



TEXAS

Department of State Health Services

Community Mental Health and Substance Abuse Services

Resiliency and Disease Management Program Manual


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Introduction

How to Use this Manual

This manual is intended to provide the reader with an overview of the Resiliency and Disease Management initiative in the Texas public Mental Health system. The manual will highlight key components of the initiative and direct the reader to primary sources, where more information can be obtained. Whenever text is blue and underlined, a hyperlink is available. If this manual is being read electronically, point the cursor at the hyperlink and a hand  will appear. On some systems the hand does not appear and you will need to hold the CTRL button down and then click. If you are connected to the Internet, your browser will display the referenced text.

Note: Some documents require Adobe Reader (pdf files). You can install a free version of Adobe Reader at:

<http://www.adobe.com/products/acrobat/readstep2.html>

Overview of the Resiliency and Disease Management (RDM) Program

National Backdrop In 2000, *Mental Health: A Report of the Surgeon General* was released highlighting the wealth of evidence on the effective treatment of mental illnesses and concluding that mental illnesses are more responsive to treatment than many other illnesses. The report also noted that there is a lag of fifteen to twenty years before scientific advances are actually implemented in the national mental health service system. The report identified a critical need to shift the paradigm for mental health treatment from one of maintenance to one of recovery.

Building on the findings of the Surgeon General's report, President George W. Bush created the New Freedom Commission on Mental Health and charged the Commission with studying mental health care in the United States and with making recommendations for improvements to the system. The President's New Freedom Commission concluded that the mental health system in the U. S. is broken.

Overview of the Resiliency and Disease Management Program, Continued

The Commission concluded that incremental improvements to the mental health system would be inadequate and concluded that a major transformation was the only solution. One fundamental change recommended by the Commission was to re-orient the focus of the public mental health system from one of maintenance to one that supports resiliency and recovery.

History in Texas

To provide guidance to system change efforts in Texas and build stakeholder support, the Texas Department of Mental Health and Mental Retardation (TDMHMR) held several conferences to reach consensus on recommendations for psychosocial treatments. Each of these conferences included national experts, state-level administrators, service provider representatives, advocacy groups, and consumer stakeholders in the development of consensus guidelines around the targeted services and treatments.

In January 2002, the University of Texas-Southwestern Medical Center held a consensus conference to develop guidelines for integrating psychotherapy interventions with medication for individuals with mood disorders. Experts in the treatment of mood disorders presented information on the research support for various therapeutic approaches and answered critical questions, such as (a) who can most benefit from psychotherapy; (b) how long and with what frequencies should therapies be provided; and (c) when and how should psychotherapy be integrated with medication therapies.

TDMHMR conducted a conference to develop consensus guidelines on adult psychosocial services in December 2002. The goal of this conference was to summarize and reach consensus on evidence-based models in the areas of employment, housing, social and life skills training, case management, dual diagnoses services, and consumer-provided services. The conference was aimed at answering critical implementation questions. In addition, participants attempted to reach consensus around the critical components or “active ingredients” that cross various evidence-based models within the service domain (e.g., employment).

A similar conference was held in Austin, Texas on April 2003 on child and adolescent psychosocial interventions. The conclusions from all three consensus conferences, the mood disorder conference, the adult psychosocial conference, and the child psychosocial conference were used to translate the current research evidence and expert opinion into guidance for the development of a mental health system.

Overview of the Resiliency and Disease Management Program, Continued

Consequently, the Texas mental health system is built on evidence-based interventions aimed at promoting recovery and resilience of individuals with mental illnesses.

Legislation

While TDMHMR was collaborating with stakeholders toward transformation of the Texas mental health system, the Texas legislature proposed [House Bill \(HB\) 2292](#), which included provisions calling for a focus on disease management and jail diversion strategies for specific major mental illnesses. This bill was signed into law and became effective September 1, 2004, providing additional support for the sweeping changes occurring in the Texas public mental health system. To underscore its focus on recovery, the transformation became known as Resiliency and Disease Management (RDM).

Mission of RDM

The mission of RDM is to foster resiliency and recovery with respect to mental illnesses.

