CARE MANAGEMENT ORGANIZATION - HIGH

Care Management Organization (CMO) - High

Program Description

Care Management Organizations (CMO) are independent, community-based organizations that combine advocacy, individualized service planning and care management into a single, integrated, cross-system process. Care Management services provide a single point of accountability to ensure services are accessed, coordinated, and delivered in a strength based, individualized, youth focused, family driven, ethnically, culturally, and linguistically relevant manner.

The CMO assesses, designs, implements and manages youth guided and family driven, Individual Service Plans (ISP) for children and adolescents whose needs are complex and require intensive care management techniques that may cross multiple service systems. CMO responsibilities also include the following elements:

- Intended to meet the needs of youth assessed with complex emotional/behavioral challenges;
- Developed through a high-fidelity Wraparound planning process, designed to ensure that the family has ownership of the planning process in partnership with the team through the Child Family Team Process, and that the family is in agreement with the treatment goals and is committed to carry out the plan;
- Consistent with Systems of Care philosophy;
- Incorporated into an individualized, flexible, and sustainable plan of care for the youth and family;
- Designed to help address the needs of youth and their families by facilitating a collaborative relationship with other youth serving systems;
- Coordinated by a CMO care manager who advocates, organizes and arranges necessary supports and/or services in the areas of behavioral health, substance use, and intellectual/developmental disability services, as well as, financial, educational, and social services to help restore, enhance and maintain a developmentally appropriate level of functioning for the youth and family;
- Time-limited in nature with the projected duration of care management services to be approximately 12 to 14 months.

Through implementation of the high-fidelity wraparound model, the CMO facilitates the child and family team process and coordinates the development of the ISP to assure that the child and family receive individualized services that are delivered in the community in which the child lives. The plan is holistic in nature and addresses areas of everyday living beyond the treatment of mental health symptoms.

Criteria

Inclusionary Criteria

The relevant clinical information indicate that the youth requires a high level of care management services and the youth must meet A, B, C, D, E, F, G, and H:

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A. The youth is between the ages of 5 and until their 21st birthday. Special consideration will be given to children under 5. Eligibility is in place up to and including the day prior to the young adult’s 21st birthday.

B. The youth has been assessed recently or within the past year to have a behavioral health need, or symptoms and behaviors consistent with, a DSM 5 diagnosis.

C. Severe intensity symptoms are evident in one or more areas within any of the following domains:
   1. Behavioral, emotional symptoms that may include psychosis, impulsivity, hyperactivity, depression, anxiety, oppositional, conduct, or anger control or
   2. Risk behaviors that may include suicide risk, self-injurious behavior, danger to others, problematic sexual behavior, substance use, fire setting, or other self-harm or
   3. Trauma which is associated with disturbance in sleeping pattern, eating patterns, elimination practices, attention abilities, impulse control abilities, mood regulation abilities, or re-experiencing past traumatic experiences. Trauma may have been explicit or implicit, and discrete or recurrent.

D. The behavioral health condition identified above has resulted in the youth’s decline from baseline in functional impairment in two or more of the following domains:
   1. Self-Care - Behaviors involving basic hygiene, nutritional needs and physical health needs which are consistent with maintaining the youth’s health and wellness.
   2. Community Functioning - Behaviors observed in the community demonstrating personal safety and developmentally appropriate decision-making skills.
   3. Social Relationships – Behaviors pertaining to maintaining positive and supportive relationships with peers and adults.
   4. Family Functioning – Behaviors indicating constructive, considerate relationships with family members. There may be concerns in regards to communication and or interactions with care providers, siblings or other family members.
   5. School/Vocational/Work Functioning – Behaviors suggesting successful function in the school or vocational setting. There may be concerns in regards to poor school attendance, decline in productivity or
maladaptive behavior in the school/vocational/work setting.

E. The severity of functional impairment poses a significant risk for psychiatric hospitalization or out-of-home treatment, or, the youth may currently be receiving inpatient psychiatric treatment or out-of-home treatment.

F. The youth appears to be in need of an array of services and supports requiring coordination and assistance through the Child Family Team process. Specifically, this youth’s clinical needs require multidimensional treatment services. Coordination of services may include: medication management services, specialized behavioral health services, child study team services, or co-occurring service needs (substance use, physical health, Intellectual/Developmental Disability). Collaboration needs may include: linkage with family and community supports, or with other youth serving agencies such as DCPP, Court, legal services or JJC.

G. The youth and caregiver require face-to-face assistance in obtaining or coordinating treatment, rehabilitation, habilitation, financial and/or social services, without which the youth could reasonably be expected to have a decline in functioning that would require more intensive behavioral health services.

H. The person(s) with authority to consent to treatment for the youth voluntarily agrees to participate. The assent of a youth who is not authorized under applicable law to consent to treatment is desirable.

