



Rhode Island Medicaid Supplemental Clinical Criteria

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Introduction & Instructions for Use

Introduction

The following State or Contract Specific Clinical Criteria defined by state regulations or contractual requirements are used to make medical necessity determinations, mandated for members of behavioral health plans managed by Optum and U.S. Behavioral Health Plan, California (doing business as Optum Health Behavioral Solutions of California (“Optum-CA”)).

Other Clinical Criteria may apply when making behavioral health medical necessity determinations for members of behavioral health plans managed by Optum®. These may be externally developed by independent third parties used in conjunction with or in place of these Clinical Criteria when required, or when state or contractual requirements are absent for certain covered services.

Instructions for Use

When deciding coverage, the member’s specific benefits must be referenced. All reviewers must first identify member eligibility, the member-specific benefit plan coverage, and any federal or state regulatory requirements that supersede the member’s benefits prior to using these Clinical Criteria. In the event that the requested service or procedure is limited or excluded from the benefit, is defined differently or there is otherwise a conflict between this Clinical Criteria and the member’s specific benefit, the member’s specific benefit supersedes these Clinical Criteria.

These Clinical Criteria are provided for informational purposes and do not constitute medical advice.

CLUBHOUSE is an outpatient program for adults who are recovering from a severe and persistent mental illness.

The goal of the program is to promote recovery through use of a therapeutic environment that includes responsibilities within the Clubhouse (e.g., clerical duties, reception, food service, transportation, financial services), as well as through outside employment, education, meaningful relationships, housing, and an overall improved quality of life.

A core component of the program is the "work-ordered day," the structure around which daily activity is organized. The day-to-day operation of the Clubhouse is the responsibility of members and staff, who work side by side in a rehabilitative environment. Other core components include transitional, supported, and independent employment through which members can secure jobs at prevailing wages in the wider community; access to community support, such as housing and medical services; assistance in accessing educational resources; "reach-out" to maintain contact with all active members; participation in program decision-making and governance; and evening, weekend, and holiday social programs.

A Clubhouse is typically open at least 5 days a week and offers recreational and social programs during evenings and on weekends. The work-ordered day equates to typical working hours.

Admission Criteria

The member is diagnosed with any of the following conditions:

- Schizophrenia
- Schizoaffective Disorder
- Schizoid Personality Disorder
- Bipolar Disorder
- Major Depressive Disorder, Recurrent
- Obsessive-Compulsive Disorder
- Borderline Personality Disorder
- Delusion Disorder
- Psychotic Disorder

Service Delivery

- The provider collects information from the member and other sources about the following:
 - The member's vocational/educational, social relationship, and independent living goals;
 - The member's current psychiatric evaluation.
- The provider and member use the findings of the initial evaluation to develop an activity plan as close to the date the member accessed Clubhouse, but no later than 1 week after accessing Clubhouse.
 - Members at their choice are involved in writing the records reflecting their participation in Clubhouse.
 - Records are signed by the provider and member.
- The activity plan includes the following:
 - The member's vocational/educational, social relationship and independent living goals;
 - The skills, knowledge, activities or other interventions that will be used for each goal;
 - Activities needed to improve the member's engagement such as motivational enhancement or learning activities;
 - The plan to coordinate Clubhouse services with the member's behavioral health provider and other service providers.
 - Documentation includes at least a weekly progress note that addresses each service provided.

Enhanced Outpatient Services

ENHANCED OUTPATIENT SERVICES (EOS)

Home/community based clinical services provided by a team of specialized licensed therapists and case managers. (Some examples of EOS clinical specialists include providers with expertise in the treatment of Developmental Disabilities, Sexual Abuse, and Post Traumatic Stress Disorder). The goal of EOS is to offer an effective and clinically supported transition of care from an inpatient or residential setting or to avoid an inpatient or residential admission for high-risk members.