RDM is an effort to redesign the way public mental health services are delivered to adults with severe and persistent mental illnesses and children with severe emotional disturbances. A primary aim of RDM is to ensure the provision of interventions with empirical support to eliminate or manage symptoms and promote recovery from psychiatric disorders. Other aims of this project include:

- (a) establishing who is eligible to receive services,
- (b) establishing ways to manage the use of services,
- (c) measuring clinical outcomes or the impact of services, and
- (d) determining how much these services should cost.

The purpose of RDM is to ensure delivery of mental health services properly tailored to the individual needs of consumers and designed to achieve the best possible results, while utilizing the limited available resources in the most efficient and cost-effective manner possible.

Piloting RDM in Texas

The RDM initiative was pilot tested in four community mental health centers during the 2004 fiscal year. The goals of the pilot phase were to:

- (a) ensure that the components of the model, including the services, assessments, and outcome measures, were appropriately designed;
- (b) determine effective strategies for implementation;
- (c) assess and reduce system barriers to implementation; and
- (d) measure the impact of implementation on the Texas mental health system.

Overview of the Resiliency and Disease Management Program, Continued

As a result of the RDM pilot phase, significant barriers were identified and reduced to provide the best opportunities. In accordance with [HB-2292](#) legislation, the newly created Texas Department of State Health Services (DSHS) began implementing RDM statewide in September of 2004.

Goals of RDM

The RDM initiative is intended to better match services to Mental Health consumers' needs, and to use limited resources most effectively. The intention is to provide the right service to the right person in the right amount to have the best outcomes. Some of the specific goals that DSHS hopes to achieve through RDM include:

1. Periodic assessments of individuals using appropriate and objective measuring tools;
 2. Consumer participation in proven-effective services tailored to their individual needs;
 3. Consumer participation in services of adequate intensity to aid in recovery from mental illness and the development of resiliency;.
 4. Provision of services with fidelity to key elements of the evidence-based practices; and
 5. Substantial improvement in measurable quality of life indicators leading toward the ultimate goal of full recovery.
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RDM Components

Because RDM represents a major transformation of the Texas mental health system, almost all aspects of the system have changed to support the goals of RDM. This manual reviews the major components designed to support RDM and directs the reader to important primary reference sources.

Key components of the mental health system created to support RDM are:

- **Uniform Assessment (UA).** A uniform assessment was created to assess the needs of consumers, recommend appropriate services based on identified needs, and monitor individual outcomes. The result of the assessment is an authorized Level of Care (LOC) that corresponds to a service package. The Adult UA includes the Adult Texas Recommended Assessment Guidelines (TRAG), the Texas Implementation of Medication Algorithms (TIMA) scales, and Community Data.

Overview of the Resiliency and Disease Management Program, Continued

- **Service Packages.** Service packages for both children and adults were developed to ensure the provision of evidence-based services to those individuals who would most benefit from those services. The Service Packages are described in the Utilization Management Guidelines. The UM Guidelines identify the services available and the intensity of service provision for each package, as well as guide decisions on eligibility and appropriate discharge from a service package.
 - **Utilization Management (UM).** Utilization management processes are an important component of RDM, allowing Local Mental Health Authorities (LMHAs) to manage limited resources and ensure reasonable access to effective services. Utilization Management Guidelines are documented in the UM Program Manual.
 - **Contracts with LMHAs.** Performance contracts between DSHS and the LMHAs include attachments that stipulate the service targets, performance measures, outcomes, remedies, sanctions, and penalties that may result from failing to fulfill contractual obligations.
 - **Quality Management.** One aspect of quality management activities created to support RDM is the development of a fidelity assessment process. This includes a Fidelity Toolkit and processes for assessing fidelity at the provider, authority, and state levels.
 - **Data Management.** Numerous changes were made to provide data support for the RDM initiative, including the creation of WebCARE and enhancement of the Mental retardation and Behavioral health Outpatient Warehouse (MBOW), which allows for extensive monitoring of data for decision-making. Analysis of cost information is provided through the Cost Accounting Methodology (CAM).
 - **Funding Strategies.** To better align funding resources with the goals of RDM, DSHS revised portions of the Medicaid State Plan of Texas, Medicaid program rules, and Medicaid Administrative Claiming (MAC). Documents referred to in this manual provide information critical to maintaining compliance with federal laws.
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Overview of the Resiliency and Disease Management Program, Continued

More Information

More information on RDM is at:

<http://www.dshs.state.tx.us/mhprograms/RDM.shtm>

Uniform Assessment

Adult Uniform Assessment for RDM

Adult
Uniform
Assessment (UA)

The **Mental Health Adult Uniform Assessment for Resiliency and Disease Management** is the uniform process used to assess the mental health service needs of adults in Texas. Adults are assessed at the following junctures: (a) crisis situations (new clients only); (b) during intake for non-crisis related services; (c) when there is a need to update the services to be delivered to an individual (including continued care); and (d) at planned discharges.

