Level of Care Guidelines: UnitedHealthcare Specialized I/DD Enhanced Supportive Housing

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INTRODUCTION

Level of Care Guidelines are a set of objective and evidence-based behavioral health criteria used by medical necessity plans to standardize coverage determinations, promote evidence-based practices, and support members' recovery, resiliency, and wellbeing.

INSTRUCTIONS FOR USE

This guideline is used to make coverage determinations as well as to inform discussions about evidence-based practices and discharge planning. 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 this guideline. 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 guideline and the member's specific benefit, the member's specific benefit supersedes this guideline. Other clinical criteria may apply.

This guideline is provided for informational purposes. It does not constitute medical advice.

BENEFIT CONSIDERATIONS

Before using this guideline, please check the member-specific benefit plan document and any federal or state mandates, if applicable.

DESCRIPTION OF SERVICE AND GENERAL INFORMATION

Specialized I/DD Enhanced Supportive Housing

Treatment services for individuals 18 yo and older with I/DD delivered in an Enhanced Supported Housing (ESH) setting. The Specialized I/DD ESH are staffed twenty-four hours per day, seven days a week with associated mental health staff supports for individuals who require treatment services and supports within a highly structured, safe, and secure setting. This level of care customarily includes additional 2:1 staffing accommodations for their I/DD and behavioral health symptoms. This program is intended to prepare individuals for more independent living in the community while providing an environment that fosters recovery and resiliency and allows individuals to live in community settings.

According to the DSM-5, co-occurring conditions are frequent in people with intellectual disability, with the rates of mental conditions three to four times higher than in the general population. Specialized mental health treatment options for individuals with intellectual disabilities and co-occurring mental health or behavior conditions continue to be sparse in the United States (Charlot and Beasley, 2013). People with intellectual disabilities who also present with co-occurring mental health issues are more likely to be

institutionalized, and this population of individual also express higher rates of dissatisfaction with community living situations when in community-based settings (Charlot and Beasley, 2013). An analysis of models of treatment suggests that a combination of behaviorally based and other psychosocial treatment can have a positive impact on individuals with intellectual disabilities with co-occurring mental health or behavioral conditions.

CLINICAL INDICATIONS

Admission Criteria: Members must meet all criteria to be admitted to the service.

A. Members must be diagnosed with a confirmed diagnosis of ID/DD and a significant co-occurring behavioral health condition such as autism or SPMI.

B. The member has treatment needs that cannot be met in a less restrictive or less supportive community-based settings, for example, needs 2:1 or higher levels of supervision that are not available in other community-based settings.

C. Members are at-risk of hospitalization or admission to an ICF/IID.

D. Members who are at risk of losing their community level services and support.

E. Member may be in need of assessment at this level of care due to risk factors for community level assessment such as significant behavioral and/or psychiatric concerns, problematic sexual behaviors, severe aggression, destruction of property, substance abuse, or self-injurious behavior.

Continued Stay Criteria (meets one of the criteria below)

A. Member continues to meet the Admission Criteria.

B. Member is responding to current treatment interventions that will lead to community stability and recovery.

C. If member is not responding, treatment plans have been reviewed and modified to address identified barriers to member progress.

D. Member is in need of at least weekly medication review and/or is having difficulty adhering to medication administration.

E. Treatment plans cannot be replicated in less-restrictive or less supportive community-based settings (e.g., need for PRN medication, 2:1or higher staffing).

F. Transition planning is ongoing and is working towards available support and services in less-restrictive community-based settings to include the following:

   a. Evidence member and/or conservator participated in the development of transition plan

   b. Specific projected date of discharge to a less intensive setting

   c. Specific anticipated aftercare services (mental health, physical health, etc.)

Discharge Criteria (meets one of the criteria below)

A. Member no longer meetings Continued Stay Criteria

B. There is lack of measurable progress and no identified clinical intervention that will likely change the lack of measurable progress.

C. Members have treatment plans that can be replicated in less-restrictive and less-supportive community-based settings and otherwise do not meet continued stay criteria

D. Members are not at imminent risk of hospitalization or admission to ICF/IID.

E. Member is in need of a higher level of care.

F. Member refuses to participate or engage in services/declines services.

Limitations on Coverage: N/A.

PROGRAM REQUIREMENTS

A. Direct service providers employed by the agency will have gone through the training to be an RBT. If not yet certified, they will be working towards certification under the supervision of a Licensed Behavioral Analyst (BA).

B. Program Providers will have access to a Licensed BA for consultation and service provision.

C. Providers will obtain weekly medication evaluation through MD or NP services.

D. Therapists should be trained in evidence-based treatment modalities specific for members with ID/DD and/or utilize interventions that are modified to work with the population.

E. Providers will have the ability to provide transitional skills training through the use of a curriculum or structured learning program.

F. Providers should ensure a minimum client-staffing ratio of 1:4 to meet the needs of this population.

G. Providers will have the ability to render Behavioral Assessments to begin within 24 hours of admission and completed so that it will inform person centered treatment plan. Still some questions around G and H. SS will follow up regarding outcome.

H. Person-Centered Treatment planning should be developed within the first 30 days of admission and available upon request and should be adjusted based on evaluation of members' needs.

I. Person-Centered Treatment plans should be reviewed at least every 90 days or based on the individualized needs of the member.

J. Goal of treatment should be focused on the ability for person to be supported safely in less-restrictive and less-supportive community-based settings.

K. The provider will train community caregivers/ supports in an effort to increase competency and ensure successful transition to less-restrictive community-based settings.

L. Caregivers should be required to present or be involved in members' care through skills training, etc.

M. Provider will coordinate dental/medical needs under Medicaid/other benefits.

N. Providers must be able to accommodate members with comorbid medical conditions and/or physical disabilities.

O. Provider will have training in an approved crisis management program.

REFERENCES

American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (5th ed.). Arlington, VA: Author.

Lauren Charlot & Joan B. Beasley (2013) Intellectual Disabilities and Mental Health: United States–Based Research, Journal of Mental Health Research in Intellectual Disabilities, 6:2, 74-105, DOI: 10.1080/19315864.2012.715724