



Mississippi 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.

Assertive Community Treatment

ASSERTIVE COMMUNITY TREATMENT (ACT) A Program of Assertive Community Treatment (PACT) is an individual-centered, recovery-oriented mental health service delivery model for facilitating community living, psychological rehabilitation and recovery for people who have the most severe and persistent mental illnesses, have severe symptoms and impairments, and have not benefited from traditional outpatient services.

Program of Assertive Community Treatment Teams serve people with severe and persistent mental illness as listed in the most current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association that seriously impair their functioning in community living. Priority is given to people with schizophrenia, other psychotic disorders (e.g., schizoaffective disorder), and bipolar disorder because these illnesses more often cause long-term psychiatric disability. People with other psychiatric illnesses are eligible dependent on the level of the long-term disability. (People with a primary diagnosis of a substance use disorder, intellectual disability or other Axis II disorders are not the intended group. Additionally, people with a chronically violent history may not be appropriate for this service.)

- Programs of Assertive Community Treatment serve people who may have gone without appropriate services. Consequently, the individual group is often overrepresented among the homeless and in jails and prisons and has been unfairly thought to resist or avoid involvement in treatment.
- Programs of Assertive Community Treatment Services are delivered by a group of multidisciplinary mental health personnel who work as a team and provide the majority of the treatment, rehabilitation, and support services people need to achieve their goals. Many, if not all, employees share responsibility for addressing the needs of all people requiring frequent contact.
- Programs of Assertive Community Treatment Services are individually tailored to each person and address the preferences and identified goals of each person. The approach with each person emphasizes relationship building and active involvement in assisting people with severe and persistent mental illness to make improvements in functioning, to manage symptoms better, to achieve individual goals, and to maintain optimism.
- The Program of Assertive Community Treatment Team is mobile and delivers services in community locations to enable each person to find and live in his/her own residence and find and maintain work in community jobs rather than expecting the person to come to the service.
- Program of Assertive Community Treatment Services are delivered in an ongoing rather than time-limited framework to aid the process of recovery and ensure continuity of care. Severe and persistent mental illnesses are episodic disorders, and many people benefit from the availability of a longer-term treatment approach and continuity of care. This allows people the opportunity to decompensate, consolidate gains, sometimes slip back, and then take the next steps forward until they achieve recovery.

Admission Criteria

People with significant functional impairments as demonstrated by at least one (1) of the following conditions:

- Significant difficulty consistently performing the range of practical daily living tasks required for basic adult functioning in the community (e.g., caring for personal business affairs; obtaining medical, legal, and housing services; recognizing and avoiding common dangers or hazards to self and possessions; meeting nutritional needs; maintaining personal hygiene) or persistent or recurrent difficulty performing daily living tasks except with significant support or assistance from others such as friends, family, or relatives.
- Significant difficulty maintaining consistent employment at a self-sustaining level or significant difficulty consistently carrying out the homemaker role (e.g., household meal preparation, washing clothes, budgeting, or child-care tasks and responsibilities).
- Significant difficulty maintaining a safe living situation (e.g., repeated evictions or loss of housing).

People must have one (1) or more of the following problems, which are indicators of continuous high-service needs (i.e., greater than eight (8) hours per month):

- High use of acute psychiatric hospitals (e.g., two [2] or more admissions per year) or psychiatric emergency services.
- Intractable (i.e., persistent, or very recurrent) severe major symptoms (e.g., affective, psychotic, suicidal).
- Coexisting substance use disorder of significant duration (e.g., greater than six [6] months).
- High risk or recent history of criminal justice involvement (e.g., arrest, incarceration).

- Significant difficulty meeting basic survival needs, residing in substandard housing, homelessness, or in imminent risk of becoming homeless.
- Residing in an inpatient or supervised community residence, but clinically assessed to be able to live in a more independent living situation if intensive services are provided or requiring a residential or institutional placement if more intensive services are not available.
- Difficulty effectively utilizing traditional office-based outpatient services.

Discharge Criteria

Discharges from the Program of Assertive Community Treatment Team occur when people and agency provider employees mutually agree to the termination of services. This must occur when people:

- Have successfully reached individually established goals for discharge, and when the person and agency provider employees mutually agree to the termination of services.
- Have successfully demonstrated an ability to function in all major role areas (i.e., work, social, self-care) without ongoing assistance from the agency provider, without significant relapse when services are withdrawn, and when the person requests discharge, and the agency provider employees mutually agree to the termination of services.
- Move outside the geographic area of the Program of Assertive Community Treatment Team's responsibility. In such cases, the Program of Assertive Community Treatment Team must arrange for transfer of mental health service responsibility to a Program of Assertive Community Treatment Service or another agency provider wherever the person is moving. The Program of Assertive Community Treatment Team must maintain contact with the person until this service transfer is implemented.
- Decline or refuse services and request discharge, despite the team's best efforts to develop an acceptable Individual Service Plan with the person.

Service Delivery

Operating as a continuous treatment service, the Program of Assertive Community Treatment Team must have the capability to provide comprehensive treatment, rehabilitation, and support services as a self-contained service unit. Services must minimally include the following (1-11):

- Service Coordination/Individual Treatment Team
 - Each person will be assigned one (1) member of the Program of Assertive Community Treatment Team to serve as a service coordinator who coordinates and monitors the activities of the person's individual treatment team (ITT) and the greater Program of Assertive Community Treatment Team.
 - The primary responsibility of the service coordinator is to work with the person to write the Individual Service Plan, to provide individual supportive counseling, to offer options and choices in the Individual Service Plan, to ensure that immediate changes are made as the person's needs change, and to advocate for the person's wishes, rights, and preferences.
 - The service coordinator is also the first employee called on when the person is in crisis and is the primary support person and educator to the person and/or person's family. Members of the person's treatment team share these tasks with the service coordinator and are responsible to perform the tasks when the service coordinator is not working. Service coordination also includes coordination with community resources, including self-help and advocacy organizations that promote recovery.
 - Each person will be assigned to an individual treatment team. The individual treatment team is a group or combination of three to five (3-5) Program of Assertive Community Treatment personnel who together have a range of clinical and rehabilitation skills and expertise. The individual treatment team members are assigned to work with a person receiving services by the team leader and the psychiatrist/psychiatric nurse practitioner by the time of the first Individual Service Planning meeting or thirty (30) days after admission.
 - The core members of the individual treatment team are the service coordinator, the psychiatrist/psychiatric nurse practitioner, and one (1) clinical or rehabilitation personnel who shares case coordination tasks and substitutes for the service coordinator when he or she is not working. The individual treatment team has continuous responsibility to:
 - be knowledgeable about the person's life, circumstances, goals, and desires;
 - collaborate with the person to develop and write the Individual Service Plan;
 - offer options and choices in the Individual Service Plan;

