

Therapeutic Group Home – Promising Practice

Context

Community-based Therapeutic Group Homes (ThGHs), exemplified by the 14-day, crisis-oriented ThGH model used by Wraparound Milwaukee, represent a step forward from more traditional group homes in that they emphasize maintaining connections to the community. This model is emerging as a promising practice and reflects “practice-based evidence” in that the model incorporates many promising elements of successful community-based models. Ranging from four to eight beds, ThGHs using this model are located in residential communities in order to facilitate community integration through public education, recreation and maintenance of family connections. In addition, the homes provide a living setting that is far closer to a “normal” family existence than is possible to provide in larger residential settings. A youth’s ability to live in a manner that is closer to normal allows greater possibility for successful transition back to a family setting or to some form of independent living as young adults.

Providers deliver an array of clinical and related services within the home including: therapy (individual, group and family, whenever possible); nursing supports; ongoing psychiatric assessment and intervention (by a psychiatrist); recreational activities; integration with community resources (social, vocational, etc.); and life skills taught within the context of the home.

Definition of Institution

Each organization owning Therapeutic Group Homes must ensure that the definitions of institutions in Attachment 1 are observed and that in no instance does the operation of multiple ThGH facilities constitute operation of an Institution of Mental Disease. All new construction, newly acquired property or facility or new provider organization must comply with facility bed limitations not to exceed eight beds. Existing facilities may not add beds if the bed total would exceed eight beds in the facility. Existing facilities of greater than eight beds may continue at the existing capacity not to exceed 16 beds in the institution until alterations of the existing facility are made. Any physical plant alterations of existing facilities must be completed in a manner to comply with the eight bed per facility limit (i.e., renovations of existing facilities exceeding eight beds must include a reduction in the bed capacity to eight beds).

Lengths of Stay

Lengths of stay range from 14 days to 6 months. ThGH programs focusing on transition or short-term crisis are typically in the 14 to 30 day range. Discharge will be based on the child no longer making adequate improvement in this facility (and another facility is being recommended) or the child no longer having medical necessity at this level of care.

Eligibility

- The child or adolescent has a Mental Health DSM-IV-TR diagnosis and/or a substance abuse diagnosis utilizing American Society of Addiction Medicine (ASAM) criteria necessitating this level of care. The diagnoses exclude developmental disabilities and pervasive developmental disorders.
- There must be clinical evidence of the following:
 - The child or adolescent exhibits significant impairment in functioning, representing potential serious harm to self or others — across settings — including the home, school and community. The serious harm does not necessarily have to be of an imminent nature
 - The child or adolescent has clear, behaviorally-defined treatment objectives that can reasonably be achieved within the ThGH setting, and there is no less restrictive environment in which the objectives can be safely accomplished
 - The accessibility and/or intensity of currently available community supports and services are inadequate to meet these needs due to the severity of the impairment
 - The child or adolescent requires services and supports to be available 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 and therapeutic services; and to develop the adaptive and functional behaviors that will allow him/her to remain successfully in his/her home and community and regularly attend and participate in work, school or training.
 - In particular, the child or adolescent requires the availability of crisis and/or mental health services seven days per week/24 hours per day, with flexible scheduling and availability of other services and supports
 - The child or adolescent also requires 24-hour care and supervision

Service

- A community-based residential service
 - Four to eight bed capacity (no greater than eight)
 - Less intensive levels of treatment have been determined to be unsafe, unsuccessful or unavailable
 - Ideally situated to allow ongoing participation of family
 - The child or adolescent attends a school in the community (e.g., a school integrated with children not from the institution and not on the institution's campus)

- The child or adolescent remains involved in community-based activities and may attend a community educational, vocational program or other treatment setting.
- Twenty-four hours/day, seven days/week structured and supportive living environment
- Individualized, strengths-based services and supports that:
 - Are identified in partnership with the child or adolescent and the family and support system, to the extent possible, and if developmentally appropriate
 - Are based on both clinical and functional assessments
 - Are clinically monitored and coordinated, with 24-hour availability
 - Are implemented with oversight from a licensed mental health professional
 - Assist with the development of skills for daily living and support success in community settings, including home and school
- Care coordination to plan and arrange access to a range of educational and therapeutic services
- Program oversight is provided by a psychiatrist or psychologist
- Targeted to support the development of adaptive and functional behaviors that will enable the child or adolescent to successfully remain in his/her home and community, and to regularly attend and participate in work, school or training
- Psychotropic medications to be used with specific target symptoms identification, with medical monitoring and 24-hour medical availability, when appropriate and relevant
- Screening and assessment for current medical problems and concomitant substance use issues
- Coordination with the child or adolescent's community resources, with the goal of transitioning the youth out of the program as soon as possible and appropriate
- Discharge planning and transitioning back into the community beginning within the first week of admission with clear action steps and target dates outlined in the treatment plan