Adult UA
Section 1

The WebCARE UA is comprised of four sections. In **Section 1**, the **Adult Texas Recommended Assessment Guidelines (Adult-TRAG)** are used by a Qualified Mental Health Professional-Community Services (QMHP-CS) in a face-to-face setting with the individual for the purpose of recommending the most effective LOC for the person in question.

The QMHP-CS rates each individual on nine dimensions, all but one of which is on a 5-point scale, with higher ratings indicating greater clinical severity. The dimension ratings of an individual, together with their most recent psychiatric diagnosis, then points to one of six LOC recommendations. Within WebCARE, the clinician need only enter the dimension ratings, and then behind-the-scenes programming integrates this information with the individual's most recent diagnosis to produce a Calculated Level of Care - Recommended (LOC-R). The next section (p. 10) in this Manual describes the Adult-TRAGs in more detail.

The Adult-TRAG was developed specifically for identifying an individual's clinical needs and matching those needs with a particular service package. Disorder-specific clinical assessments are conducted to guide clinicians in treatment decisions. Although these assessments primarily serve a clinical purpose, they also serve as indicators of treatment outcomes.

Section 2

An LMHA-UM staff member completes **Section 2**, the **Authorized Level of Care (LOC-A)**. The UM staff member may authorize the recommended level of care (LOC-R) noted in Section 1 or may authorize a different level of care. However, if the LOC-A differs from the LOC-R, then reasons for deviation from the LOC-R must be specified in Section 2.

Adult Uniform Assessment for RDM, Continued

Section 3 In **Section 3**, the **Diagnosis-Specific Clinical Symptom Rating Scales** must be completed by a Licensed Vocational Nurse (LVN) or a QMHP, as part of the Texas Implementation of Medication Algorithms (TIMA). These scales are used clinically to evaluate an individual's response to medication treatment.

Section 4 In **Section 4, Community Data** is gathered to meet federal reporting requirements. The QMHP-CS records the person's residence type, paid employment type, and if applicable, their main reason for being out of the labor force at the time of the assessment.

Child/Adolescent Uniform Assessment for RDM

Child/Adolescent Uniform Assessment The **Child and Adolescent Uniform Assessment for Resiliency and Disease Management** is the uniform process used to assess the mental health service needs of children and adolescents in Texas. Children and adolescents are assessed in crisis situations (new clients only), at intake for non-crisis-related services, when updating their services (e.g., continued care or change in clinical needs), and at planned discharges.

Child UA-RDM Section 1 The WebCARE CUA-RDM is comprised of three sections. In **Section 1**, the **Child and Adolescent Texas Recommended Assessment Guidelines (CA-TRAG)** are used in face-to-face assessments performed with input from the child/adolescent in question and/or the child's caregiver(s) by a QMHP-CS for the purpose of recommending the most effective LOC.

Each child/adolescent is rated on the Ohio Youth Problem Severity Scale (OYPSS) and the Ohio Youth Functioning Scale (OYFS) by their caregiver when at all possible. The youth or worker versions of the scale are used in situations where the caregiver report is deemed invalid or cannot be obtained. The caregiver, youth, and worker versions of the OYPSS and OYFS were developed by Ogles, Melendez, Davis, and Lunnen in 1999 at the University of Ohio. They were found to be highly reliable and valid measures, with applicability to children in Texas. Next, the child/adolescent is rated on eight domains, all but one of which is on a 5-point scale, with higher ratings indicating greater clinical severity.