- ensure that immediate changes are made as a person's needs change; and,
 - advocate for the person's wishes, rights, and preferences. The individual treatment team is responsible for providing much of the person's treatment, rehabilitation, and support services. Individual treatment team members are assigned to take separate service roles with the person as specified by the person and the individual treatment team in the Individual Service Plan.
- Crisis Assessment and Intervention
 - Crisis assessment and intervention must be provided twenty-four (24) hours per day, seven (7) days per week. These services will include telephone and face-to-face contact and will be provided in conjunction with the local community mental health system's emergency services program as appropriate.
 - A system must be in place that assures the person can contact the Program of Assertive Community Treatment Team as necessary.
- Symptom Assessment and Management includes but is not limited to the following:
 - Ongoing comprehensive assessment of the person's mental illness symptoms, accurate diagnosis, and the person's response to treatment.
 - Psychoeducation regarding mental illness and the effects and side effects of prescribed medications.
 - Symptom-management efforts directed to help each person identify/target the symptoms and occurrence patterns of his or her mental illness and develop methods (internal, behavioral, or adaptive) to help lessen the effects.
 - Individual supportive therapy.
 - Psychotherapy.
 - Generous psychological support to people, both on a planned and as-needed basis, to help them accomplish their personal goals, to cope with the stressors of day-to-day living, and to recover.
- Medication Prescription, Administration, Monitoring and Documentation
 - The Program of Assertive Community Treatment Team psychiatrist/psychiatric nurse practitioner must:
 - Establish an individual clinical relationship with each person.
 - Assess each person's mental illness symptoms and provide verbal and written information about mental illness.
 - Make an accurate diagnosis based on the comprehensive assessment which dictates an evidence-based medication pathway that the psychiatrist/psychiatric nurse practitioner will follow.
 - Provide education about medication, benefits, and risks, and obtain informed consent.
 - Assess and document the person's mental illness symptoms and behavior in response to medication and monitor and document medication side effects.
 - Provide psychotherapy.
 - All Program of Assertive Community Treatment Team members must regularly assess and document the person's mental illness symptoms and behavior in response to medication and must monitor for medication side effects. This information should be shared with the prescriber.
 - The Program of Assertive Community Treatment Teams must establish medication policies and procedures which identify processes to:
 - Record physician orders;
 - Order medication;
 - Arrange for all individual medications to be organized by the team and integrated into people's weekly schedules and daily employee assignment schedules;
 - Provide security for medications (e.g., daily, and longer-term supplies, and long-term injectables) and set aside a private designated area for set-up of medications by the team's nursing personnel;
 - Administer medications per state law to people receiving Program of Assertive Community Treatment services; and,
 - Comply with Rule 13.8.
- Co-Occurring Substance Use Services
 - Co-Occurring Substance Use Services are the provision of a stage-based treatment model that is non-confrontational, considers interactions of mental illness and substance use, and has individual-determined goals. This must include but is not limited to individual and group interventions in:
 - Engagement (e.g., empathy, reflective listening, avoiding argumentation);
 - Assessment (e.g., stage of readiness to change, individual-determined problem identification);

- Motivational enhancement (e.g., developing discrepancies, psychoeducation);
 - Active treatment (e.g., cognitive skills training, community reinforcement); and,
 - Continuous relapse prevention (e.g., trigger identification, building relapse prevention action plans).
- Work-Related Services
 - Work-related services to help people value, find, and maintain meaningful employment in community-based job sites and services to develop jobs and coordinate with employers but also includes but is not necessarily limited to:
 - Assessment of job-related interests and abilities through a complete education and work history assessment as well as on-the-job assessments in community-based jobs.
 - Assessment of the effect of the person's mental illness on employment with identification of specific behaviors that interfere with the person's work performance and development of interventions to reduce or eliminate those behaviors and find effective job accommodations.
 - Development of an ongoing employment plan to help each person establish the skills necessary to find and maintain a job.
 - Individual supportive therapy to assist people to identify and cope with mental illness symptoms that may interfere with their work performance.
 - On-the-job or work-related crisis intervention.
 - Work-related supportive services, such as assistance with grooming and personal hygiene, securing of appropriate clothing, wake-up calls, and transportation, if needed.
 - Activities of Daily Living
 - Services to support activities of daily living in community-based settings include individualized assessment, problem solving, sufficient side-by-side assistance and support, skill training, ongoing supervision (e.g., prompts, assignments, monitoring, encouragement), and environmental adaptations to assist people to gain or use the skills required to:
 - Find housing, which is safe, of good quality, and affordable (e.g., apartment hunting; finding a roommate; landlord negotiations; cleaning, furnishing, and decorating); and, procuring necessities (such as telephones, furnishings, linens).
 - Perform household activities, including house cleaning, cooking, grocery shopping, and laundry.
 - Carry out personal hygiene and grooming tasks, as needed.
 - Develop or improve money-management skills.
 - Use available transportation.
 - Have and effectively use a personal physician and dentist.
 - Social/Interpersonal Relationship and Leisure-Time Skill Training
 - (a) Services to support social/interpersonal relationships and leisure-time skill training include supportive individual therapy (e.g., problem solving, roleplaying, modeling, and support); social-skill teaching and assertiveness training; planning, structuring, and prompting of social and leisure-time activities; side-by-side support and coaching; and, organizing individual and group social and recreational activities to structure people's time, increase their social experiences, and provide them with opportunities to practice social skills and receive feedback and support required to:
 - Improve communication skills, develop assertiveness, and increase self-esteem;
 - Develop social skills, increase social experiences, and develop meaningful personal relationships;
 - Plan appropriate and productive use of leisure time;
 - Relate to landlords, neighbors, and others effectively; and,
 - Familiarize themselves with available social and recreational opportunities and increase their use of such opportunities.
 - Peer Support Services
 - Services to validate people's experiences and to guide and encourage people to take responsibility for and actively participate in their own recovery. In addition, services to help people identify, understand, and combat stigma and discrimination against mental illness and develop strategies to reduce people's self-imposed stigma;
 - Peer counseling and support; and,
 - Introduction and referral to self-help services and advocacy organizations that promote recovery.

- Support Services
 - Support services or direct assistance to ensure that people obtain the necessities of daily life, including but not necessarily limited to:
 - Medical and dental services;
 - Safe, clean, affordable housing;
 - Financial support and/or benefits counseling (e.g., SSI, SSDI, Food Stamps, Section 8, Vocational Rehabilitation, Home Energy Assistance);
 - Social services;
 - Transportation; and,
 - Legal advocacy and representation.
- Education, Support, and Consultation to People’s Families and other Major Supports
 - Services provided regularly under this category to people’s families and other major supports, with individual agreement or consent, include:
 - Individualized psychoeducation about the person’s illness and the role of the family and other significant people in the therapeutic process;
 - Intervention to restore contact, resolve conflict, and maintain relationships with family and/or other significant people;
 - Ongoing communication and collaboration, face-to-face and by telephone, between the Program of Assertive Community Treatment’s Team and the family;
 - Introduction and referral to family self-help services and advocacy organizations that promote recovery;
 - Assistance to people with children (including individual supportive counseling, parenting training, and service coordination) including but not limited to i. Services to help people throughout pregnancy and the birth of a child; ii. Services to help people fulfill parenting responsibilities and coordinate services for the child/children; and iii. Services to help people restore relationships with children who are not in the person’s custody.

Community Support and Treatment

COMMUNITY SUPPORT SERVICES (CSS) provides an array of support services delivered by community based mobile professionals. Services address the individualized mental health needs of the client. They are directed towards adults, children, adolescents, and families and will vary with respect to hours, type, and intensity of services, depending on the changing needs of everyone. The purpose/intent of CSS is to provide specific, measurable, and individualized services to each person served. CSS should be focused on the individual’s ability to succeed in the community; to identify and access needed services; and to show improvement in school, work and family and integration and contributions within the community.

CSS not only assists the individual in gaining access to needed services necessary for community integration and sustainability within the community but may also provide direct services such as supportive counseling/reality orientation, skills training, enlisting social supports, financial management counseling, and monitoring physical and mental health status.

Admission Criteria

- Documentation that the CSS provided are medically necessary to maintain the child or adult in the least restrictive, yet appropriate environment within the community.

Service Delivery

- CSS includes the following as indicated:
 - Identification of strengths which will aid the enrollee in their recovery and the barriers that will challenge the development of skills necessary for independent functioning in the community.
 - Individual therapeutic interventions with an enrollee that directly increase the acquisition of skills needed to accomplish the goals set forth in the Individual Service Plan.
 - Monitoring and evaluating the effectiveness of interventions, as evidenced by symptom reduction and program toward goals.
 - Psychoeducation on the identification and self-management of prescribed medication regimen and communication with the prescribing provider.
 - Direct interventions in deescalating situations to prevent crisis.