Since ThGH is not in itself a specific research-based model, it must instead incorporate research-based models developed for a broader array of settings that respond to the specific presenting problems of the clients served. Each ThGH program should incorporate appropriate research-based programming for both treatment planning and service delivery.

For treatment planning, the program should use a standardized assessment and treatment planning tool such as the Child and Adolescent Needs and Strengths. The State is working toward a standardized assessment tool (Child and Adolescent Needs and Strengths – Mental Health version or CANS-MH) and encourages the facilities to use the CANS-MH as a standardized assessment tool for all children. The CANS should ideally be utilized at intake and discharge to monitor changes in functioning, as well as every 90 days for longer term stays.

The assessment protocol must sufficiently differentiate across life domains, as well as risk and protective factors, so that a treatment plan can be tailored to the areas related to the presenting problems of each youth and their family in order to ensure targeted treatment.

The tool should also allow tracking of progress over time. The specific tools and approaches used by each program must be specified in the program description and are subject to approval by the State. In addition, the program must ensure that requirements for pretreatment assessment are met prior to treatment commencing (see Attachment 2).

For service delivery, the program must incorporate at least two research-based approaches pertinent to the sub-populations of ThGH clients to be served by the specific program. Examples of specific research-based approaches that could be used for various sub-populations of clients include:

- **Family Integrated Transitions (FIT)** is an intensive treatment program that begins in the ThGH and continues for four to six months in the community. It incorporates elements of Multisystemic Therapy (MST), Dialectic Behavior Therapy (DBT), Motivational Enhancement Therapy (MET) and Relapse Prevention/Community Reinforcement to increase the youth and family awareness of substance use and high-risk situations, increase the repertoire of effective coping strategies, and establish a plan for resumption of treatment following relapse.
- **Dialectic Behavior Therapy (DBT)** is used extensively with adolescents in residential settings with good outcomes. It is ideal if the family is also involved in treatment and learns the DBT skills so that they can support the youth upon return to home.
- **Cognitive Behavioral Therapy (CBT) for Adolescent Depression** is a developmental adaptation of the classic cognitive therapy model. CBT emphasizes collaborative empiricism, the importance of socializing clients to the cognitive therapy model, and the monitoring and modification of automatic thoughts, assumptions and beliefs.
- **Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)** is a psychosocial treatment model designed to treat post-traumatic stress and related emotional and behavioral problems in children and adolescents.
- **Aggression Replacement Training (ART)** is a program designed to address the behavior of aggressive youth, reduce anti-social behaviors and offer an alternative of pro-social skills. The three components of ART include Social Skills, Anger Control Training, and Moral Reasoning.
- **Functional Family Probation** is a derivative of Functional Family Therapy (FFT) for use in more structured settings, including ThGH.
- **Brief Strategic Family Therapy (BSFT)** is designed to (1) prevent, reduce, and/or treat adolescent behavior problems such as drug use, conduct problems, delinquency, sexually risky behavior, aggressive/violent behavior and association with antisocial peers; (2) improve pro-social behaviors such as school attendance and performance; and (3) improve family functioning, including effective parental leadership and management, positive parenting, and parental involvement with the child and his or her peers. It is normally a community-based intervention, but has been used in transitional settings like ThGH.