The child/adolescent's OYPSS and OYFS scores and domain ratings, along with their diagnostic category (*i.e.*, externalizing disorders category, internalizing disorders category, bipolar disorder,

Child/Adolescent Uniform Assessment for RDM, Continued

schizophrenia, or major depressive disorder with psychosis or other psychotic disorders category, or other diagnoses), then point toward one of eight LOC-Rs.

Within WebCARE, the clinician need only enter the child/adolescent's OYPSS and OYFS scores, and domain ratings, which are then programmatically integrated with the individual's diagnostic categorization to produce a calculated LOC-R. The next section on Service Packages in this Manual (p.12) describes the CA-TRAG in more detail.

Section 2 In **Section 2, Community Data** is gathered to meet federal reporting requirements. The QMHP-CS must record the following information for each child/adolescent: (a) number of arrests, if any; (b) number of school days missed, if any; and (c) the child's primary residence type during the last 90 days.

Section 3 In **Section 3, the Authorized Level of Care (LOC-A)** must be completed by an LMHA-UM staff member. The UM staff member may authorize the LOC recommended by the CA-TRAG in Section 1 or another LOC. However, if the LOC-A differs from the LOC-R, then reasons for deviation from the LOC-R must be specified in Section 3.

More Information The Adult CARE-UA-RDM form and instructions for completing the form are found at:
<http://www2.hhsc.state.tx.us/655/CIS/Training/files/forms/adult%20ua-rdm.pdf>
and
<http://www2.hhsc.state.tx.us/655/CIS/Training/files/forms/Adult%20Form%20Completion%20and%20Schedule.pdf>

The Child/Adolescent CARE-CUA-RDM form and instructions for the completing the form are found at:
<http://www2.hhsc.state.tx.us/655/CIS/Training/files/forms/Child%20CUA-RDM.pdf>
and
<http://www2.hhsc.state.tx.us/655/CIS/Training/files/forms/Child%20Form%20Completion%20and%20Schedule.pdf>

Service Packages

Adult Texas Recommended Assessment Guidelines (TRAG)

Quantifiable Measures

With the implementation of RDM, the use of quantifiable measures to guide assessments and LOC-Rs are essential. The Adult-TRAG was developed by DSHS to address this need. Recommendations in the Adult-TRAG may not supersede federal, state, or local licensing or operating requirements.

User's Manual

The User's Manual guides the QMHP-CS in providing the face-to-face assessment of service needs that result in a LOC-R for adults in the public mental health system. The Adult-TRAG is only one of the components of the DSHS *MH Adult Uniform Assessment for RDM*.

The goal of the Adult-TRAG is two-fold:

- 1) Establish a systematic assessment process for measuring mental health service needs among individuals based on their most recent diagnosis and nine dimensions for assessment.
 - 2) Establish a methodology for quantifying the assessment of service needs to allow reliable recommendations into the various service packages.
-

Manual Organization

The User's Manual for the Adult-TRAG is divided into six sections:

- **Section 1** focuses on the rationale and principles underlying the development of the Adult-TRAG.

Adult Texas Recommended Assessment Guidelines, Continued

- **Section 2** includes a description and rating system for each of the following nine assessment dimensions:
 1. Risk of Harm;
 2. Support Needs;
 3. Psychiatric-Related Hospitalizations;
 4. Functional Impairment;
 5. Employment Problems;
 6. Housing Instability;
 7. Co-Occurring Substance Use;
 8. Criminal Justice Involvement; and
 9. Response to Medication Treatment (MDD Only).

- **Section 3** of the User's Manual describes the following five LOCs in the service system:
 - **Crisis Services;**
 - **Service Package 1:** Pharmacological Management, Medication Training and Supports, and Routine Case Management;
 - **Service Package 2:** Pharmacological Management, Medication Training and Supports, Routine Case Management, Rehabilitative Counseling, and Psychotherapy;
 - **Service Package 3:** Pharmacological Management, Medication Training and Supports, Psychosocial Rehabilitation, Supported Employment, and Medical Services; and
 - **Service Package 4:** Assertive Community Treatment (ACT) Urban or Rural.

The recommended assessment guidelines, including the most recent diagnosis and dimension ratings, are then applied to each LOC. A simplified Level of Care Decision Grid is also provided to facilitate the translation of assessment results into LOC-Rs.

- **Section 4** contains sample case vignettes, as well as simplified Adult-TRAG Scoring Sheets, to assess the level of understanding of the material presented.