- Assisting the enrollee and natural supports in implementation of therapeutic interventions outlined in the Individual Service Plan.
- Relapse prevention and disease management strategies.
- Psychoeducation and training of family, unpaid caregivers, and/or others who have a legitimate role in addressing the needs of the individual.
- Facilitation of the Individual Service Plan which includes the active involvement of the enrollee and the people identified as important in the enrollee's life.

Day Treatment

DAY TREATMENT SERVICES are mid-level intensity programs designed to promote successful community living and well-being for children and youth with serious emotional disturbance. The services provide an alternative to the more restrictive community-based services, such as acute partial hospitalization and MYPAC, and serve to prevent the need for residential treatment, unnecessary acute psychiatric hospitalizations and/or minimize disruptions to the child/youth's participation in the regular school setting. Day Treatment Services are based on therapeutic interventions that address the child/youth's underlying condition, as well as the alleviation of current symptomology. Programmatic activities are based on behavior management principles and include, at a minimum, positive feedback, self-esteem building and social skills training. Additional components are determined by the needs of the participants at a particular service location and may include skills training in the areas of impulse control, anger management, problem solving, and/or conflict resolution.

Admission Criteria

- Children/youth must have the following in order to receive Day Treatment Services:
 - The member has an eligibility determination for (1) of the following: Serious Emotional Disturbance or Autism/Asperger's.
 - A justification of the need for Day Treatment Services which must include documentation of the intensity and duration of problems, as part of the initial assessment or as part of a post-intake case staffing and at least annually thereafter.
- Children/youth must be between the ages of three and twenty-one (3-21) to be considered for enrollment in Day Treatment Services. Group composition must be both age and developmentally appropriate.

Service Delivery

- Each individual Day Treatment program must operate at a minimum of two (2) hours per day, two (2) days per week up to a maximum of five (5) hours per day, five (5) days per week. Each child/youth enrolled in Day Treatment Services must receive the service a minimum of four (4) hours per week.
- To ensure each child/youth's confidentiality, no children/youth other than those enrolled in Day Treatment Services can be present in the room during the time Day Treatment Services are being provided. Only one (1) Day Treatment Service program is allowed per room during the same time period.
- Each individual Day Treatment Services program must operate under a separate DMH Certificate of Operation.
- The Day Treatment Services Director or his/her designee must:
 - Supervise, plan, coordinate, and evaluate Day Treatment Services. Supervision must be provided at least one (1) continuous hour per month. This should include participation in clinical staffing and/or Treatment Plan review for the people in the program(s) that he/she implements or directs.
 - Provide at least thirty (30) continuous minutes of direct observation to each individual Day Treatment Services program at least quarterly. Documentation of the supervision/observation must be maintained for review.
- The Day Treatment Specialist must participate in clinical staffing and/or Treatment Plan review for the people in the program that he/she serves as the primary clinical employee.
- DMH Division of Certification must be notified immediately of any interruption of service with an individual Day Treatment program extending over thirty (30) days. If operation has been interrupted for sixty (60) calendar days, the DMH Certificate of Operation for that individual program must be returned to the DMH Division of Certification.
- Day Treatment Services are intended to operate year-round and cannot be designed to operate solely during the summer months. M. Day Treatment Service programs that are unable to provide services during a school's summer vacation will be allowed to hold that individual program Certificate of Operation until it can be reopened the following school year. If the program has not reopened within sixty (60) calendar days from the first day of the school year, the Certificate of Operation must be returned to the DMH Division of Certification.

- Individual Day Treatment Service programs that do not meet during summer vacation must offer services (i.e., Community Support Services, outpatient therapy, etc.) for the child/youth to the parent(s)/legal representative(s) for the period Day Treatment Services are temporarily not in operation. Documentation must be maintained in each child/youth's record that availability of other services was explained and offered to the parent(s)/legal representative(s).
- Individual Day Treatment programs operated in a school must ensure that Day Treatment Services continue to adhere to all DMH Operational Standards for MH/IDD/SUD Community Service Providers for this service. Day Treatment Services are a separate program from educational programs which must meet applicable MS Department of Education standards and regulations. Day Treatment Services and educational services may not be provided concurrently.
- Each Day Treatment program must be designed and conducted as a therapeutic milieu as evidenced by the use of a curriculum approved by DMH and must include, but not be limited to, such skill areas as functional living skills, socialization, or social skills, problem-solving, conflict resolution, self-esteem improvement, anger control and impulse control. The approved curriculum must be kept on-site. All activities and strategies implemented must be therapeutic, age appropriate, developmentally appropriate, and directly related to the objectives in each child/youth's Individual Service Plan.
- All Day Treatment Programs must include the involvement of the family or people acting in loco parentis as often as possible, but not less than twice per month, in order to achieve improvement that can be generalized across environments.
- Each Day Treatment Program must operate with a minimum of four (4) and a maximum of ten (10) children/youth. A Day Treatment roll/roster cannot exceed ten (10) children/youth per program.
- Day Treatment Programs developed and designed to serve primarily children/youth with a diagnosis of Autism shall not include more than four (4) children/youth with a diagnosis of Autism.
- In order to participate in the Day Treatment Program, a child/youth must be on the permanent roster for the program. They shall not participate on an intermittent basis.
- Each Day Treatment Program must have a monthly Master Schedule on file at each location to include, at a minimum, the specific skill areas being addressed each day and the specific times these skill areas are being addressed. Skill area activities shown on the Master Schedule must be curriculum specific.
- Each Day Treatment Program must comply with the following:
 - A minimum of twenty (20) square feet of usable space per child/youth.
 - In cases of programs located in a school, the mental health provider is responsible for ensuring that the school district provides a location that meets all DMH Health and Safety requirements. Programs that are conducted in space that is currently accredited by the MS Department of Education will be considered as meeting all Environment/Safety standards.
 - Furnishings, equipment, square footage, and other aspects of the Day Treatment Program environment must be age-appropriate, developmentally appropriate, and therapeutic in nature.
- The ratio of employees to children/youth receiving services in each Day Treatment Program will be maintained at a minimum ratio of two (2) employees on-site for a minimum of four (4) up to a maximum of ten (10) children/youth per program. Each program must be led by a Day Treatment Specialist. Day Treatment Assistants serve as the second needed employee in this ratio.
- For all children/youth participating in Day Treatment Programs, there must be documentation of plans for transitioning a child/youth to a less intensive therapeutic service. This documentation must be a part of each child/youth's Individual Service Plan and/or case staffing. Transition planning should be initiated when the child/youth begins to receive Day Treatment Services and must be documented within one (1) month of the child/youth's start date for the service.

Intensive Community Outreach and Recovery Team

The Intensive Community Outreach and Recovery Team is a recovery and resiliency oriented, intensive, community-based rehabilitation and outreach service for adults with a severe and persistent mental illness. It is a team-oriented approach to mental health rehabilitation intervention and supports necessary to assist people in achieving and maintaining rehabilitative, resiliency and recovery goals.

Intensive Community Outreach and Recovery services are provided primarily in natural settings and are delivered face-to-face with the person and their family/significant other as appropriate, to the primary well-being and benefit of the recipient. Intensive Community Outreach and Recovery assists in the setting and attaining of individually defined recovery/resiliency goals. The Intensive Community Outreach and Recovery primary treatment objective is to assist in keeping the people receiving the service in the community in which they live, avoiding placement in state-operated behavioral health service locations.