Youth who receive Out of Home Substance Use Treatment (short term or long term residential) and exhibit co-occurring behavioral health treatment needs are considered presumptively eligible for 30 days from date of enrollment due to serious substance use treatment needs, but must meet the Inclusionary criteria I:

I. Youth is diagnosed with a behavioral health disorder consistent with a DSM 5 diagnosis or symptoms consistent with a DSM 5 diagnosis within the 30 days from the date of enrollment.

Youth with an Intellectual and/or Developmental Disability (I/DD) in the absence of a co-occurring mental health disorder, may be exempted from the Inclusionary Criteria B above, but must additionally meet the following criteria J:

J. Youth has been determined by CSOC to be eligible or presumptively eligible for CSOC Functional or Division of Developmental Disabilities (DDD) services. Youth who were determined eligible by DDD need not re-apply for a determination of eligibility for CSOC Functional Services. The CSOC will accept the DDD eligibility determination regarding whether the youth has a developmental disability;
## Exclusionary Criteria

Any of the following criteria is sufficient for exclusion from this level of care.

A. The youth’s parent/guardian/caregiver or youth if age 18 and older does not voluntarily consent to CMO High services;

B. The clinical information presented indicates that the youth can be safely maintained and effectively supported in a less intensive level of care management;

C. The Behavioral symptoms are the sole or primary result of a medical condition that warrants a medical setting for treatment;

D. The youth has a sole presenting diagnosis of substance use disorder;

E. For youth presenting with I/DD only, the youth has not been determined eligible or presumptively eligible for CSOC Functional Services or DDD Services.

F. The youth is not a resident of New Jersey. For minors who are under 18 years of age, the residency of the parent or guardian shall determine the residence of the minor;

## Continued Stay Criteria

All of the following criteria A through G are necessary for continuing services at the Care Management Organization.

A. The clinical information presented indicate that the youth continues to exhibit needs consistent with current intensity of service;

B. The Individual Service Plan (ISP) is individualized and appropriate to the youth’s changing condition with realistic and specific goals and objectives that are clearly documented.

C. Progress is clearly described in objective terms, but goals of treatment have not been fully achieved. The ISP has been modified and updated to reflect the current treatment status.

D. Care Management Organization High services are indicated to maintain the youth, or support reintegration of the youth, in the community and improve level of functioning in the identified life domain(s)

E. The ISP indicates that the youth and the parent/guardian/caregiver are actively involved in the youth’s services, to the extent that is reasonably possible. Limitations to the parent/guardian/caregiver involvement and strategies to optimize caregiver involvement should be clearly documented in the ISP.

F. Collaboration between all Child Family Team (CFT) members, which may include, but not limited to: IIC providers, IIH providers, OOH treatment providers, substance use providers, school staff, medical providers, DCPP case workers, JJC staff, parent/legal guardian, and youth, is clearly
documented in the treatment plan.

G. There is documentation of active transition planning with a sustainable community-based after-care plan.

Youth in an out-of-home treatment setting must additionally meet the following criterion:

H. The youth is in a CSOC out-of-home (OOH) treatment setting, requiring intensive service coordination and transition planning, in order to facilitate successful transition back into the community.

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<tr>
<th>Discharge Criteria</th>
<th>Any of the following discharge criteria (A through G) is sufficient for discharge from this level of care management and fulfillment of discharge criteria G:</th>
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<tbody>
<tr>
<td>A.</td>
<td>The youth’s documented ISP goals and objectives for this Intensity of Service have been substantially met.</td>
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<tr>
<td>B.</td>
<td>The clinical information presented indicates that the youth requires a different clinical treatment focus or less intensive treatment service.</td>
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<tr>
<td>C.</td>
<td>The family has demonstrated that the identified strengths of the caregiver and youth can be sustained in the community with services and supports.</td>
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<td>D.</td>
<td>Consent for treatment is withdrawn by the parent/guardian/caregiver or young adult if age 18 and older.</td>
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<td>E.</td>
<td>Youth and/or the parent/guardian/caregiver are competent, but non-participatory in treatment or in following the program requirements. The non-participation is of such a degree that intervention, at this intensity of service, is rendered ineffective or unsafe, despite multiple, documented attempts to address non-participation issues.</td>
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<td>F.</td>
<td>Youth has not demonstrated measurable improvement toward ISP/treatment goals that has generalized outside of the treatment sessions, after a treatment period of at least 12 to 16 months.</td>
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<td>G.</td>
<td>Parent/guardian/caregiver or young adult if age 18 and older is unreachable for an extended period of time despite documented best efforts to contact or has moved out of state. A youth should be discharged from CMO services if there is no contact with the youth or family within a 2-month time period.</td>
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In addition to any one of the above discharge criteria A through G, the following criteria H shall be achieved:

H. A transition plan with specific follow-up recommendations for treatment (including follow up appointments, intake appointments etc.) and community supports has been arranged and documented in the youth’s transition ISP.