Adult Texas Recommended Assessment Guidelines, Continued

- **Section 5** includes questions and answers to help the reader in applying the Adult-TRAG.
 - **Section 6** includes sample questions to assist in gaining a complete understanding of each assessment dimension of the Adult-TRAG.
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More Information The Adult-TRAG and additional information are found at:
<http://www.dshs.state.tx.us/mhprograms/RDMTRAG.shtm>

Child/Adolescent Texas Recommended Assessment Guidelines (TRAG)

User's Manual The User's Manual guides the QMHP-CS in conducting the face-to-face assessment of service needs that results in a LOC-R for children and adolescents in the public mental health system. The CA-TRAG is a component of the DSHS *Child & Adolescent Uniform Assessment for RDM*.

The CA-TRAG was created in response to calls from numerous clinicians and administrators for the development of a uniform decision-making framework for recommending the most effective LOC for children/adolescents. The CA-TRAG is substantively similar to the Adult-TRAG, but has been adapted to reflect the developmental perspective of children/adolescents, the need for family focus, as well as the array of services available to children/adolescents with serious emotional disturbances.

The CA-TRAG is applicable to children ages 3 to 17 years. The goal of the CA-TRAG is two-fold:

- 1) Establish a systematic assessment process for measuring mental health service needs among children/adolescents based on their diagnostic category and ten domains for assessment, including the OYPSS and OYFS by Ogles et al. (1999).
 - 2) Establish a methodology for quantifying the assessment of service needs to allow reliable recommendations into the various service packages.
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Child/Adolescent Texas Recommended Assessment Guidelines, Continued

Manual Organization

The User's Manual for the CA-TRAG is divided into six sections:

- **Section 1** focuses on the rationale and principles underlying the development of the CA-TRAG.
- **Section 2** includes a description and rating system for each of the following ten assessment domains:
 1. OYPSS (Ogles et al., 1999);
 2. OYFS (Ogles et al., 1999);
 3. Risk of Self-Harm;
 4. Severe Disruptive or Aggressive Behavior;
 5. Family Resources;
 6. History of Psychiatric Treatment;
 7. Co-Occurring Substance Use;
 8. Juvenile Justice Involvement;
 9. School Behavior; and
 10. Psychoactive Medication Treatment.
- **Section 3** of this User's Manual describes the following five LOCs in the service system:
 - **Crisis Services;**
 - **LOC 1: Brief Outpatient**
 - ◆ Service Package 1.1: Brief Outpatient (externalizing disorders)
 - ◆ Service Package 1.2: Brief Outpatient (internalizing disorders);
 - **LOC 2: Intensive Outpatient**
 - ◆ Service Package 2.1: Intensive Outpatient (multi-systemic therapy)
 - ◆ Service Package 2.2: Intensive Outpatient (externalizing disorders)
 - ◆ Service Package 2.3: Intensive Outpatient (internalizing disorders)
 - ◆ Service Package 2.4: Intensive Outpatient (bipolar disorder, schizophrenia, major depressive disorder with psychosis or other psychotic disorders);
 - **LOC 3: NO LONGER USED (Treatment Foster Care);** and
 - **LOC 4: After-Care Services.**

Child/Adolescent Texas Recommended Assessment Guidelines, Continued

The recommended assessment guidelines, including the diagnostic category, OYPSS and OYFS scores, and domain ratings are then applied to each LOC. A simplified Level of Care Decision Grid is also provided to facilitate the translation of assessment results into LOC-Rs.

- **Section 4** contains sample case vignettes, as well as simplified CA-TRAG Scoring Sheets, to assess the level of understanding of the material presented.
 - **Section 5** includes questions and answers to help the reader in applying the CA-TRAG.
 - **Section 6** includes sample questions to assist in gaining a complete understanding of each assessment domain of the CA-TRAG.
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More Information

The CA-TRAG, as well as other information, is found at:
<http://www.dshs.state.tx.us/mhprograms/RDMCAtrag.shtm>

Utilization Management

Utilization Management (UM) Guidelines

Adult and Child/ Adolescent UM Guidelines

The UM Guidelines are designed to assist the clinician in determining the best possible course of treatment for the individual. Note that the Utilization Management Guidelines are just, as their name suggests, guidelines; and circumstances may warrant greater or lesser care for a particular individual.