Intensive Community Outreach and Recovery Team for Children/Youth with Serious Emotional Disturbance

The Intensive Community Outreach and Recovery Team is a resiliency oriented, intensive, community-based rehabilitation service for children and youth with serious emotional/behavioral disturbance. Intensive Community Outreach and Recovery Services support the entire family lacking access to office-based services and/or when needs cannot be met by traditional outpatient services and failure to intervene through community-based intervention could result in the child or youth becoming at risk for out-of-home therapeutic resources.

Intensive Community Outreach and Recovery services are provided primarily in natural settings and are delivered face-to-face with the child or youth and/or his/her family/guardian/caregiver. Intensive Community Outreach and Recovery assists in the setting and attaining of youth-guided and family-driven resiliency goals. The ultimate goal is to stabilize the living arrangement, promote reunification or prevent the utilization of out-of-home therapeutic resources (i.e., psychiatric hospital, therapeutic foster care, and residential treatment facility).

Admission Criteria – Adults

- Intensive Community Outreach and Recovery only serves people with severe and persistent mental illness as listed in the most current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association which seriously impairs their functioning in community living. Priority is given to people with schizophrenia, other psychotic disorders (e.g., schizoaffective disorder), and bipolar disorder because these illnesses more often cause long-term psychiatric disability. People with other psychiatric illnesses are eligible dependent on the level of the long-term disability. (People with a primary diagnosis of a substance use disorder, mental retardation or other Axis II disorders are not the intended group. Additionally, people with a chronically violent history may not be appropriate for this service.)
- People with significant functional impairments as demonstrated by at least one (1) of the following conditions:
 - Significant difficulty consistently performing the range of practical daily living tasks required for basic adult functioning in the community (e.g., caring for personal business affairs; obtaining medical, legal, and housing services; recognizing and avoiding common dangers or hazards to self and possessions; meeting nutritional needs; maintaining personal hygiene) or persistent or recurrent difficulty performing daily living tasks except with significant support or assistance from others such as friends, family, or relatives.
 - Significant difficulty maintaining consistent employment at a self-sustaining level or significant difficulty consistently carrying out the homemaker role (e.g., household meal preparation, washing clothes, budgeting, or child-care tasks and responsibilities).
 - Significant difficulty maintaining a safe living situation (e.g., repeated evictions or loss of housing).
- People with one (1) or more of the following problems, which are indicators of continuous high-service needs (i.e., greater than eight [8] hours per month):
 - High use of acute psychiatric hospitals (e.g., two [2] or more admissions per year) or psychiatric emergency services (extensive use of Mobile Crisis Response Team services).
 - Intractable (i.e., persistent, or very recurrent) severe major symptoms (e.g., affective, psychotic, suicidal).
 - Coexisting substance use disorder of significant duration (e.g., greater than six [6] months).
 - High risk or recent history of criminal justice involvement (e.g., arrest, incarceration) due to behavioral problems attributed to the person's mental illness.
 - Significant difficulty meeting basic survival needs, residing in substandard housing, homelessness, or imminent risk of becoming homeless.
 - Residing in an inpatient or supervised community residence, but clinically assessed to be able to live in a more independent living situation if intensive services are provided or requiring a residential or institutional placement if more intensive services are not available.
 - Difficulty effectively utilizing traditional office-based outpatient services (office-based individual and/or group therapy, psychosocial rehabilitation, and medication monitoring).

Admission Criteria – Children/Adolescents

- In order to be admitted into Intensive Community Outreach and Recovery Services, children and youth must meet the criteria.
- Intensive Community Outreach and Recovery serves children and youth with a serious emotional/behavioral disturbance as listed in the most current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association which seriously impairs their functioning in community living. Priority is given to children, and youth and their families who lack

access to office-based services and/or who have experienced multiple acute hospital and/or residential care stays, who are at risk of out-of-home placement or have been recommended for residential care, and for those children and youth for whom traditional outpatient care has not been successful.

- Children and youth with functional impairments as demonstrated by at least one (1) of the following conditions:
 - Child or youth has a serious emotional/behavioral disturbance as listed in the most current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association which impairs his/her functioning in community living.
 - Child or youth is at-risk for out-of-home placement or use of out-of-home therapeutic resources without community-based intervention.
 - Child or youth has difficulty demonstrating success in the home and educational environment due to emotional, social, and/or behavioral challenges.
 - Child or youth has had difficulty effectively utilizing traditional office-based or school-based outpatient services (office-based individual and/or group therapy, day treatment services, school-based therapies).
 - Family members of the child or youth have needs to be met and/or the family is experiencing multiple system involvement.
 - Youth has high risk or recent history of juvenile justice involvement (e.g., arrest, incarceration) due to behavioral problems attributed to the youth's emotional and/or behavioral problems.

Discharge – Adults

- Discharges from the Intensive Community Outreach and Recovery Team occur when people and service personnel mutually agree to the termination of services. This must occur when people:
 - Have successfully reached individually established goals for discharge, and when the person and service personnel mutually agree to the termination of services.
 - Have successfully demonstrated an ability to function in all major role areas (i.e., work, social, self-care) without ongoing assistance from the agency provider, without significant relapse when services are withdrawn, and when the person requests discharge, and the agency provider employees mutually agree to the termination of services.
 - Move outside the geographic area of the Intensive Community Outreach and Recovery Team's responsibility. In such cases, the Intensive Community Outreach and Recovery Team must arrange for transfer of mental health service responsibility to an Intensive Community Outreach and Recovery Service or another agency provider wherever the person is moving. The Intensive Community Outreach and Recovery Team must maintain contact with the person until this service transfer is implemented.
 - Decline or refuse services and request discharge, despite the team's best efforts to develop an acceptable Individual Service Plan with the person.

Discharge – Children/Adolescents

- Discharges from the Intensive Community Outreach and Recovery Team occur when the child/youth's family and service personnel mutually agree to the termination of services. This must occur when children/youth:
 - Have successfully reached individually established goals for discharge, and when the child/youth's family and service personnel mutually agree to the termination of services.
 - Have successfully demonstrated an ability to function in the areas of home, school and other entities, and social interactions without ongoing assistance from the agency provider, without significant relapse when services are withdrawn, and when the child or youth's family requests discharge and the agency provider employees mutually agree to the termination of services.
 - Move outside the geographic area of the Intensive Community Outreach and Recovery Team's responsibility. In such cases, the Intensive Community Outreach and Recovery Team must arrange for transfer of mental health service responsibility to an Intensive Community Outreach and Recovery Service or another agency provider. The team must maintain contact with the person until this service transfer is implemented.
 - Decline or refuse services and request discharge, despite the team's best efforts to develop an acceptable Individual Service Plan with the child/youth.

Service Delivery – Adults

- The Intensive Community Outreach and Recovery Team must have seventy-five to eighty-five percent (75-85%) of Intensive Community Outreach and Recovery work and contact time in a community setting. Intensive Community Outreach and Recovery is for people with intensive needs that traditional outpatient clinic services have not been successful in treating.

- People served in Intensive Community Outreach and Recovery must be in the community (non-office based or non-facility-based settings). People that can make and maintain appointments at a clinic should not qualify for Intensive Community Outreach and Recovery Services.
- The Intensive Community Outreach and Recovery Team must have the capacity to rapidly increase service intensity to a person when his or her status requires it, or a person requests it.
- Each person can receive services as often as necessary but at a minimum they must be seen two (2) times a week at a minimum of two (2) hours (total).
- Each employee must provide services to each person as often as therapeutically necessary but at a minimum, each individual must be seen by Intensive Community Outreach and Recovery Team personnel one (1) time a week.
- Each person must receive services from a psychiatrist or psychiatric nurse practitioner as often as necessary but at a minimum of one (1) time per every thirty (30) days. These services can be provided in an office or community setting. Intensive Community Outreach and Recovery personnel must facilitate and provide transportation (if necessary) to the appointment.
- Intensive Community Outreach and Recovery will provide Peer Support Services, individual mental health therapy, medication administration/monitoring, general healthcare monitoring/treatment, supportive counseling, social/hygiene skills training, recovery/resiliency support, symptom management, budgeting skills, and leisure time activities.