Providers offer prompt access to this service and are able to provide varying levels of service intensity (multiple times per day and tapering to multiple times per week) to meet the unique needs of children and their families. This service may be used to assist a child transitioning from an inpatient stay or to prevent an admission.

Minimum program requirements include:

- Home/community based clinical services provided to meet the member's clinical needs. It is recommended that services are provided for up to 5 days per weeks.
- Services are provided to the member based on the member's need. It is recommended that this includes 4 hours per day of service by a multi-disciplinary clinical team.

Admission Criteria

- The member requires engagement and support through extended interaction with EOS in order to remain in the community. Examples include:
 - The member is at risk of admission to Inpatient or a Residential Treatment Center.
 - The member requires a coordinated transition back into the community after treatment in Inpatient or a Residential Treatment Center.

AND

- Either of the following:
 - The member is an adult who meets criteria for a Serious Mental Illness.
 - The member is a child or adolescent who meets criteria for a Serious Emotional Disturbance.

Service Delivery

- Services are provided to meet the member's clinical needs. It is recommended that services are provided for up to 5 days per week.
- Services are provided to meet the member's needs. It is recommended that this includes 4 hours per day of service by a multi-disciplinary clinical team.

Home-Based Treatment Services

HOME BASED TREATMENT SERVICES (HBTS) HBTS is an intensive home or community-based service for children and adolescents who have chronic, moderate, or severe cognitive, developmental, medical/neurological, and/or psychiatric conditions whose level of functioning is significantly compromised. HBTS is a phased system approach that includes in person, high frequency, specialized treatment (including Applied Behavioral Analysis discrete trial interventions) and supervision of direct care staff. HBTS is administered routinely with the child/adolescent and parents/guardians engaged in treatment. Children may require up to 20 hours per week, or more as clinically indicated. Key goals of this treatment are person/family centered and could include:

- Increased ability of caregiver to meet the needs of their child/adolescent;
- increased language and communication skills; c) improved attention to tasks;
- enhanced imitation; e) generalized social behaviors;
- developing skills for independence;
- decreased aggression and other maladaptive behaviors; and
- improved learning and problem-solving skills. The Contractor is responsible for contracting with providers to provide the level of service indicated in this section and ensure timely and needed access to these services per EOHHS Practice Standards.

The goals of HBTS include increased ability of the caregiver to meet the needs of their child, increased language and communication skills, improved attention to tasks, enhanced imitation, generalized social behaviors, development of independence skills, decreased aggression or other maladaptive behaviors, improved learning and problem-solving skills.

HBTS is not intended to replace or substitute necessary behavioral health or educational services or be a form of respite or childcare. It may not be provided when Child and Adolescent Intensive Treatment Services (CAITS), Child and Family Intensive Treatment (CFIT), or enhanced Outpatient Services (EOS) are being used.

Admission Criteria

- The member meets the following eligibility criteria:
 - Member is aged birth to 21 and is Medicaid eligible.
 - Member is eligible for Medical Assistance through SSI, Katie Beckett (through age 18), Adoption Subsidy, rite care, or rite Share.
 - Member has a potentially chronic (12 months or longer) and moderate to severe cognitive, developmental, medical/neurological, and/or psychiatric condition whose level of functioning is significantly compromised.

AND

- The member has impairments in one or more of the following areas:
 - Cognitive functioning
 - Problem solving
 - Adaptive skills
 - Regulation of mood
 - Medical/neurological conditions

AND

- A formal diagnosis was made within the last 3 years by a licensed health care professional with competence in child psychology, child psychiatry, or child development. The member's symptoms and behaviors are consistent with a diagnosis from the current version of the DSM/ICD, and on the basis of best available clinical and evidence-based practice standards can be expected to respond to HBTS.

AND

- The member presents with medical and/or psychiatric conditions that require intensive therapeutic intervention.

AND

- Outpatient services provided at an intensified level have not been sufficient due to the member's special healthcare needs. This does not preclude from consideration family therapy or other supports for a family seeking HBTS.