- **Multidimensional Family Therapy (MDFT)** is a comprehensive and multisystemic, family-based outpatient or partial hospitalization (day treatment) program for substance-abusing adolescents, adolescents with co-occurring substance use and mental disorders and those at high risk for continued substance abuse and other problem behaviors such as conduct disorder and delinquency.
- **Residential American Society of Addiction Medicine (ASAM) level 3.0** Residential/Inpatient Treatment including Addiction-Only Services, Dual Diagnosis Capable, and Dual Diagnosis Enhanced Programs. Level III encompasses organized services staffed by designated addiction treatment and mental health personnel who provide a planned regimen of care in a 24-hour live-in setting. Such services adhere to defined sets of policies and procedures. They are housed in, or affiliated with, permanent facilities where patients can reside safely. They are staffed 24 hours a day. The defining characteristic of all Level III programs is that they serve individuals who need safe and stable living environments in order to develop their recovery skills.
 - III.1 Clinically-Managed, Low Intensity Residential Treatment
 - III.5 Clinically-Managed, Medium/High Intensity Residential Treatment

For milieu management, all programs should also incorporate some form of research-based, trauma-informed programming and training, if the primary research-based treatment model used by the program does not (e.g., Sanctuary Model).¹ Annually, facilities must submit documentation demonstrating compliance with at least two evidence-based practice fidelity monitoring or ASAM criteria. The State must approve the auditing body providing the EBP/ASAM fidelity monitoring. ThGH facilities may specialize and provide care for sex offenders, substance abuse, or dually diagnosed individuals. If a program provides care to any of these categories of youth, the program must submit documentation regarding the appropriateness of the research-based, trauma-informed programming and training, as well as compliance with the ASAM level of care being provided.

In addition, programs may propose other models, citing the research base that supports use of that model with the target population (e.g., gender-specific approaches). They may also work with the purveyors of research-based models to develop more tailored approaches, incorporating other models (much in the same way that FIT and Functional Family Probation were developed).

¹ The "Sanctuary Model" is a model for milieu and organizational structure to support quality, trauma-informed treatment. The Sanctuary Model is a trauma-informed method for creating or changing an organizational culture in order to provide a cohesive context within which healing from traumatic experience can be addressed. It is a whole system approach designed to facilitate the development of structures, processes, and behaviors, on the part of staff, youth, and the organizational community, that addresses the neurological, emotional, cognitive, social, and behavioral challenges experienced by youth in care. Preliminary research would allow us to characterize this as a promising practice.

The specific research-based models to be used should be incorporated into the program description and submitted to the State for approval. All research-based programming in ThGH settings must be approved by the State.

Goals

- Focus on reducing the behavior and symptoms of the psychiatric disorder that necessitated the removal of the child or adolescent from his/her usual living situation
- Decrease problem behavior and increase developmentally-appropriate, normative and pro-social behavior in children and adolescents who are in need of out-of-home placement
- Transition child or adolescent from ThGH to home or community based living with outpatient treatment (e.g., individual and family therapy)

Outcomes/Continued Stay Criteria

- Must be based on an individualized and behaviorally-specific treatment plan that aims to return the child or adolescent to his/her home community environment at the earliest possible time
 - Treatment plan should include behaviorally-measurable discharge goals
- Active treatment that would not be able to be provided at a less restrictive level of care is being provided on a 24-hour basis with direct supervision/oversight by professional behavioral health staff
- ThGH treatment is successful in reducing the severity of the behavioral health issue that was identified as the reason for admission
 - Most often, targeted behaviors will relate directly to the child or adolescent's ability to function successfully in the home and school environment (e.g., compliance with reasonable behavioral expectations; safe behavior and appropriate responses to social cues and conflicts)
- While the child or adolescent is in a ThGH, the treatment plan is reviewed at least every 14 days to track progress and revise the treatment plan to address any lack of progress
- Continued ThGH stay should be based on a clinical expectation that continued treatment in the ThGH can reasonably be expected to achieve treatment goals and improve or stabilize the child or adolescent's behavior, such that this level of care will no longer be needed and the child or adolescent can return to the community
- Discharge should occur if treatment plan goals have been accomplished (i.e., child or adolescent's behavior/condition has improved sufficiently to move to an outpatient level of care)
- Transition should occur to a more appropriate level of care (either more or less restrictive) if the child or adolescent is not making progress toward treatment goals and there is no reasonable expectation of progress at this level of care (e.g., child or adolescent's behavior and/or safety needs requires a more restrictive level of care, or

alternatively, child or adolescent's behavior is linked to family functioning and can be better addressed through a family/home-based treatment)

Staffing, Ratios, and Staff Qualifications

ThGH staff must be supervised by a licensed mental health professional with experience in evidence-based treatments.

Staff includes paraprofessional, Master's and Bachelor's level supervised by a psychologist or psychiatrist.