Service Delivery – Children/Adolescents

- The Intensive Community Outreach and Recovery Team must have seventy-five to eighty-five percent (75-85%) of Intensive Community Outreach and Recovery work and contact time in a community setting. Intensive Community Outreach and Recovery is for children and youth with intensive needs that traditional outpatient services have not been successful in treating.
- Children, youth, and their families that can make and maintain appointments at a clinic should not qualify for Intensive Community Outreach and Recovery Services.
- The Intensive Community Outreach and Recovery Team must have the capacity to rapidly increase service intensity to a child or youth when his or her status requires it or when his or her family requests it.
- The family being served by the Intensive Community Outreach and Recovery Team and team members determine the frequency that services are provided. Services must be provided as often as therapeutically necessary, but at a minimum, or youth must be seen by Intensive Community Outreach and Recovery Team personnel two (2) times a week. Frequency of services provided must be documented in the child's or youth's ISP.
- Each child or youth must receive services from a psychiatrist or psychiatric nurse practitioner as often as necessary but at a minimum of one (1) time per every thirty (30) days. These services can be provided in an office or community setting. Intensive Community Outreach and Recovery team members must facilitate and provide transportation (if necessary) to the appointment.
- Intensive Community Outreach and Recovery will provide Peer Support Services, individual mental health therapy, medication monitoring, linkage to medical and educational services, supportive counseling, social skills training, recovery/resiliency support, and symptom management.
- Wraparound Facilitation Services can be provided in conjunction with Intensive Community Outreach and Recovery Services.

Intensive Outpatient Treatment

INTENSIVE OUTPATIENT TREATMENT is an all-inclusive, psychiatric clinical suite of multifaceted services acting as a wrap-around to families with children/youth with Serious Emotional Disturbances (SED) for family stabilization in the home and community. It is used to diffuse a current crisis, stabilize the living arrangement, and offer the family and children/youth alternatives to being crisis.

Admission Criteria

- The member has a Serious Emotional Disturbance .
- A primary focus of symptoms and diagnosis related to the primary psychiatric disorder as defined in the most recent Diagnostic and Statistical Manual (DSM) and symptoms which require rehabilitative services
- An evaluating psychiatrist or licensed psychologist advising that the beneficiary needs IOP services
- Families that request treatment but cannot commit to the intensity of services in their home and:

- Can safely manage the crisis with clinical professional services and support two (2) to four (4) hours, three (3) to five (5) days per week,
- Have sufficiently stabilized following ninety (90) days of services and request or choose less intensive interventions than to safely address and stabilize,
- Have children/youth discharging from PRTF care greater than one hundred eighty (180) days, and/or
- Have children/youth with greater than one (1) acute inpatient admission in the past six (6) months.
- Intensive Outpatient Program is recommended by the member's provider or is otherwise indicated by the results of a biopsychosocial assessment.
- The member needs specialized services and supports from multiple agencies including case management, and an array of clinical interventions and family supports.

Service Delivery

- Intensive Outpatient Program includes involvement of the family or individuals acting in place of the parents as often as possible, but not less than twice per month, in order to achieve improvement that can be generalized across environments.
- The individual must have an individualized service plan that addresses services and the frequency provided, formal and informal support available to the participant and family, and a plan for anticipating, preventing, and managing crises.

Psychiatric Residential Treatment Facility (PRTF)

PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY (PRTF) services are delivered 24 hours/7 days a week to members under age twenty-one (21) that do not require emergency or acute psychiatric care but do require supervision and treatment on a twenty-four (24) hour basis. The goal of PRTF treatment is to help the individual reach a level of functioning where the least restrictive treatment will be possible.

Admission Criteria

- The member does not require emergency or acute psychiatric care but does require supervision and treatment on a twenty-four (24) hour basis.
- A board-certified child/adolescent psychiatrist or a psychiatrist who has successfully completed an approved residency in child/adolescent psychiatry with admitting privileges must approve each admission.
- The member has a psychiatric disorder that is documented by the assignment of an appropriate diagnosis, as per the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM).
- The member can participate and process information as evidenced by an appropriate IQ for the program to which they have been admitted, unless there is substantial evidence that the IQ score is suppressed due to psychiatric illness.
- The member's psychiatric symptoms are severe enough to warrant residential treatment under the direction of a psychiatrist.
- The referring psychiatrist or psychologist advises that residential treatment is needed.
- At least one (1) of the following:
 - The member has failed to respond to less restrictive treatment in the last three (3) months.
 - Adequate less restrictive options are not available in the member's community.
 - The member is currently in an acute care facility whose professional staff advise that residential treatment is needed.
 - The admission has been certified as medically and psychologically necessary.

Continued Service Criteria

- Active treatment is being provided to include multidisciplinary diagnostic assessment, interdisciplinary treatment planning, therapeutic intervention, treatment evaluation/revision and discharge and aftercare planning.
- Documentation of treatment successes including which goals have been achieved/not achieved.
- Updates are made to the treatment plan including the re-assessment of the need for continued residential care or less restrictive care.
- Revisions are made to the discharge plan and discharge date as progress is made.

Discharge Criteria

- The member has reached age twenty-two (22).

OR

- PRTF goals have been met.

OR

- PRTF goals have not been met, the member is transferred to a more restrictive or less restrictive level of care.

OR

- PRTF goals have not been met, the member or member's guardian chooses to discontinue services.

Service Delivery

Evaluation and Treatment Planning

- The diagnostic evaluation must document the need for the PRTF level of care.
- Diagnostic evaluations must be completed within the first fourteen (14) days of admission.
- The assessment process must include, but is not limited to, the following:
 - A psychiatric evaluation.
 - A psychological evaluation signed by a licensed psychologist, which must have been completed in the sixty (60) days prior to admission. If no psychological evaluation has been conducted within the last twelve (12) months, one must be completed within fourteen (14) days following PRTF admission.
 - A medical history and examination.
 - A psychosocial assessment, which includes a psychological profile, a developmental profile, a behavioral assessment, and an assessment of the potential resources of the member's family.
 - An educational evaluation.
 - A nursing assessment.
 - A nutritional assessment, if indicated.
- Treatment planning is a collaborative venture in which the members of varying disciplines jointly develop a comprehensive, individualized plan for the treatment of each member.
 - The treatment plan charts a course designed to help the member move to a less restrictive level of care as quickly as possible.
 - An initial treatment plan must be in effect within seventy-two (72) hours after the member's admission to the facility.
 - The interdisciplinary treatment team must meet to discuss, approve, and implement a more comprehensive treatment plan within fourteen (14) days after the member's admission, once at the conclusion of the first (1st) month of stay, and once a month thereafter.
 - The treatment plan document must contain evidence of the member's and his/her parent/guardian's active participation in the treatment planning/review/revision process.
- At a minimum, the team must include, either:
 - A board-certified child/adolescent psychiatrist or a psychiatrist who has successfully completed an approved residency in child/adolescent psychiatry; or
 - A Psychiatric Mental Health Nurse Practitioner (PMHNP) and a physician licensed to practice medicine or osteopathy; or
 - A licensed psychologist and a physician licensed to practice medicine or osteopathy.
- The team must also include one (1) of the following:
 - A licensed certified social worker who has a minimum of one (1) years' experience in treating children with serious emotional disturbances (SED); or
 - A registered nurse who has a minimum of one (1) years' experience in treating individuals with SED.
- The treatment plan outlines all aspects of treatment including:
 - Diagnosis;
 - An assessment of the member's immediate therapeutic needs;
 - An assessment of the member's long-range therapeutic needs;
 - An assessment of the member's personal strengths and liabilities;
 - Identification of the clinical problems that are to be the focus of treatment;
 - Measurable and realistic treatment goals for each identified problem;
 - Observable, measurable treatment objectives that represent incremental progress towards goals, coupled with target dates for their achievement;
 - Specific treatment modalities and/or strategies that will be employed to reach each objective.