AND

- There is evidence that the member requires a comprehensive and integrated program of medical and psychosocial services to support improved functioning at the least restrictive level of care.

AND

- The member and their family require support in order to remain stable outside of an inpatient environment, or to transition to independent living from a more restrictive setting.

AND

- The member and their parent/caregiver/guardian are willing to accept and cooperate with HBTS including the degree of parent/caregiver/guardian participation outlined in the HBTS treatment plan.

AND

- The member's home environment does not present safety risks to HBTS staff. Risks include, but are not limited to sexual harassment, threats of violence or assault, alcohol or illegal drug use, firearms, and health risks.

AND

Additional Criteria for Treatment Support

- There is indication that:
 - The frequency and intensity of Specialized Treatment may be too taxing for the member.

AND

- The structure, guidance, supervision, and redirection provided in Treatment Support may benefit the member.

Continued Stay Criteria

- The severity of the member's condition and resulting impairment continue to require this level of treatment.

AND

- Treatment planning is individualized to the member and their family's changing condition; realistic and specific goals and objectives are stated. The mode, intensity and frequency of treatment are consistent with best known clinical and/or evidence-based practice.

AND

- Active treatment is occurring and continued progress toward goals is expected. Progress in relation to goals is clearly evident, measurable and described in observable terms. If treatment objectives have not yet been achieved; documentation support continued interventions.

Discharge Criteria

- The member's documented Treatment Plan goals and objectives have been successfully met.
- The member no longer meets service initiation or continuing care criteria or meets criteria for a less/more intensive level of care.
- Consent for treatment has been withdrawn by a youth 18 or older, or his/her parent(s) or legal guardian(s).

Service Delivery

- See also the Behavioral Clinical Policy, "Intensive Behavioral Therapy / Applied Behavior Analysis for Autism Spectrum Disorder"
- An evaluation of the member by a licensed mental health professional must have taken place within 2 years prior as part of demonstrating the need for HBTS.
- The provider utilizes all referral and collateral information (i.e., IEP, IFSP, contact with providers/teachers, review relevant medical or behavioral health evaluations/records), and maintains ongoing communication with the parent/guardian.
- The provider identifies and prioritizes individualized treatment goals and objectives that are clearly written, specific and measurable. Interventions used to achieve treatment goals and objectives are defined. The expected level of parent/caregiver/guardian participation is clear and consistent. The parent/caregiver/guardian signs all proposed treatment plans.
- Upon referral, the provider assesses current treatment needs and determines the intensity of treatment up to 20 hours per week (excluding ABA programs). Treatment intensity takes the following into account:
 - The child's age
 - The child and family's ability to engage in sustained treatment and expectations for progress
 - Type, nature and course of presenting conditions and diagnosis
 - Severity of presenting behaviors
 - Other treatment or educational services being received
 - Impact on family functioning
 - Presence of co-existing conditions
 - Presence of biological or neurological abnormalities
 - The child's current functional capacities
 - Family factors (e.g., parenting skills, living environment, and psychosocial problems)
 - Interaction with other agencies and providers
- The treatment plan addresses how HBTS is coordinated with referral sources, the member's medical home and other providers of care. Coordination of care involves consistent communication with involved parties about treatment and recommendations, as well as receiving input from others and ongoing coordination during transitions of care.
- The provider in conjunction with the member/member's parent/caregiver/guardian conducts a formal review of the treatment plan at least every 6 months.

Integrated Health Home

INTEGRATED HEALTH HOME (IHH) is a service provided to community-based clients and collaterals by professional behavioral health staff and peers in accordance with an approved person-centered plan for the purpose of ensuring the client's stability and continued community tenure.

IHH builds linkages to other community and social supports and enhances coordination of medical and behavioral healthcare in keeping with the needs of persons with multiple chronic illnesses.

IHH teams monitor and provide medically necessary interventions to assist in the management of symptoms as well as overall life situations, including accessing needed medical, social, educational and other services. Specifically, services include:

- Comprehensive care management;
- Care coordination and health promotion;
- Comprehensive transitional care from inpatient to other settings including follow-ups;
- Individual and family support services;
- Referral to community and social support services;
- The use of health information technology to link services.