1. A minimum of two (2) staff on duty per shift in each living unit, with one (1) staff awake during overnight shifts (may be Bachelors level of relevant experience) with the ability to call in as many staff as necessary to maintain safety and control in the facility depending upon the needs of the current population at any given time
2. A ratio of not less than one (1) staff to four (4) youth is maintained at all times; however, two (2) staff must be on duty at all times
3. At least one (1) staff member per shift is required to have a current CPR and First Aid certification
4. Staffing schedules shall reflect overlap in shift hours to accommodate information exchange for continuity of youth treatment, adequate numbers of staff reflective of the tone of the unit, appropriate staff gender mix and the consistent presence and availability of professional staff. In addition, staffing schedules should ensure the presence and availability of professional staff on nights and weekends, when parents are available to participate in family therapy and to provide input on the treatment of their child.
5. Individual, group and family therapists are Master's level staff available at least three (3) hours per week (individual and group) or two (2) hours per month (family)
6. A licensed registered nurse is on staff or under contract to establish the system of operation for administering or supervising residents' medications, and medical needs or requirements; monitoring the residents' response to medications; tracking and attending to dental and medical needs and training staff to administer medications and proper protocols
7. Psychiatrist or psychologist that provides twenty-four (24) hour, on-call coverage seven (7) days a week
8. The psychologist or psychiatrist must see the client at least once, prescribe the type of care provided, and, if the services are not time-limited by the prescription, see the child and review the need for continued care every 14 days. Although the psychologist or psychiatrist does not have to be on the premises when his/her client is receiving covered services, the supervising practitioner must assume professional responsibility for the services provided and assure that the services are medically appropriate.
9. At least 21 hours of active treatment per week for each child is required to be provided by qualified staff (e.g., having a certification in the EBPs selected by the facility and/or

licensed practitioners operating under their scope of practice in Nebraska), consistent with each child's treatment plan and meeting assessed needs.

Attachment 1: IMD Principles

An Institution of Mental Disease (IMD) is defined by Medicaid regulations as a hospital, nursing facility or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental illness including medical attention, nursing care, and related services. Whether an institution is an IMD is determined by its overall character as that of a facility established and maintained for the care and treatment of individuals with mental diseases whether or not it is licensed as such. (42 CFR 435.1010) An institution for the mentally retarded is not an institution for mental diseases.

When making the determination regarding whether or not a particular facility is an IMD, CMS applies five criteria. If any of the following criteria are met, a thorough IMD assessment must be made by the team that includes “qualified medical personnel” in order to determine whether the overall character of the facility is that of a facility established maintained primarily for the care and treatment of individuals with mental disease. The five criteria are as follows:

1. The facility is licensed as a psychiatric facility.
2. The facility is accredited as a psychiatric facility.
3. The facility is under the jurisdiction of the State’s mental health authority.
4. The facility specializes in providing psychiatric/psychological care and treatment.
5. The current need for institutionalization for more than 50% of all the patients in the facility results from mental disease.

Additional criteria to consider when making a decision whether two facilities are a single institution regarding IMD status are the following:

1. Are all components controlled by one owner or one governing body?
2. Is the Chief Medical Officer responsible for the medical staff activities in all components?
3. Does one chief executive officer control all administrative activities in all components?
4. Are all components separately licensed.
5. Are the components so organizationally and geographically separate that it is not feasible to operate as a single entity?
6. If two or more of the components are participating under the same provider category (such as nursing facilities), can each component meet the conditions of participation independently?

Nebraska Principles for determining if facilities should be viewed as a single institution

- If facilities only share an owner/governing body and all administrative and clinical staff are not shared, and the components are licensed separately and are organizationally and geographically separate, then the facilities are separate institutions.

- If facilities share an owner/governing body and a CEO for administrative operations, then if medical staff are also shared between 2 or more facilities, the two or more facilities are considered to be a single institution.
- If facilities share an owner/governing body and a CEO for administrative operations, then a single institution with multiple facilities may provide treatment at a single facility that is part of the institution.
- If facilities share an owner/governing body and a CEO for administrative operations, then shared medical staff means that one of the following occurs: a single medical director is over all facilities, a clinical staff person such as a psychologist/psychiatrist person is shared with all facilities, or direct care staffs with responsibilities in multiple facilities are shared.
- If facilities share an owner/governing body and a CEO for administrative operations and no medical staff are shared, then a component that is licensed separately and is geographically separate and not contiguous to other shared ownership facilities is considered to be not feasible to operate as a single institution. Geographically Separate means facilities that are not in close proximity or adjacent and the facilities do not share operational responsibilities and staffing responsibilities between facilities.