Discharge Planning

- An individualized discharge plan includes:
 - Discharge criteria, indicating specific goals to be met;
 - An estimated discharge target date; and
 - No later than seven (7) days prior to discharge, the discharge plan must also include an aftercare plan that addresses coordination of family, school/vocational and community resources to provide the greatest possible continuity of care for the member;
 - When applicable, a minimum of a seven (7) day supply of each of the member's medication(s), and a prescription for a thirty-day supply of each of the member's medication(s).

Psychosocial Rehabilitation

Psychosocial Rehabilitation as an active treatment program designed to support and restore community functioning and well-being of a beneficiary who has been diagnosed with a serious and persistent mental illness by providing systematic, curriculum-based interventions for skills redevelopment and to promote recovery in the beneficiary's community by alleviating psychiatric decompensation, confusion, anxiety, feelings of low self-worth, isolation, and withdrawal.

The purpose of the service is to promote recovery, resiliency, and community integration by maintaining the person's optimal level of functioning and preventing psychiatric decompensation, thereby decreasing the risk of unnecessary hospitalization and the need for higher level intensity services such as Program of Assertive Community Treatment (PACT) and Acute Partial Hospitalization. Service activities aim to alleviate current symptomatology and address the person's underlying condition by reducing the negative effects of social isolation, promoting illness education, creating, and monitoring wellness action plans, and the development of other coping and independent living skills

Psychosocial Rehabilitation Services are provided up to five (5) hours per day, five (5) days per week when medically necessary.

Admission Criteria and Service Delivery

- Psychosocial Rehabilitation Services must utilize systematic curriculum-based interventions for recovery skills development for participants. The curriculum-based interventions must be evidence-based or recognized best-practices in the field of mental health as recognized by Substance Abuse and Mental Health Services Administration (SAMHSA). Curriculum based interventions must address the following outcomes for the people participating in Psychosocial Rehabilitation Services:
 - Increased knowledge about mental illnesses;
 - Fewer relapses;
 - Fewer re-hospitalizations;
 - Reduced distress from symptoms;
 - Increased consistent use of medications; and,
 - Increased recovery supports to promote community living.
- The Psychosocial Rehabilitation Services systematic and curriculum-based interventions must address the following core components:
 - Psychoeducation;
 - Relapse Prevention;
 - Coping Skills Training; and,
 - Utilizing Resources and Supports (inclusive of crisis planning).
- The Psychosocial Rehabilitation Services systematic and curriculum-based interventions must, at a minimum, include the following topics:
 - Recovery strategies;
 - Facts about mental illnesses;
 - Building social supports;
 - Using medications effectively;
 - Drug and alcohol use;

- Reducing relapse;
- Coping with stress;
- Coping with problems and symptoms of mental illnesses; and,
- Self-advocacy.
- All people are required to have a Recovery Support Plan. People must participate in setting goals and assessing their own skills and resources related to goal attainment. Goals are set by exploring strengths, knowledge and needs in the person's living, learning, social, and working environments.
- Each person must be provided assistance in the development and acquisition of needed skills and resources necessary to achieve stated recovery goals.
- Documentation of therapeutic activities must be provided in weekly progress notes.
- Psychosocial Rehabilitation Services must be provided in each location a minimum of three (3) days per week for a minimum of four (4) hours per day, excluding travel time.
- Psychosocial Rehabilitation Service locations must have sufficient space to accommodate the full range of therapeutic activities and must provide at least fifty (50) square feet of space for each person.
- Psychosocial Rehabilitation Services must be located in their own physical space, separate from other mental health center activities or institutional settings and impermeable to use by other services during hours-of-service operation.
- Psychosocial Rehabilitation Services must include, at each service location, a full-time supervisor.
 - A director or Mental Health Therapist with the responsibility of therapeutic oversight must be on-site a minimum of five (5) hours per week.
 - The service director or Mental Health Therapist must plan, develop, and oversee the use of an Evidenced-Based Curriculum implemented to address the needs of people receiving Psychosocial Rehabilitation Services.
 - The chosen Evidence-Based Curriculum must be implemented to fidelity.
 - In addition to the minimum of five (5) hours of on-site supervision, the director or Mental Health Therapist must also participate in clinical staffing and/or Treatment Plan review for the people in the service(s) that he/she directs.
- Psychosocial Rehabilitation Services must maintain a minimum of one (1) qualified employee to each twelve (12) or fewer people present in a Senior Psychosocial Rehabilitation Service. The supervisor may be included in this ratio.

Mississippi Youth Programs Around the Clock (MYPAC)

Wraparound Facilitation/Targeted Case Management

Wraparound Facilitation/Targeted Case Management - Wraparound facilitation as a targeted case management program that includes the creation and facilitation of a child/youth and family team for the purpose of developing a single care plan to address the needs of children/youth who require the level of care provided in a Psychiatric Residential Treatment Facility (PRTF). *Please see the PRTF service definition and criteria in this document for additional guidance.

The child and family team will meet regularly to monitor and adjust the plan of care if necessary or progress is not being made. Wraparound facilitation is intended to serve individuals who have serious mental health challenges that exceed the resources of a single agency or service provider, experienced multiple acute hospital stays, at risk of out-of-home placement or have been recommended for residential care or have had interruptions in the delivery of services across a variety of agencies due to frequent moves, failure to show improvement, lack of previous coordination by agencies providing care, or reasons unknown.

Admission Criteria

- Services are medically necessary according to the Mississippi Medicaid Administrative Code:
 - Appropriate and consistent with the diagnosis of the treating provider and the omission of which could adversely affect the patient's medical condition,
 - Compatible with the standards of acceptable medical practice in the United States,

- Provided in a safe, appropriate, and cost-effective community-based setting given the nature of the diagnosis and the severity of the symptoms,
- Not provided solely for the convenience of the beneficiary or family, or the convenience of any health care provider,
- Not primarily custodial care,
- There is no other effective and more conservative or substantially less costly treatment service and setting available,
- The service is not experimental, investigational, or cosmetic in nature, and
- All Mississippi Medicaid regulations, program rules, exclusions, limitations, and service limits, etc., apply. The fact that a service is medically necessary does not qualify the service for reimbursement; and
- The member has serious mental health challenges that exceed the resources of a single agency or provider; and/or
- The member has experienced multiple acute hospital stays; and/or
- The member is at risk of out-of-home placement; and/or
- The member has had interruptions in the delivery of services across a variety of agencies providing care.

Service Delivery

Service components include:

- Engaging the family,
- Assembling the beneficiary and family team which includes all of the required entities and individuals described in the DMH operational standards.
- Facilitating the beneficiary and family team meeting, at a minimum, once every thirty (30) days,
- Facilitating the development of a wraparound service plan (WSP) through decisions made by the beneficiary and family team during the beneficiary and family team meeting, including a plan for anticipating, preventing, and managing crisis,
- Working with the beneficiary and family team in identifying providers of services and other community resources to meet the family and beneficiary's needs,
- Making necessary referrals for beneficiaries,
- Documenting and maintaining all information regarding the WSP, including revisions and beneficiary and family team meetings,
- Presenting WSP for approval to the beneficiary and family team,
- Providing copies of the WSP to the entire team including the beneficiary and family/guardian,
- Monitoring the implementation of the WSP and revising as necessary to achieve outcomes,
- Maintaining communication between all beneficiary and family team members,
- Evaluating the progress toward needs being met to ensure the referral behaviors have decreased,
- Leading the beneficiary and family team to discuss and ensure the supports and services continue to meet the caregiver and the beneficiary's needs,
- Educating new team members about the wraparound process,
- Maintaining team cohesiveness,
- Meeting face-to-face with the beneficiary once a week,
- Meeting face-to-face with the family twice a month,
- Meeting with other collateral contacts related to WSP implementation at least three (3) times a week, and
- Ensuring medication and management and monitoring of beneficiaries on medication(s) used in the treatment of the beneficiary's Serious Emotional Disturbance (SED) occur at a physician visit every ninety (90) days at a minimum.