The services offered within each service package are designed to provide the optimum care for the individual. Every service package must be tailored to the particular needs of the individual and his/her diagnoses and degree of functioning. Furthermore, the services contained within each service package must operate as a whole to promote recovery. Although there maybe variances in the quantity of any particular service within a service package, generally most services should be provided in the same quantity to each individual who is assigned the same type of service package.

When an individual needs more units of one or more services than are recommended in the authorized service package, the provider must contact the LMHA-Utilization Manager to request an exception in order for the individual to receive the additional units.

Basic Services

Basic services comprise the core of each adult and child/adolescent service package. The UM Guidelines recommend average units that an individual should receive over the course of an authorized period, and aim to ensure the delivery of services essential to improving the individual's mental health and functioning.

Add-ons

In some situations "add-on" services may be clinically indicated. The basic criteria for receiving add-on services are set forth in the UM Guidelines. Examples of add-ons for children include: psychiatric evaluations, medication management, and flex funds. Add-ons for adults typically include: supported employment, supported housing, individual/group rehabilitative services, and flex funds.

Utilization Management Guidelines, Continued

Admission/Discharge Criteria

Admission	<p>For each service package, whether for a child or an adult, there are criteria for admission and discharge that differ from the criteria of any other service package. These criteria are designed to meet the particular needs of the individual depending on the diagnoses, symptoms, and level of functioning. There are five principal factors to be weighed for admission: (1) diagnoses; (2) TRAG scores; (3) TIMA or Ohio scale scores, (4) clinician judgment, and (5) the individual's willingness to participate in services.</p>
Discharge	<p>Although the criteria for discharge vary for each service package, the criteria can typically be narrowed down to: achieving maximum benefit and individual choice. In some situations, the individual may reach a point at which he/she has attained the maximum benefit from an authorized service package. In other cases, the individual, or the individual's parent(s) if the individual is a minor, may choose to withdraw from services.</p> <p>In WebCARE, if a completed Intake or Update RDM assessment expires (or any portion of the assessment or authorization period expires) and at least 30 days have elapsed without any updates to the assessment, the assessment will be automatically closed, or "Auto-Closed." When an assessment is Auto-Closed, a discharge assessment is automatically entered and the authorization is terminated.</p>
Stepping Down	<p>As the individual begins to recover, it may be possible for the person to be "stepped-down" to a lower LOC, if his/her TRAG scores show significant improvement. However, a step-down must only be initiated on the basis of medical necessity and clinical judgment, and not on TRAG scores alone. If TRAG scores improve, clinicians may opt to do one additional TRAG assessment prior to assigning a new service package. With higher LOCs, successive lower scores on two TRAG assessments should generally result in an individual being "stepped-down" to a lower LOC.</p>

Admission/Discharge Criteria, Continued

Successful Treatment

As previously noted, the purpose of the service packages is to promote resiliency and recovery in adults and children. When it is agreed upon by clinicians, family members, and the individual that there is a remission of the major symptoms and improved functioning (as evidenced by a drop and/or a stabilization in the Uniform Assessment scores), it may be appropriate to prepare the individual to transition out of treatment.

Also, if the individual is able to obtain appropriate medications and services through means other than the public mental health system, it may be a good indication that the individual is ready to transition to natural support networks or other available community supports or service providers.

Refusal

An individual's refusal of services and other forms of resistance to treatment, are issues that need to be addressed from a clinical perspective. Failure to address such resistance can result in the individual's deterioration and hospitalization. Thus, it is inappropriate to terminate services or refer an individual out to other providers simply because the individual exhibits resistance to treatment. Providers are expected to exert reasonable and documented efforts toward engaging the individual in clinically appropriate services prior to transitioning the individual to a less appropriate service package, referral, or discharge from services.

Engaging Individuals

There are numerous techniques that can be used to engage an individual in services that are clinically appropriate to his/her needs. Examples include:

- 1) Basic rapport building – smiles, eye contact, body language, willingness to slow down and listen, respect for the individual, etc.
- 2) Staff attitude – confidence in the individual's ability to recover, confidence in their ability and their co-workers' ability to assist the individual in obtaining recovery, belief that what they are doing with the individual has value, etc.
- 3) Staff availability – making the provider's interest in and concern for the individual known through repeated contact via home visits, phone calls, and letters. Home visits convey more interest and concern than phone calls. Phone calls convey more interest and concern than letters. More frequent contact conveys more interest and concern than less frequent contact.