DEFINITIONS

For the purposes of determining IMD status, Medicaid will use the following definitions when referring to the items or words identified under the “Principles for Determining IMD Status”:

- Campus means a location in which MHSA treatment services are provided. More than one facility is delivering 24 hours per day of MHSA treatment services. The locations of the facilities are in close proximity to each other.
- Facilities means more than one structure in which a mental health/substance abuse treatment provider delivers 24 hours per day of MHSA treatment services. These structures may or may not be located in close proximity to each other.
- Facility means a structure in which a mental health/substance abuse treatment provider delivers 24 hours per day of MHSA treatment.
- MHSA means mental health and substance abuse.
- PRTF means Psychiatric Residential Treatment Facilities.
- *Active treatment in intermediate care facilities for the mentally retarded* means treatment that meets the requirements specified in the standard concerning active treatment for intermediate care facilities for persons with mental retardation under §483.440(a) of this subchapter.
- *Child-care institution* means a nonprofit private child-care institution, or a public child-care institution that accommodates no more than twenty-five children, which is licensed by the State in which it is situated, or has been approved by the agency of the State responsible for licensing or approval of institutions of this type, as meeting the standards established for licensing. The term does not include detention facilities, forestry camps, training schools or any other facility operated primarily for the detention of children who are determined to be delinquent.

- *In an institution* refers to an individual who is admitted to live there and receive treatment or services provided there that are appropriate to his requirements.
- *Inpatient* means a patient who has been admitted to a medical institution as an inpatient on recommendation of a physician or dentist and who –
 - (a) Receives room, board and professional services in the institution for a 24 hour period or longer, or
 - (b) Is expected by the institution to receive room, board and professional services in the institution for a 24 hour period or longer even though it later develops that the patient dies, is discharged or is transferred to another facility and does not actually stay in the institution for 24 hours.
- *Institution* means an establishment that furnishes (in single or multiple facilities) food, shelter, and some treatment or services to four or more persons unrelated to the proprietor.
- *Medical institution* means an institution that –
 - (a) Is organized to provide medical care, including nursing and convalescent care;
 - (b) Has the necessary professional personnel, equipment, and facilities to manage the medical, nursing, and other health needs of patients on a continuing basis in accordance with accepted standards;
 - (c) Is authorized under State law to provide medical care; and
 - (d) Is staffed by professional personnel who are responsible to the institution for professional medical and nursing services. The services must include adequate and continual medical care and supervision by a physician; registered nurse or licensed practical nurse supervision and services and nurses' aid services, sufficient to meet nursing care needs; and a physician's guidance on the professional aspects of operating the institution.
- *Outpatient* means a patient of an organized medical facility or distinct part of that facility who is expected by the facility to receive, and who does receive, professional services for less than a 24-hour period regardless of the hour of admission, whether or not a bed is used or whether or not the patient remains in the facility past midnight.
- *Patient* means an individual who is receiving needed professional services that are directed by a licensed practitioner of the healing arts toward maintenance, improvement, or protection of health, or lessening of illness, disability, or pain.
- *Persons with related conditions* means individuals who have a severe, chronic disability that meets all of the following conditions:
 - (a) It is attributable to –
 - (1) Cerebral palsy or epilepsy; or
 - (2) Any other condition, other than mental illness, found to be closely related to mental retardation because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of mentally retarded persons, and requires treatment or services similar to those required for these persons.
 - (b) It is manifested before the person reaches age 22.
 - (c) It is likely to continue indefinitely.