Wraparound services are provided by a Certified Wraparound Facilitator.

The ISP must be approved by one (1) of the following team members: a psychiatrist, physician, psychologist, PMHNP, PA, LCSW, LPC, or LMFT.

MYPAC Clinical Service/Community Supportive Treatment

MYPAC services are defined as treatment provided in the home and/or community to children and youth with serious emotional disturbance from birth up to the age of twenty-one years (21). MYPAC services are time-limited, intensive intervention intended to diffuse a crisis, evaluate its nature, and intervene to reduce the likelihood of a recurrence. The ultimate goal is to stabilize the living arrangement, promote reunification, and/or prevent the over-utilization of out-of-home therapeutic resources (i.e., psychiatric hospital, therapeutic foster care, therapeutic group home, and/or residential treatment facility). MYPAC services are

provided until stabilization has occurred by evaluating the nature and course of psychiatric needs and providing intensive interventions intended to diffuse psychiatric needs and reduce the likelihood of a recurrence.

- MYPAC services are individualized for children and youth who experience severe and impairing psychiatric symptoms and behavioral disturbances.
- MYPAC services are most appropriate for children and youth who have not benefitted from traditional outpatient services, have experienced frequent acute psychiatric hospitalizations and/or psychiatric emergency stabilization services in the past 90 days.
- MYPAC services are person-centered and individually tailored to each child or youth and family and address the preferences and identified goals of each child/youth and family.
- MYPAC is mobile and delivers services in the community and in the child/youth's home.
- Staff assigned to each child/youth's case work as a team and provide the treatment and support services the children/youth need to achieve their goals. Staff share responsibility for addressing the needs of the children/youth and their families receiving this service.
- Each MYPAC therapist will serve only children/youth receiving MYPAC services and will have a minimum caseload requirement of at least five (5) children/youth and a maximum caseload of 20 children/youth. The provider agency must maintain a roster for each MYPAC therapist of children/youth served for review.

Admission Criteria

To receive MYPAC services, children/youth must meet one or more of the following criteria:

- The child/youth has been evaluated and/or diagnosed by a psychiatrist or licensed psychologist in the past ninety (90) days as it relates to a mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria for a Serious Emotional Disturbance (SED) specified within the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM). The primary diagnosis must be psychiatric.
- The child/youth must be able demonstrate a capacity to respond favorably to rehabilitative counseling and training in areas such as problem-solving, life skills development, and medication compliance training (i.e., demonstrates a capacity for positive response to rehabilitative services).
- The evaluating psychiatrist, licensed psychologist, or psychiatric nurse practitioner advises that the child/youth meets criteria of the MYPAC program and/or is at risk for out-of-home placement.
- The child/youth requires specialized services and supports, and an array of clinical interventions and family supports to be maintained in the community.
- The child/youth presents with a high use of acute psychiatric hospitalizations (i.e., two [2] or more admissions per year) or psychiatric emergency/stabilization services.
- The child/youth is currently residing in an inpatient facility or Psychiatric 4 Residential Treatment Facility level of care due to the lack of availability of appropriate placement but has been clinically assessed to be able to live in a community-based setting if intensive services are provided.
- The child/youth is at high risk for juvenile justice involvement or has a recent history of juvenile justice involvement (e.g., arrest, incarceration) and has a SED diagnosis.
- The child/youth is involved or at risk of being involved in child protective services.

Discharge Criteria

In order to discharge from MYPAC services, children/youth must meet the following criteria:

- Have successfully reached individually established goals for discharge, and when the person and agency provider employees mutually agree to the termination of services.
- Have successfully demonstrated an ability to function at home and in the school setting without ongoing assistance from the agency provider, without significant relapse when services are withdrawn, and when the person requests discharge, and the agency provider mutually agrees to the termination of services.
- Move outside the geographic area. In such cases, the agency provider must arrange for transfer of mental health service responsibility to another agency provider and maintain contact with the child/youth and family until this service transfer is implemented.
- Decline or refuse services and request discharge, despite the provider/agency's best efforts to develop an acceptable Individual Service Plan with the child/youth and family.
- Not deemed clinically appropriate for service, and treatment elsewhere would be more beneficial.
- Have reached the age of 21 and will be referred to an appropriate service for adults.

Service Delivery

Providers Requirements of MYPAC services

- Hold certification by DMH to provide Crisis Response Services, Community Support Services, Peer Support Services, Physician/Psychiatric Services, and Outpatient Therapy Services.
- Have a psychiatrist or psychiatric nurse practitioner on staff that is at least part-time to evaluate and treat children/youth receiving MYPAC services.
- Have appropriate clinical staff that meet DMH requirements to provide the therapeutic services needed.
- Provide training topics (e.g., CPI, MANDT, MAB, etc.) that are appropriate to the needs of MYPAC service providers.
- Coordinate services and needed supports with other providers and/or natural supports when appropriate and with consent.
- Provide education on wellness, recovery, and resiliency.
- Have procedures in place for twenty-four (24) hour, seven (7) days a week availability and response (inclusive of crisis response services).
- The following services must be available, (but are not limited to):
 - Individual and Family Therapy
 - Peer Support Services
 - Community Support Services
 - Psychiatric/Psychiatric Nurse Practitioner Services.
- MYPAC services must be included in the Individual Service Plan (ISP) and, if also receiving Wraparound Facilitation Services, the Wraparound Plan of Care, and provided to children/youth based on their needs identified in the treatment plan.
- If the child/youth entering the MYPAC program does not have an Initial Assessment, one must be completed by the provider within fourteen (14) working days of admission.
- If the child/youth is receiving Wraparound Facilitation Services, the provider needs to have input into the Wraparound Plan of Care (which needs to be available for review upon request). In the event that the child/youth is no longer receiving Wraparound Services, the MYPAC provider MUST complete all required forms (Individual Service Plan, Individual Crisis Support Plan, Recovery Support Plan, etc.) within fourteen (14) working days of discharge from Wraparound Facilitation.
- The provider agency must be able to respond to crises/emergencies, for each child/youth and family served, twenty-four (24) hours per day, seven (7) days per week. The MYPAC provider is required to be the first responder and make every effort to assist the child/youth and the family. Non-MYPAC team members (e.g., MCERT) should only be contacted and respond if the MYPAC provider is unable to assist the child/youth and the family, or on the rare occasion when a MYPAC team member is unable to respond within one (1) hour. MYPAC providers must show documentation of their attempted assistance upon request for review.
- The provider agency must designate a MYPAC supervisor to coordinate MYPAC services and conduct supervision weekly and as needed. The MYPAC supervisor shall supervise no more than six (6) MYPAC therapists.