Admission/Discharge Criteria, Continued

- 4) Willingness to accommodate the individual – altering clinic hours to accommodate work and school hours, allowing the individual to prioritize his/her treatment needs, using the individual’s own language when identifying treatment goals, etc.
- 5) Educating the individual – providing explanations for why the clinically appropriate service package will be more effective, and for why recovery does not happen in a vacuum, and explanations of terms like “Evidence-Based Practices,” etc.
- 6) Motivational Interviewing – as a tool for all staff to use starting at intake and throughout the course of service provision. (Numerous resources are available on the Web – key words “Motivational Interviewing” and “William R. Miller.”)
- 7) Ensuring that every staff member who interacts with the individual knows his/her role in the engagement process - engagement begins with the very first contact, even if it is just a call to the main switchboard. Regardless of which techniques the provider chooses to employ, those techniques need to be applied consistently from the very beginning. Employing engagement techniques only upon the individual’s resistance to treatment is significantly less effective than incorporating engagement techniques as standard practice from the beginning and encouraging the individual to engage in other services when he/she is ready to do so.
- 8) Provide services that the individual is willing to accept - an individual may refuse one or more services within a service package and be eligible to receive other services within that service package.

However, if the provider has aggressively addressed treatment resistance and the individual continues to refuse the services within the authorized LOC, then the provider should explore classifying the individual to a lower level service package (if applicable) based on individual preference.

If the individual continues to refuse all services within an authorized service package, then the physician, in collaboration with the treatment team, should weigh the clinical risks and benefits to the individual of referring the individual to another provider. If the physician and treatment team, based on clinical analysis, determine that the individual would benefit from such a referral, then the referral should be made.

Admission/Discharge Criteria, Continued

In these instances, the provider needs to carefully document how treatment resistance was addressed, the objective evidence of the individual's repeated refusals, and the clinical rationale for referring the individual to another provider. The LMHA needs to assure continuity of services for the individual by ensuring that another provider has accepted the individual for service prior to discontinuing services.

An individual's refusal of one or more services within a package (i.e., partial refusal) should never result in a denial of other services. The proper approach should be to educate the individual or parent about the benefits of participating in all services within the package versus some of the benefits.

Guidelines for Over-rides

Over-rides

An Over-ride is the established process of assigning a consumer to a particular LOC other than the one recommended by the TRAGs. There are several reasons for which a UM can grant an override, including the following:

- Clinical reasons (in which specific and documented clinical circumstances exist that warrant assignment to a different LOC than the one indicated by the TRAGs)
- Consumer preference (in instances in which a consumer refuses to participate in services in a higher level and is moved to a lower level package)
- Resource limitations (not available for Medicaid-eligible individuals).

Guidelines for Over-rides, Continued

In addition, there are certain circumstances in which UM staff specifically can or cannot over-ride the LOC recommended by the TRAGs:

Can Over-ride:

- Individual preference for a lower service package.
- Only medical reasons warranting an over-ride that has the clinician's approval can result in an over-ride to a higher-level service package.
- When scarcity of resources requires an over-ride to a lower level service package and it is noted in the record that the individual is "underserved." (Caveat: Medicaid-eligible individuals may **not** be over-ridden into lower level service packages for a lack of resource.)
- Any member of a priority population who is not otherwise eligible for services may be over-ridden into services if there is a clinical basis for the over-ride and said basis is documented.

Cannot Over-ride:

- Individual choice cannot result in a clinical over-ride to a more intensive LOC.
- Individuals cannot be over-ridden into higher levels of care due to resource limitations.
- Medicaid-eligible individuals cannot be over-ridden into lower (or higher) levels of care due to resource limitations.

Before an over-ride can be granted, a TRAG must be administered.

Children

It is important to note that service packages for children differ significantly from services packages for adults. Service packages for children are structured to meet the needs of children who have either internalizing or externalizing disorders. Evidence-Based Practices or EBPs indicate that counseling is the best therapy for children with internalizing disorders, whereas skills training is the best therapy for children with externalizing disorders.