Admission Criteria

- The State of Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH) determine the member is eligible for IHH. Eligibility criteria includes both of the following:
- The member has been diagnosed with any of the following conditions:
 - Schizophrenia
 - Schizoaffective Disorder
 - Schizoid Personality Disorder
 - Bipolar Disorder
 - Major Depressive Disorder, Recurrent
 - Obsessive-Compulsive Disorder
 - Borderline Personality Disorder
 - Delusion Disorder
 - Psychotic Disorder
- The member meets the highest level of care in use of the Daily Living Activities Functional Assessment (DLA) (i.e., the member has a DLA score of >3.0-5.0)
 - BHDDH may determine that a member qualifies for IHH when the member does not have a qualifying condition, but it is determined by their DLA score to have significant functional impairment.

Continued Stay Criteria

- Services continue to be medically necessary.

Discharge Criteria

- The member has successfully reached individually established goals for discharge, and when the member and program staff mutually agree to the termination of services.
- The member has successfully demonstrated an ability to function in all major role areas (i.e., work, social, self-care) without ongoing assistance from the program, without significant relapse when services are withdrawn, and when the member requests discharge, and the program staff mutually agree to the termination of services.
- The member has not participated in any service for a period of 90 days despite documented efforts to engage the member in treatment.

Service Delivery

- Upon referral, the provider in collaboration with the member and the IHH psychiatrist, completes a health assessment screening which includes at least the following:
 - Suicide risk
 - Depression
 - Metabolic syndrome screen

- Alcohol/drug use
- Tobacco use
- Chronic health conditions highly prevalent among the populations served by the program
- Status of at least the following conditions:
 - Diabetes;
 - Hypertension;
 - Cardiovascular disease;
 - Asthma/COPD
 - Chronic pain.
- Perception of needs from the perspective of the person served.
- The initial evaluation:
 - Gathers information about the presenting issues from the member's perspective, and includes the member's understanding of the factors that lead to requesting services (i.e., the "why now" factors);
 - Focuses on the member's specific needs;
 - Identifies the member's goals and expectations;
 - Is completed in a timeframe commensurate with the member's needs, or otherwise in accordance with clinical best practices.
- As part of the assessment, the provider confirms the name of the member's Primary Care Provider (PCP), and date of last visit. The provider confirms that the PCP assignment matches the member's understanding of his/her PCP selection.
- DLA findings are also used to identify where interventions are needed for rehabilitation and recovery.
- The provider in collaboration with the member and other service providers use the finding of the health assessment as well as available information from referral and collateral sources to develop a person-centered plan that addresses the member's medical and behavioral health needs. The plan identifies and prioritizes clear, specific and measurable individualized goals and objectives for four IHH activities:
 - Care coordination and health promotion;
 - Chronic condition management and population management;
 - Comprehensive transitional care from inpatient to other setting;
 - Individual and family services.
- The IHH team and other service providers ensure that the plan and the delivery of services reflect evidence-based practices.
- For members with significant medical morbidity or who are taking multiple medications for medical conditions, the plan will ensure that the provider and the member's PCP or key prescriber(s) will collaborate at least quarterly.
- The IHH team has mechanisms in place to facilitate effective communication and coordination of care among providers in routine and emergency circumstances. Examples of mechanisms include team meetings, electronic medical records, as well as secure faxes and emails.
- The IHH team collaborates with medical and/or behavioral health case managers to create an intervention/management plan to assist members who frequently utilize the Emergency Room.
- The IHH team meets with Optum at least quarterly to review performance metrics and to collaborate on improvement plans.
- The health assessment and person-centered plan are updated at least every 6 months. The assessment and plan may be updated more frequently when there are significant changes.
- The IHH team uses health information technology (HIT) to facilitate the health home's work and establish quality improvement efforts to ensure that the work is effective at the individual and population level.