- (d) It results in substantial functional limitations in three or more of the following areas of major life activity:
 - (1) Self-care.
 - (2) Understanding and use of language.
 - (3) Learning.
 - (4) Mobility.
 - (5) Self-direction.
 - (6) Capacity for independent living.
- *Public institution* means an institution that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control. The term “public institution” does not include –
 - (a) A medical institution as defined in this section;
 - (b) An intermediate care facility as defined in §§440.140 and 440.150 of this chapter;
 - (c) A publicly operated community residence that serves no more than 16 residents, as defined in this section; or
 - (d) A child-care institution as defined in this section with respect to –
 - (1) Children for whom foster care maintenance payments are made under title IV-E of the Act; and
 - (2) Children receiving AFDC – foster care under title IV-A of the Act.
- *Publicly operated community residence that serves no more than 16 residents* is defined in 20 CFR 416.231(b)(6)(i). A summary of that definition is repeated here for the information of readers.
 - (a) In general, a publicly operated community residence means –
 - (1) It is publicly operated as defined in 20 CFR 416.231(b)(2).
 - (2) It is designed or has been changed to serve no more than 16 residents and it is serving no more than 16; and
 - (3) It provides some services beyond food and shelter such as social services, help with personal living activities, or training in socialization and life skills. Occasional medical or remedial care may also be provided as defined in 45 CFR 228.1; and
 - (b) A publicly operated community residence does not include the following facilities, even though they accommodate 16 or fewer residents:
 - (1) Residential facilities located on the grounds of, or immediately adjacent to, any large institution or multiple purpose complex.
 - (2) Educational or vocational training institutions that primarily provide an approved, accredited, or recognized program to individuals residing there.
 - (3) Correctional or holding facilities for individuals who are prisoners, have been arrested or detained pending disposition of charges, or are held under court order as material witnesses or juveniles.
 - (4) Hospitals, nursing facilities, and intermediate care facilities for the mentally retarded.

Principles for Determining if a Facility is an IMD

1. A community-based facility of 16 beds or less may choose to be
 - a. a PRTF if the facility follows all of the principles of a PRTF and wishes to receive Medicaid payment for 24-hour per day of MHSA services or
 - b. a small therapeutic group home receiving Medicaid payment for MHSA treatment services. In a small group home, payment of room and board will be the responsibility of the legally responsible payer other than Medicaid.
2. To not be considered an IMD, a group of facilities with 16 or fewer beds in any one facility and a total number of beds of 17 or more must be geographically separate, as well as, operationally separate in such things as budgeting, clinical staffing (including the medical director), supplies and equipment and upkeep of the building. The group of facilities may share the same ownership and the same executive director if the other criteria are met.
3. A community-based facility of 17 beds or more may be a PRTF if the facility is interested in receiving Medicaid funding and adheres to all the PRTF requirements for 24-hour per day MHSA services.
4. Medicaid providers including inpatient general hospitals, other than inpatient psychiatric hospitals and PRTFs, may not receive Medicaid funding for any child residents in a facility of 17 beds or more with more than 50% of their children having mental health diagnoses because it is considered an Institution of Mental Disease (IMD).
5. A general medical surgical hospital (which is not a IMD) may operate a separate facility that is geographically and functionally separate that shares no staff and be eligible for Medicaid funding. The hospital becomes an IMD only if the number of mental health inpatient psychiatric hospital beds and the number of PRTF beds would exceed 50% of the total bed numbers of the general hospital combined. A medical surgical hospital with that is geographically and functionally separate that shares no staff may operate a facility, if the facility is:
 - a. one or more small therapeutic group homes or
 - b. PRTFs if the facility follows or adheres to all of the conditions of a PRTF and the facility is interested in receiving Medicaid funding for 24-hour per day treatment services. Note: If the PRTF is geographically and functionally separate, shares no staff and is greater than 16 beds, the PRTF may be considered an IMD.
6. An IMD hospital may receive Medicaid funding to operate a PRTF facility of 17 or more beds if the facility adheres to all the PRTF rules and principles.
7. Any small community based group home or therapeutic group home operated by an IMD must be operated as a separate institution and comply with all rules for separate operational and medical staff, separate licensure, and being organizationally and geographically separate. This facility/facilities would be eligible for payment of treatment services, and the room and board becomes the responsibility of the legally responsible party
8. A facility or group of small facilities who share operational services and clinical staff and whose bed numbers are 17 or more when combined are considered an IMD and may choose to become a PRTF if the facility can meet all of the principles of a PRTF and if the facility wishes to receive 24-hour per day funding through Medicaid.

9. DD principle – An ICF-MR or DD group home is not considered to be an IMD. A MH/DD facility greater than 16 beds would be an IMD if more than 50% of patients have a mental health diagnosis and need active mental health treatment. Two smaller MH/DD group homes/facilities are only considered a single institution if they share ownership/governing bodies, CEO/administrative staff, mental health clinical staff, and are not so geographically separate that they could not be considered to operate as a single institution. *Institution for the mentally retarded or persons with related conditions* means an institution (or distinct part of an institution) that –
 - a. Is primarily for the diagnosis, treatment, or rehabilitation of the mentally retarded or persons with related conditions; and
10. Provides, in a protected residential setting, ongoing evaluation, planning, 24-hour supervision, coordination, and integration of health or rehabilitative services to help each individual function at his greatest ability.

