Adult Mental Health Group Home

Definition

Adult Mental Health Group Homes provide rehabilitative treatment services for individuals age 18 and older under the purview of the state Department of Mental Health and Addiction Services (DMHAS). Private, non-profit Mental Health Group Homes of 16 beds or less are designed to assist individuals with serious, persistent mental illness, including co-occurring substance use disorders, to achieve the maximum reduction of mental disability and restoration of an individual to the best possible functional level. The following service components are included: intake and psychosocial assessment; development of plans of care; individual, family, and group rehabilitative counseling; and care coordination. Services are designed to reduce functional impairments, promote restoration of basic life skills, and reduce or eliminate psychological and social barriers that interfere with the ability to perform Activities of Daily Living, achieve community integration, and live independently. The services are provided to adults who meet medical necessity for this level of care, and have demonstrated an inability to live independently, and function safely and successfully in the lesser restrictive setting.

Authorization Process and Time Frame for Service

This level of care requires prior authorization. The first authorization is for up to six months. Subsequent authorizations for up to six months each can be given if the individual meets continued care criteria.

Medical Necessity Criteria:

E.1.0 **Admission Criteria**

E.1.1 Individual is able to participate in and benefit from rehabilitative services directed toward skill restoration, psychiatric stability, promoting recovery, achieving community integration, and safe, independent living in the least restrictive setting.

E.1.2 Symptoms and functional impairment include all of the following:

E.1.2.1 Diagnosable behavioral health disorder, according to the most recent ICD, which requires and can reasonably be expected to respond to therapeutic intervention, excluding Z codes, and is not solely a result of an Autism Spectrum Disorder or an Intellectual Disability.

E.1.3 Chronic (> 6 months) presentation, as a result of a psychiatric disorder, consistent with at least one of the following:

E.1.3.1 Risk of self-injury: Risk of self-injury as manifested by sustained recklessness and/or impulsivity suggesting an inability or unwillingness to consider potential for risk to self (e.g., flagrant exposure to victimization, and other serious

All requests for services not satisfying these criteria must be individually reviewed and may not be denied unless the request does not meet the Department's definition of medical necessity and, for anyone under 21, does not meet the EPSDT criteria.

risk- taking behavior) which requires constant monitoring. There is a reasonable expectation that the frequency of the risky behavior is likely to decrease in a 24-hour supervised setting and does not require 24-hour medical monitoring.

E.1.3.2 Risk of danger to others: Risk of harm to others as manifested by sustained recklessness and/or impulsive behavior that poses potential risk to others that requires constant monitoring. There is a reasonable expectation that the frequency of risky behavior is likely to decrease in a 24-hour supervised setting and does not require 24-hour medical monitoring.

E.1.3.3 Severe functional disabilities in the area of independent living skills that are secondary to serious and persistent mental illness. The disabilities are so great that they require these individuals to reside in a non-medical residential setting with rehabilitative services and supports. Presentation must be consistent with one or more of the following:

E.1.3.4 Severe impairment of activities of daily living skills as evidenced by:

E.1.3.4.1 Evidence of severe neglect of personal hygiene despite appropriate and repeated attempts by supports to alter behaviors; or

E.1.3.4.2 Evidence of inability to attend to a medical condition(s) which may pose significant health problem; or

E.1.3.4.3 Malnutrition and/or highly compromised nutrition or eating patterns which may be related to paranoid, delusional, or severe eating-disordered beliefs or rituals; or

E.1.3.4.4 Evidence of inability to maintain a habitable living environment despite repeated attempts by others to support independence) or

E.1.3.4.5 Inappropriate social interactions or poor judgment that puts the individual at risk for victimization.

E.1.3.5 Severe reality impairment as evidenced by:

E.1.3.5.1 Response to command/threatening hallucinations which could result in harm to self/others; or

E.1.3.5.2 Response to delusions, excessive preoccupations, or inability to sort out fantasy from reality, which interferes with functioning and places the individual or others at risk.

E.1.3.6 Inability to call for help independently.

E.1.3.7 Lack of awareness of medication compliance needs.

E.1.4 Intensity of Service Need

E.1.4.1 Individual requires care in a group home setting with 24-hour staff support and rehabilitative services. The above symptoms cannot be contained, attenuated, evaluated and treated in a lower level of care as evidenced by:

E.1.4.1.1 Individual requires that a staff member be awake in an adjoining area of the same residence, 24 hours a day seven days a week, which allows for monitoring of individuals who may not have the capacity to initiate a call for help; and

E.1.4.1.2 Individual requires at least 40 direct service hours per month of rehabilitative services to develop or maintain skills needed for independent living; and

E.1.4.1.3 Arrangements for supervision at a lower level of care cannot be adequately made to assure a reasonable degree of safety; and

E.1.4.1.4 Individual's medical complications <u>do not</u> require on-site medical personnel

E.2.0 **Continued Care Criteria**

E.2.1 Individual has met admission criteria within the past 60 days as evidenced by:

E.2.1.1 The individual's symptoms or behaviors persist at a level of severity documented at the most recent start for this episode of care; or

E.2.1.2 The individual has manifested new symptoms or maladaptive behaviors that meet admission criteria and the treatment plan has been revised to incorporate new goals, and

E.2.2 Evidence of active treatment and care management as evidenced by:

E.2.2.1 Individual's participation in treatment is consistent with the Master Treatment Plan (MTP) and Residential Rehabilitation Plan (RRP) or active efforts to engage the individual are in progress. Type, frequency, and intensity of services are consistent with these plans, and

E.2.2.2 A Master Treatment Plan (MTP) and Residential

Rehabilitation Plan (RRP) with evaluation and treatment objectives appropriate for this level of care has been established and identification of staff responsible has been described. Treatment objectives are related to readiness for discharge and progress toward objectives is being monitored no less than every 90 days; and

E.2.2.3 Vigorous efforts are being made to affect a timely discharge (e.g., meeting with caseworker, convening aftercare planning meetings with aftercare providers, identifying and referring for aftercare, coordination with/education of natural supports, area resources and/or local systems of care, orientation to and assistance with accessing self-help and advocacy resources, scheduling initial aftercare appointments) including anticipating and developing interventions to address possible barriers.

E.2.3 If the individual does not meet criterion E.2.1, continued stay may still be authorized under any of the following exceptional circumstances:

E.2.3.1 Individual has clear behaviorally defined treatment objectives that can be reasonably achieved within 90 days and are determined necessary in order for the discharge plan to be successful, and there is no lesser restrictive environment in which the objectives can be safely accomplished; or

E.2.3.2 Individual has achieved treatment objectives in the current level of care but requires a period of stability to strengthen the habit of newly acquired skills to reduce the likelihood of deterioration after discharge. Continued stay to allow habit formation to be strengthened may be as long as 90 days; or

E.2.3.3 Individual is expected to transfer to another setting (e.g. supervised or supported apartment or boarding home) within 90 days of discharge and continued stay at this level of care, rather than an interim placement (e.g. a shelter) can avoid disrupting care and compromising stability. Continued stays for this purpose may be as long as 90 days; or

E.2.3.4 Individual is scheduled for discharge, but the aftercare plan is missing critical components. These components have been vigorously pursued but are not available (including but not limited to such resources as placement options, psychiatrist or therapist appointments, day treatment or partial hospital programs, etc.). Continued stays for this purpose may be as long as 90 days.