Psychiatric Rehabilitation Residence

MENTAL HEALTH PSYCHIATRIC REHABILITATION RESIDENCE (MHPRR) licensed residential program which also provides a range of therapeutic, rehabilitative, and casework services to people who also qualify for Integrated Health Home (IHH) services. MHPRR services are provided in any of the following settings:

- Supportive Psychiatric Rehabilitative Residence-Apartments
- Basic Psychiatric Rehabilitative Residence5
- Specialized Mental Health Psychiatric Rehabilitative Residence

Services offered vary by type of MHPRR, but include the following:

- Counseling: Individual, group and family
- Medication: Prescription, education, administration and monitoring
- Social casework: Client-based advocacy, linkage to outside services, monitoring the use of outside services, individualized treatment planning and skill teaching, income maintenance, and medical care assistance
- Limited physical assistance as required: Mobility, assistance with non-injectable medications, dressing, range-of-motion exercises, transportation, and household services.
- Skill assessment and development: Personal hygiene, health care needs, medication compliance, use of community resources, social skills development and assistance, support in the development of appropriate behaviors to allow members to participate in normalized community activities.

Admission Criteria

- The State of Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH) determine the member is eligible for IHH. Eligibility criteria includes both of the following:
 - The member is 18 years old or older and not under the jurisdiction of the Department of Children, Youth and Families.
 - The member has been diagnosed with any of the following conditions:
 - Schizophrenia
 - Schizoaffective Disorder
 - Schizoid Personality Disorder
 - Bipolar Disorder
 - Major Depressive Disorder, Recurrent
 - Obsessive-Compulsive Disorder
 - Borderline Personality Disorder
 - Delusion Disorder
 - Psychotic Disorder
 - The member is receiving Integrated Health Home services.
 - The member is in active behavioral health treatment and is referred to MHPRR by a physician.
 - The member meets any of the following priority placement criteria:
 - A history of being incarcerated, institutionalized, or in a controlled environment of any kind including, but not limited to the Eleanor Slater Hospital, the Forensic Service at the Eleanor Slater Hospital, or the Adult Correctional Institute;
 - Exhibits dangerous behavior and/or has a history of violence that requires close supervision and a highly structured setting to ensure the safety of the individual and/or the community;
 - Requires assistance to complete daily living and self-care tasks;
 - A co-occurring physical health problem, developmental disability, and/or substance use disorder that requires more intensive treatment monitoring, and support than can be provided in a less restrictive community setting;
 - Has received care and treatment pursuant to a Court Order for outpatient treatment and the member is in compliance with the order;
 - The member has had more than 1 psychiatric hospitalization within the past year.

Continued Stay Criteria

- Services Continue to be medically necessary.

Service Delivery

- Upon admission the responsible provider in collaboration with the member completes the initial evaluation of the following:

- The factors which led the member to access services.
- The member's readiness for rehabilitation.
- The member's overall rehabilitation goal.
- The member's functional skills and knowledge in relation to the overall rehabilitation goal.
- The member's resources in relation to the overall rehabilitation goal.
- The initial evaluation also includes an assessment of harm to self, others, and/or property.
- The responsible provider in collaboration with the member develops a multidisciplinary rehabilitation plan that focuses on the following:
 - The member's rehabilitation goal;
 - The member's present level of skills and knowledge relative to the rehabilitation goal;
 - The skills and knowledge needed to achieve the member's rehabilitation goal;
 - The member's present resources and the resources needed to achieve the member's rehabilitation goal.
- The rehabilitation plan includes specific and measurable objectives aimed at assisting the member with achieving the rehabilitation goal, and interventions for each skill, knowledge, or resource objective.
- The rehabilitation plan may be informed by the findings of the initial clinical evaluation.
- When the initial assessment identifies a potential risk of harm to self, others, and/or property, a personal safety plan is completed that includes:
 - Triggers;
 - Current coping skills;
 - Warning signs;
 - Preferred interventions;
 - Advance directives, when available.
- The program provides an effective system for reaching out to members who are not attending, becoming isolated, or who are hospitalized.
- The provider in collaboration with the member conducts a formal review of the rehabilitation plan at least every 6 months. The rehabilitation plan reviewed more often than once every 6 months when there are significant changes.