Staffing Requirements

- Providers of MYPAC services must meet the following staffing requirements:
 - Psychiatrist and/or Psychiatric Nurse Practitioner (i.e., psychiatric staff) must hold a current professional license and be employed by the MYPAC provider at least part-time to evaluate and treat children/youth receiving MYPAC services.
 - MYPAC supervisor must hold a minimum of a master's degree in a mental health or related field and have either a current (1) professional license or (2) DMH credential (as appropriate to the service and population served) to coordinate/oversee services.
 - MYPAC therapist must hold a minimum of a master's degree in a mental health or related field and have either a current (1) professional license or (2) DMH credential (as appropriate to the service and population served).
 - Peer Support Specialist must be an individual with lived experience of having a child with a Serious Emotional Disturbance diagnosis and hold a current DMH Certified Peer Support Specialist credential.
 - Community Support Specialist must hold a minimum of a bachelor's degree in a mental health or human services/behavioral health-related field and a current DMH Community Support Specialist credential.

Contact requirements

- The agency must have the capacity to provide multiple contacts during a week with children/youth being served through MYPAC. These multiple contacts may be frequent and depend on individual need and a mutually agreed upon plan between the family and agency provider staff providing services.

- All children/youth must be evaluated for appropriateness for psychopharmacological treatment by the on-staff psychiatric provider within forty-five (45) working days of entering the MYPAC program. Only those who are actively prescribed psychotropic medication will be required to see the on-staff psychiatric provider at least every ninety (90) days. Children/youth not taking psychotropic medication will be re-evaluated by the on-staff psychiatric provider when there is a significant change in symptoms, environment (e.g., foster care), and/or loss/trauma.
- Children/youth receiving MYPAC must participate in at least three (3) individual therapy sessions per month and at least one (1) family therapy session per month provided by the MYPAC therapist for a total of a minimum of four (4) therapy sessions per month. A Peer Support Specialist and/or Community Support Specialist must contact the family at least two (2) times per month via telephone or face-to-face.
- If the child/youth is participating in Wraparound Facilitation, the MYPAC provider must be a participating team member and attend the monthly Child and Family Team Meetings. The MYPAC provider must show evidence of attendance of the Child and Family Team Meeting in the child/youth's record (e.g., copy of sign-in sheet).
- All sessions and contacts and/or visits must be documented in the case record.

Documentation Requirements

- Employee records must indicate that within ninety (90) days of hire/placement employees receive orientation on the MYPAC program and supervised on-the-job training prior to being assigned independent responsibilities. This requirement is separate from any other orientation specified elsewhere in the DMH Operational Standards document.
- Employee records must indicate weekly supervision provided by the MYPAC supervisor.
- Agency provider must maintain a roster for each MYPAC therapist of children/youth who are served.
- The following documents must be provided to the individual, family, and/or legal guardian and be included in the child/youth's record:
 - Consent to Receive Services
 - Rights of Persons Receiving Services
 - Acknowledgment of Grievance Procedures
 - Individual Service, Individual Crisis Support and Recovery Support Plans
 - Wraparound Plan of Care (if applicable)
 - Medication/Emergency Contact Information (if applicable).
- The provider agency must complete an Initial Assessment within fourteen (14) working days of admission, if not already on file.
- Each child/youth receiving MYPAC services must have an Individual Service Plan completed in its entirety on file (no blank fields). The following information must be included:
 - Signatures:
 - Individual/Child/Youth
 - Parent and/or Legal Guardian
 - MYPAC Therapist
 - Peer Support Specialist and/or Community Support Specialist
 - Psychiatrist and/or Psychiatric Nurse Practitioner.
 - Timelines:
 - Developed within fourteen (14) working days of admission
 - Document review at least every thirty (30) days and as needed on Periodic Staffing/Review of the ISP
 - Periodic Staffing/Review of the ISP reviewed, approved, and signed off on by psychiatric staff at least every six (6) months
 - Updated at least annually.
 - Reviews and updates must include the following changes in specific detail and applicable signatures:
 - Change in diagnosis
 - Change in symptoms
 - Change(s) in service activities
 - Change(s) in treatment/treatment recommendations
 - Other significant life change
 - Signatures of individual; parent/legal guardian; MYPAC therapist; psychiatrist/psychiatric nurse practitioner (if ISP rewritten).
- Each child/youth receiving MYPAC services must have an Individual Crisis Support Plan completed in its entirety on file (no blank fields). The following must be included:
 - Signatures:

- Individual/Child/Youth
 - MYPAC Therapist.
- Timeline:
 - Developed within thirty (30) days of admission.
- Required Elements:
 - Documentation that all team members have a copy (to refer to when needed)
 - Documentation that individual receiving services has a copy (for reference).
- Each child/youth receiving Peer Support Services and/or Community Support Services must have a Recovery Support Plan completed in its entirety (no blank fields). The following information must be included:
 - Signatures:
 - Individual/Child/Youth
 - Parent and/or Legal Guardian
 - Peer Support Specialist and/or Community Support Specialist
 - MYPAC Therapist
 - Any other individuals who participated in plan development.
 - Timelines:
 - Developed within thirty (30) days of admission.
- The child/youth's record must contain documentation of Peer Support Specialist and/or Community Support Specialist contact at least two (2) times per month either via telephone or face-to-face contact.
- Each child/youth who receives both Wraparound Facilitation services and MYPAC services must have in the record:
 - Wraparound Plan of Care (current copy)
 - Crisis Management Plan (current copy)
 - Monthly Child and Family Team sign-in sheets (documenting MYPAC provider's participation by evidence of the provider's signature)
 - Medication/Emergency Contact Information (if taking/has taken psychotropic medication).
- Psychotherapy Services:
 - A minimum of three (3) individual therapy sessions and at least one (1) family therapy session per month for a total of a minimum of four (4) therapy sessions documented and signed by a master's level therapist.
- Any child/youth on psychotropic medication must have a Medication/Emergency Contact Information form completed in its entirety (no blank fields) and included in the record:
 - Medication recorded during the admission process
 - Current medications listed
 - Form updated when medications are added, discontinued and/or changed
 - Form updated annually
 - MYPAC therapist signs/initials all changes made to the form.
- The child/youth's individual record must contain documentation that the child/youth is being seen by the psychiatric staff at least every ninety (90) days (if actively taking psychotropic medications), or as often as needed based on the child/youth's needs. If any child/youth who is not taking psychotropic medication is re-evaluated, the record must contain documentation pertaining to the significant change in symptoms, environment (e.g., foster care), and/or loss/trauma.

References

Mississippi Division of Medicaid Administrative Code, Title 23, Part 206: Assertive Community Treatment; Community Support Services; Day Treatment; Intensive Outpatient Psychiatric; Mississippi Youth Programs Around the Clock (MYPAC). Mississippi Division of Medicaid website: <https://medicaid.ms.gov/providers/administrative-code/>.

Mississippi Division of Medicaid Administrative Code, Title 23, Part 207, Chapter 4: Psychiatric Residential Treatment Facility. Mississippi Division of Medicaid website: <https://medicaid.ms.gov/providers/administrative-code>

Mississippi Department of Mental Health Operational Standards for Mental Health, Intellectual/Developmental Disabilities, And Substance Use Community Service Providers, Effective September 1, 2020.

Mississippi Department of Mental Health, Operational Standards for Mental Health, Intellectual/Developmental Disabilities, and Substance Use Community Service Providers, Effective September 1, 2020, Section 41-4-7 of the Mississippi Code, 1972, as amended: <http://www.dmh.ms.gov/wp-content/uploads/2020/08/Final-DMH-2020-Operational-Standards-7-31-20.pdf>

Revision History

Date	Summary of Changes
05/2018	Combined previously separate LOCGs into one document
10/2018	Added new MYPAC and PRTF guidelines
01/2020	Supplemental Criteria
01/2021	Removed Evidence Based Practice Criteria section, updated references
10/2021	Wraparound Facilitation
12/2021	Revisions to Day Treatment and MYPAC
02/2022	Revisions to MYPAC and ACT and Annual Review
06/2022	Revisions to MYPAC Final Adoption Notice
10/2022	Addition of PSR Criteria