other.

J. *Services:*

Service History:

- Services used in past, reason, level of participation, and effectiveness. Include all levels of care, psychotropic medication, out-of-home placements (mental health and other), and services from other systems.

Service Update.

- Current services-including hours and sites-with summary of recent service history.
- Impact of services:
  - Role of service providers and of family.
  - Progress/degree of attainment of treatment goals and objectives. Identify effective and ineffective interventions.
  - Receptivity of the child and family to services, and level of participation.
- Nature of planned modifications of goals and services.
- Specific indications for, and use of, psychotropic medication. Include names and dosages and, where applicable, blood levels. Indicate medication adherence and effectiveness of medication, when in use.
- Nature of regular clinical updates to prescriber by involved mental health staff, during most recent service period.

K. *Other:*

- Other domains as relevant, or added to earlier information.

**IV. Interview:**

- A. Identification of participants.
- B. The child/adolescent's appearance, hygiene, self-care.
- C. The child/adolescent's manner of relating to the interviewer and other identified adults present. Emphasis on level of engagement, cooperation, openness to input.
- D. The child/adolescent's formal mental status. Include verbalized goals, needs, requests, response and commitment to treatment, degree of understanding and insight, other individualized ideas of the child/adolescent, and ability to contract for safety, when relevant. Compare with previous contacts, if applicable.
- E. Key issues/themes addressed, and areas of agreement/consensus.

**V. Discussion:**

- A. Overview/summary.
- B. Hypothesis/formulation.
- C. Diagnostic considerations.
- D. Rationale for recommended services.
- E. Nature of consensus and agreements with the child/adolescent, family if present, and others.
- F. Prognosis.

**VI. Diagnosis:** 5-Axis diagnosis.

**VII. Recommendations:**

- A. Identification of each specific behavioral health service recommended, listing the amount, duration, and scope of each.
- B. Other treatment recommendations, both global and specific (e.g., other needed services and interventions for the team to consider; psychotropic medication referral or recommendation; additional recommended assessment(s); community referral(s) and natural supports; education and/or vocational recommendations; consultation with primary care physician; other)
- C. For continued care requests, criteria for service tapering or modification of level of care, and recommendations to increase natural supports.

**APPENDIX II**  
**INDIVIDUAL RESIDENTIAL TREATMENT (IRT)/COMMUNITY**  
**RESIDENTIAL REHABILITATION (CRR) HOST HOME**  
**MEDICAL NECESSITY CRITERIA**

**SECTION I: INDIVIDUAL RESIDENTIAL TREATMENT (IRT)/COMMUNITY  
RESIDENTIAL REHABILITATION (CRR) HOST HOME MEDICAL  
NECESSITY CRITERIA**

**All of the** following criteria in Sections 1 and 2 must be met for admission to an IRT/CRR Host Home

1. A Best Practice (BP) evaluation following the Life Domain Format for Psychiatric/Psychological Evaluations, 2<sup>nd</sup> edition, as defined by Dr. Hodas in the *Guidelines for Best Practice in Child and Adolescent Mental Health Services, Copyright 2001*, must be completed by a psychiatrist or a licensed psychologist prior to admission; **and**
2. The strengths-based BP evaluation must identify strengths of the child, family, community, and natural resources; **and**
3. The BP eval documents an Axis I Diagnosis (MR or D&A cannot stand alone); **and**
4. The BP eval indicates that, due to severe mental/emotional illness and/or a behavioral disorder, a 24-hr/day structured environment is necessary for the child/adolescent to support his/her efforts to meet basic needs, utilize appropriate judgment, coping skills and comply with treatment. (24-hr supervision and observation may be provided by the Host Home family or professional staff from the IRT/CRR host home in this setting as needed); **and**
5. The BP eval indicates that IRT/CRR Host Home is the most appropriate and least restrictive level of care to meet the mental health needs of the child; **and**
6. If the child/adolescent has been involved in specialized treatment services, he/she has received treatment and symptoms have stabilized; and the child/adolescent is able to access continuing specialized mental health or drug and alcohol treatment services as needed while in this level of care; **and**
7. The child/adolescent is under the age of 21; **and**
8. The risk of safety to self and others is manageable in the community; **and**
9. The child needs services and support in order to function in the community; **and**
10. The parent/guardian and child are involved in the treatment planning process and agreeable to participate in IRT/CRR Host Home treatment; **and**
11. A less restrictive treatment setting has been provided and/or has been considered and reasons for its rejection have been documented, or the child is being discharged from a higher level of care and needs treatment in a IRT/CRR Host Home to obtain or sustain gains or to prevent further deterioration of symptoms. The child's behavior cannot be safely maintained in a lower level of care; **and**
12. The ISPT recommends IRT/CRR Host Home as the least restrictive and most clinically appropriate service for the child; **and**

13. The ISPT develops realistic and achievable treatment goals and discharge criteria for the child/adolescent and family; **and**
14. The ISPT must include the following participants:
  - a. the parent/legal guardian and child (if age 14 or older); **and**
  - b. the host home parent(s) for the Continued Stay Review(s); **and**
  - c. a representative from the child's home school district for the initial ISPT and from the host home school district for the Continued Stay Review(s); **and**
  - c. ICM/RC or county case manager