Attachment 2: Pretreatment Assessment

For ThGH services to be covered by NMAP, clinical necessity shall be established through an assessment by a licensed mental health practitioner practicing under their scope of practice under State law (see 471 NAC 32-001.01, Assessment). The client must have a diagnosable mental health or substance abuse disorder of sufficient duration to meet diagnostic criteria specified within the current Diagnostic and Statistics Manual of the American Psychiatric Association that results in functional impairment which substantially interferes with or limits the person's role or functioning within the family, school, or community. This does not include V-codes or developmental disorders.

32-001.01 Pre-Treatment Assessment (Biopsychosocial Assessment and Initial Diagnostic Interview): This assessment is used to identify the problems and needs, develop goals and objectives, and determine appropriate strategies and methods of intervention for the client. This comprehensive plan of care will be outlined in the individualized treatment plan and should reflect an understanding of how the individual's particular issues will be addressed with the service. The assessment must occur prior to the initiation of treatment interventions and must include a baseline of the client's current functioning and treatment needs. Providers must encourage families to actively participate in the pretreatment assessment.

The Biopsychosocial Assessment must be completed by a staff person, acting within his/her scope of practice, who is enrolled as a provider of Mental Health Services for Children and Adolescents. The staff person is responsible for gathering the information included on the assessment through direct face-to-face interview (with the family) and the comprehensive review of the client's past records. The licensed practitioner of the healing arts who is able to diagnose and treat major mental illness within his/her scope of practice must complete an Initial Diagnostic Interview as defined in each chapter. The recommendations must be developed by the practitioners and the practitioners must sign the assessment. Licensed practitioners who are able to practice independently under their scope of practice must provide a comprehensive mental health/substance abuse assessment which must include all of the components of a biopsychosocial assessment and initial diagnostic interview. (See fee schedule for the appropriate code and modifier). The assessment must include, to the degree deemed clinically appropriate by the qualified mental health professional, the following information:

Biopsychosocial Assessment

1. Presenting Problem and Goals as Described by
 - a. Client
 - b. Family
 - c. Others
2. Social History

- a. Environmental influences (moves and reasons, housing conditions)
- 3. Family Dynamics
 - a. Demographic and historical information
 - b. Divorces, separations, deaths, and incarcerations of parents and significant others (include reasons)
 - c. Parent and family vocational history
 - d. Parent and family treatment history
- 4. Mental Health History
 - a. Symptoms
 - b. Diagnoses
 - c. Treatment interventions including psychotropic medications (outcome)
- 5. Academic and Intellectual History
 - a. Academic history
 - b. Most recent IQ and historical
 - c. Learning disabilities, behavior disorders or impairment
 - d. Interventions and outcomes
 - e. Vocational history or training
- 6. Medical History
 - a. Physical development
 - b. Prenatal, birth, development milestones
 - c. History of injuries and illnesses, handicapping conditions
 - d. Chronic medical conditions and medications taken
 - e. Sexual development, menstrual history, pregnancies, births or fathered children
- 7. Legal History
 - a. Offenses against the client
 - b. History and current legal status
- 8. Offender Issues
 - a. Status Offenses
 - b. Violence to property
 - c. Violence and assault to others
 - d. Other
- 9. Victim Issue
 - a. Physical Abuse
 - b. Sexual Abuse
 - c. Emotional Abuse
 - d. Neglect
 - e. Other
- 10. Substance Abuse History
 - a. Client use
 - b. Family history
 - c. Treatment history
- 11. Personal Assets and Liabilities

Initial Diagnostic Interview

1. Psychiatric evaluation with mental status exam and diagnosis
2. Recommendations
 - a. Treatment needs and recommended interventions for client and family
 - b. Identification of who needs to be involved in the client's treatment
 - c. Overall plan to meet the treatment needs of the client including transitioning to lower levels of care and discharge planning
 - d. A means to evaluate the client's progress throughout their treatment and outcome measures at discharge
 - e. Recommended linkages with other community resources
 - f. Other areas that may need further evaluation
3. Pre-treatment assessments that are incomplete or do not include the initial diagnostic interview assessment will not be reimbursable