Personal Assistance Services and Supports

PERSONAL ASSISTANCE SERVICES & SUPPORTS (PASS) is a comprehensive integrated program that includes intermittent, limited, or extensive one-to-one personal assistance services needed to support, improve or maintain functioning in age-appropriate natural settings. These specialized consumer-directed services are available to children who have been diagnosed with certain physical, developmental, behavioral or emotional conditions living at home. PASS Services are designed to assist children and youth with attaining goals and identifying objectives within three areas: activities of daily living, making self-preserving decisions, and participating in social roles and social settings. The goals of the services provided are to support the family in helping the child participate as fully and independently as possible in natural community settings and to reach his or her full potential. This is achieved through maximizing control and choice over specifics of service delivery and the child's family assumes the lead role in directing support services for their child.

Admission Criteria

- The enrollee meets the following eligibility criteria:
- Aged birth to 21, and is Medicaid eligible;
- Eligible for Medical Assistance through Supplemental Security Income (SSI), Katie Beckett (through age 18), Adoption subsidy, Rite Care, or Rite Share;
- Meets the Federal definition of disability;
- Lives at home with a consenting legal guardian, or services/supports.

AND

- The member has impairments in one or more of the following areas:
- Ability to accomplish/perform essential activities of daily life;
- Ability to make self-preserving decisions;
- Ability to participate in social roles and settings.

AND

- A formal diagnosis was made within the last 2 years by a licensed health care professional with competence in child psychology, child psychiatry, or child development. Clinical information must demonstrate that the child is disabled with evidence of functional impairment(s), as reflected by the use of a standardized assessment tool (e.g., Vineland).

AND

- The enrollee demonstrates symptoms and behavior consistent with a diagnosis from the current version of the DSM and/or ICD that requires therapeutic intervention.

AND

- The enrollee and the parent(s)/caregiver(s)/legal guardian(s) are willing to accept and cooperate with PASS, including the degree of parental participation outlined in the PASS service plan.

AND

- The enrollee's home environment does not present safety risks to PASS staff. Risks include sexual harassment, threats of violence or assault, alcohol or illegal drug use, firearms, and health risks.

Continued Stay Criteria

- Severity of condition(s) and resulting impairment continue to require a PASS service plan to maintain and/or improve level of adaptive and functional skills. Clinical information must demonstrate that the child is disabled with evidence of functional impairment(s), as reflected by the use of a standardized assessment tool (e.g., Vineland).

AND

- Progress in relations to goals is clearly evident, measurable and described in observable terms.

AND

- The family is adhering to requirements set forth in the PASS treatment plan.

Discharge Criteria

- The enrollee's documented Service Plan goals and objectives have been successfully met.

OR

- The enrollee meets criteria for a less/more intensive level of care.

OR

- The enrollee (age 18) or his/her parent(s)/legal guardian(s), has withdrawn consent for treatment.

OR

- Loss of Medicaid eligibility.