**SECTION II: SYMPTOMS SEVERITY FOR ADMISSION AND CONTINUED STAY**

1. The child's problematic behavior and/or severe functional impairment as indicated in the Best Practice Life Domain Psychiatric Evaluation must include at least one of the following:
  - a. suicidal/homicidal ideation
  - b. dangerous risk-taking behavior
  - c. aggression
  - d. psycho-physiological condition (i.e., an eating disorder)
  - e. psychomotor retardation or excitation
  - f. affect/function impairment (i.e., withdrawn, reclusive, labile, reactivity)
  - g. psychosocial functional impairment
  - h. thought impairment (i.e., psychosis)
  - i. cognitive impairment related to the child's psychiatric condition; **and**
2. The child demonstrates exacerbation or continues to display severely impaired judgment or functional capacity and capability (i.e., interpersonal skills and/or self-maintenance is severely compromised); **and**
3. If there is risk of harm to self, others, or property, the child with host home family and parent/guardian/caregiver develop and sign a safety plan; **and**
4. The child's treatment needs cannot be appropriately met in the current living environment(s), i.e.,
  - a. h  
ome, even if services were delivered in the home/community, and/or
  - b. R  
TF or inpatient unit because a less intensive/restrictive setting is needed for a step-down or transition; **and**
5. The child/adolescent is able to function and participate safely in age-appropriate, community-based activities for limited periods of time with appropriate supervision and support; **and**
6. Commitment to treatment by primary caregivers and child is documented

### **SECTION III: EXCLUSION CRITERIA FOR ADMISSION AND CONTINUED CARE**

**Any of the following criteria is sufficient for exclusion from this level of care:**

1. The child/adolescent currently exhibits severe suicidal or homicidal threats/attempts, acute mood symptoms, active psychosis, dangerous behavior or significant cognitive impairment which requires a more intensive level of behavioral health care; *or*
2. Child/adolescent has primary acute substance abuse problems requiring residential D & A treatment; *or*
3. The child/adolescent has medical conditions or impairments that prevent participation in services and/or require daily care that is beyond the usual program scope

### **SECTION IV: IRT/CRR HOST HOME CONTINUED STAY CRITERIA**

**All of the following criteria in Sections 2 and 4 must be met for continued stay in an IRT/CRR Host Home**

1. Initial diagnosis and evaluation is updated and revised as a result of a face-to-face BP evaluation by the treating psychiatrist or psychologist and the child/adolescent's special needs continue to meet medical necessity criteria at this level of care; *and*
2. Less restrictive treatment environments have been considered in consultation with the ISPT, and the ISPT recommends IRT/CRR Host Home as the least restrictive/intrusive and most clinically appropriate service for the child; *and*
3. Continued active intervention in IRT/CRR Host Home is likely to be of substantial benefit in achieving discharge goals; *and*
4. The symptom severity and updated treatment plan supports the likelihood that:
  - a. substantial benefit is expected as a result of continued active intervention in a IRT/CRR Host Home setting w/o which there is great risk of a recurrence of symptoms; *or*
  - b. Axis I symptom severity is such that treatment cannot be safely delivered at a lesser level of care (MR and D & A symptoms cannot stand alone); *and*
5. Care is rendered in a clinically appropriate manner and focused on the child/adolescent's behavioral and functional outcomes as described in the treatment plan; *and*
6. Service providers document efforts at least weekly to engage parent/legal guardians or discharge caregivers in the treatment process; *and*
7. There is documented active discharge and aftercare planning with the child and discharge caregivers; *and*
8. The ISPT review recommends continued stay and documents the need for further improvement, with the corresponding modifications in both the tx plan and discharge goals; *and*
9. ONE OF THE FOLLOWING MUST ALSO BE MET:

- a. Further progress must occur before transition to a lesser level of care is advisable; *or*
- b. Symptoms or behaviors that required admission continue with sufficient acuity that a lower level of care would be insufficient to stabilize the child's condition; *or*
- c. New symptoms meeting admission criteria have appeared

**SECTION V: IRT/CRR HOST HOME DISCHARGE CRITERIA**

**Any one of the following can be met for discharge from an IRT/CRR Host Home:**

- 1. The child/adolescent no longer meets Continued Stay Criteria for IRT/CRR Host Home (Section 2 and 4); *or*
- 2. Consensus is reached among all treatment team members that treatment plan goals and objectives have been substantially achieved and the child/adolescent is able to function with a less intensive level of care; *or*
- 3. The child exhibits severe disruptive or dangerous behavior which may include, but is not limited to, suicide or homicide attempt, symptoms of psychosis, drug addiction, fire setting, or sexual offending, requiring immediate attention in a more intensive level of care or an alternative placement with another child serving system; *or*
- 4. Child/adolescent's discharge criteria have been met and aftercare plan has been activated; *or*
- 5. Progress is not being made towards treatment goals and/or discharge criteria and there is no reasonable expectation of progress at this level of care (for example, the child/adolescent is unwilling to participate in treatment offered at this level of care); *or*
- 6. Parent/guardian or an adolescent who can legally consent requests termination of services, because of belief that service goals and objectives have been substantially achieved; *or*
- 7. Parent/guardian or an adolescent who can legally consent indicates the intention to terminate services despite efforts by the treatment team to address treatment concerns.