Service Delivery

- The service plan begins with an assessment of the needs and activities of the child and family based upon their daily routines. During assessment a PASS Agency coordinator works with the family to assure families have the requisite information and/or tools to participate in a consumer-directed approach and to manage the services. It is essential that the family's readiness to participate be first assessed by the PASS Agency. Additionally, the PASS Agency reviews the family's ability to effectively participate in PASS services.
 - The PASS Agency offers a first meeting with the family within 14 calendar days of referral.
- A minimum of one home visit to assess health and safety issues occurs before submission of the service plan.
- From the assessment flows the identification of goals and objectives with details of service plan implementation and monitoring. All goals and objectives must be focused on at least one of the three PASS domains (activities of daily living, making self-preserving decisions, and participating in social roles and social settings).
 - The PASS Agency completes the assessment and service plan within 30 calendar days of the first meeting with the family.
- Treatment intensity is based on the enrollee's need. Collaboration with the enrollee's family and all relevant parties is required and maintained throughout treatment. Arriving at a level of intensity takes into account:
 - The child's age;
 - Ability to engage in sustained treatment (e.g., span of attention, stamina, developmental level) and expectations for progress;
 - Type, nature and course of presenting condition and diagnosis;
 - Severity of presenting behaviors;
 - Other treatment or educational services being received;
 - Impact on family functioning;
 - Presence of co-existing conditions;

- Presence of biological or neurological abnormalities;
- Current functional capacities of the enrollee;
- Family factors (e.g., parenting skills, living environment, and psycho-social problems);
- Interaction with other agencies.
- The PASS Agency initiates services within 30 calendar days of signing the service plan.
- The service plan includes a reassessment of the progress toward goals from the previous plan. Revisions and modifications of the goals and objectives may be needed as result of changes in the enrollee's status or family circumstances and must be agreed upon and approved by all parties.
- The PASS Agency completes reauthorization of the PASS service plan requiring renewal at least 15 calendar days prior to expiration of the existing approved plan.

Supported Employment

SUPPORTED EMPLOYMENT is a program that assists adults who are recovering from a severe and persistent mental illness with finding and keeping meaningful jobs that pay at least minimum wage and are in work settings that include people who are not disabled.

Supported Employment programs adhere to the following core values:

- Integration of rehabilitation services with mental health treatment
- Rehabilitation unit
- Open enrollment (zero exclusion criteria)
- Ongoing work-based assessment
- Individualized rapid search for gainful employment
- Individualized job search
- Diversity of jobs developed
- All job experiences are viewed positively as part of the recovery process
- Competitive jobs prioritized
- Follow-along supports
- Community-based services
- Assertive engagement and outreach

Admission Criteria

- The member is diagnosed with any of the following conditions:
 - Schizophrenia
 - Schizoaffective Disorder
 - Schizoid Personality Disorder
 - Bipolar Disorder
 - Major Depressive Disorder, Recurrent
 - Obsessive-Compulsive Disorder
 - Borderline Personality Disorder
 - Delusion Disorder
 - Psychotic Disorder

Service Delivery

- Upon referral the provider conducts an initial evaluation. The initial evaluation:
 - Gathers information about the presenting issues from the perspective of the member, and includes the member's understanding of the factors that lead to requesting services;
 - Focuses on the member's specific vocational needs;
 - Identifies the member's goals and expectations;
 - Is completed in a timeframe commensurate with the member's needs, or otherwise in accordance with evidence-based practices.
- The provider and the member use the findings of the initial evaluation to develop a plan that includes:
 - The member's vocational goals;
 - Nonwork needs that may impact the member's ability to work;

- The skills, knowledge, activities or other interventions that will be used for each goal;
- Activities needed to improve the member's engagement such as motivational enhancement or learning activities;
- The plan to coordinate Supported Employment services with the member's behavioral health provider and other service providers.
- Supported Employment services include at least the following:
 - Job seeking skills training;
 - Job development and job matching services;
 - Job coaching;
 - Follow-along supports;
 - Benefits counseling;
 - Referral to the Office of Rehabilitation Services;
 - Career counseling and training;
 - Referral to other community resources that provide employment assistance;
 - Planning for transportation necessary to gain or keep employment.
- Supported Education Services shall, at a minimum, assist an individual with the following:
 - Planning for, and applying to GED and post-secondary educational programs and opportunities;
 - Researching and applying for financial aid;
 - Accessing the disability services of the educational institution;
 - Planning for transportation necessary for attaining educational goals;
 - Implementing follow-along supports to include on-site and/or off-site supports;
 - Referral to other community organizations that will support the individual's educational goals.
- The program provides an effective system for ensuring that the member can access crisis intervention services in the event that a critical incident could impact the member's employment.
- The provider in collaboration with the member utilizes information about the member's interests and skills to perform an ongoing work-based assessment aimed at identifying the type of work and environment for which the member is best suited.
- The provider takes the member's lead in finding a good-fit job as quickly as possible. The member's preferences, skills, needs, and process of recovery dictate the timeline.
- The provider prioritizes mainstream jobs with permanent status over sheltered or time-limited jobs.
- The provider helps the member end jobs when appropriate and assists the member with finding another job.
- As needed, the provider provides the member with time-limited follow-along supports such as education and training that address the member's social and vocational needs. Opportunities for peer support are facilitated.
- The provider regularly meets with the member's behavioral health service team, and shares information needed to assist the member with reaching their goals for recovery.
- The provider in collaboration with the member conducts a formal review of the plan at least every 6 months. The provider and member involve the employer in the review as appropriate. The plan is reviewed more often than once every 6 months when there are significant changes.

Evidence-Based Practices

EVIDENCE-BASED PRACTICES (EBP) are Home and Community Based Treatment modalities designed for children with complex health needs that include an array of services to meet the continuum of care a child, adolescent, and family needs.

EBP services include but are not limited to Multisystemic Treatment (MST)²⁰, Parenting with Love and Limits (PLL)²¹, and Trauma Systems Therapy (TST)²². While models of EBP vary, the overarching goals of these services are as follows:

- Improve Care and Access: improve overall health and quality of life of children and families, improve family ability to manage symptoms and behaviors in the home, and improve ability for children to thrive in their communities.
- Reduce Cost: decrease utilization of the Emergency Room, decrease utilization of higher cost settings such as hospitals or residential placements, encourage alternative payment methodologies for these services.
- Improve Quality: promote evidence-based practices and encourage provider incentives to improve quality of care.

Admission Criteria

- The member meets the following eligibility criteria:
 - Member is aged birth to 21 and is Medicaid eligible.

- Member is eligible for Medical Assistance through Supplemental Security Income (SSI), Katie Beckett (through age 18), Adoption Subsidy, Rite Care, or Rite Share.

AND

- There are acute changes in the member's signs and symptoms, and/or psychosocial and environmental factors which suggest that the member is at risk for out-of-home care or hospitalization, or otherwise requires ongoing involvement with multiple systems due to high-risk behaviors. The member's current condition can be safely, efficiently, and effectively assessed and/or treated in this setting. Examples of factors that put the member at risk include:
 - Complex and persistent behavioral health conditions with/without co-occurring medical conditions.
 - Behavioral health conditions coupled with abuse, neglect, or other forms of trauma.
 - Behavioral health conditions coupled with delinquency, truancy, or running away.

AND

- The member meets the target criteria for the proposed EBP:
 - Multisystemic Therapy: member is aged 12 to 17, is a juvenile offender, and presents with externalizing behavior symptomatology consistent with Disruptive, Impulse-Control and Conduct Disorders (e.g., Conduct Disorder).
 - Parenting with Love and Limits: member is aged 10-18, is a juvenile offender, and presents with externalizing behavior symptomatology consistent with Disruptive, Impulse-Control and Conduct Disorders (e.g., Conduct Disorder) or a severe form of another externalizing condition (e.g., Attention-Deficit/Hyperactivity Disorder).
 - Trauma Systems Therapy: member is aged 5-21, and has ongoing trouble regulating their emotions/behavior as a result of trauma.

References

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Revision History

Date	Summary of Changes
January, 2016	Version 1
January, 2017	Version 2
February, 2018	Version 3
July, 2019	Version 4
January, 2020	Version 5: Added Evidence-Based Practice Criteria section, updated with LOCUS/CASII/ECSII language.
January, 2021	Version 6: Annual Review
April, 2022	Version 7: Annual Review
June, 2023	Version 8: Annual Review
September, 2024	Version 9: Annual Review