In addition, the intensive Multi-Systemic Therapy (MST) package (2.1) should be offered not only on the basis of need, but also on the basis of population density. In rural or frontier areas of the state, the population may be insufficient to justify MST (SP2.1). In which case, Service Package 2.2 may be substituted without being regarded as an over-ride.

Guidelines for Over-rides, Continued

Once a child has stabilized at his/her present service level, it may be appropriate to transfer the child into a new service package level in order to counteract new behaviors that may begin to manifest negatively and are not addressed by the present service package. In such cases, an additional assessment should be made and will not be considered an over-ride.

Children and adolescents are frequently diagnosed with both externalizing and internalizing disorders. The primary diagnosis is the key basis for the LOC-R. A child or an adolescent cannot be over-ridden into a service package if its intended purpose is inconsistent with treating the child or adolescent's primary diagnosis. If the child has both an externalizing and an internalizing disorder, the recommended LOC should correspond to the disorder that is causing the most significant functional impairment or distress for the child and family.

Adult

There is substantial research supporting Cognitive Behavioral Therapy (CBT) for the treatment of adults with Major Depressive Disorder (MDD). There is also strong evidence to support the use of rehabilitative services (such as Supported Employment, Supported Housing, and Assertive Community Treatment) for individuals with schizophrenia or bipolar disorder.

In addition, Assertive Community Training (ACT) Service Package 4 (SP-4) is provided if population density makes a team feasible and there is a sufficient number of individuals who need this particular service. Rural ACT services are provided when population density does not make an urban ACT team feasible.

Requirements for All Services

Requirements The following are required for all services, both Medicaid and General Revenue.

Medical Necessity The determination of medical necessity must be completed by an LPHA (see glossary for more information) and must be properly documented. A service is medically necessary if it is:

- A. reasonable and necessary for the diagnosis or treatment of a mental health disorder or a mental health and substance use disorder in order to improve or maintain an individual's level of functioning;
- B. in accordance with professionally recognized guidelines and standards of clinical practice in behavioral health care;
- C. provided in the most appropriate and least restrictive setting in which the service can safely be delivered;
- D. provided at a level that is safe and appropriate for the individual's needs and facilitates the individual's recovery; and
- E. could not be omitted without adversely affecting the individual's mental or physical health or the quality of care rendered.

Case Management Mental health case management services assist an individual in gaining access to care and services necessary and appropriate to the individual's needs. The two types of mental health case management services are: **routine** and **intensive**.

Routine case management for individuals of all ages is primarily site-based, while intensive case management, which is for children and adolescents only, is primarily community-based. The goal of case management is to assist a person in obtaining necessary care and services and to coordinate those services as necessary to meet the individual's identified needs.

Routine case management is only available to adults through Service Packages 1, 2, and 5; and it is only available to children through SP-1.1, 1.2, and 5. Adults in Service Packages 3 and 4 must receive psychosocial rehabilitation that includes a coordination component within the service. Children in other service packages (*e.g.*, 2.1 – 2.4) must receive intensive case management services.

(For staffing credentials, please refer to the [Mental Health Case Management Services Rule](#)).

Requirements for all Services, Continued

Rehabilitation

Rehabilitative services include individualized age-appropriate training and instructional guidance that address an individual's functional deficits due to a severe and persistent mental illness or serious emotional disturbance. Such services must be designed to improve or maintain the individual's ability to remain in the community as a fully integrated and functioning member of the community.

Although there are several different types of rehabilitative services, they each share the common goal of developing the individual's skills to: (a) reduce and manage symptoms; (b) reduce functional deficits; (c) maximize functioning; and (d) attain or maintain active participation in the community.

(For staffing credentials, refer to the [Medicaid Mental Health Rehabilitative Services Rule](#))

Clinically Different Services

Skills Training & Development is clinically different from Psychosocial Rehabilitative Services. Skills Training & Development comprises traditional rehabilitative skills training activities. Psychosocial Rehabilitation comprises rehabilitative skills training provided by a therapeutic team and the case management activities are incidental to the Rehabilitation to assist the rehabilitation trainer in teaching the individual how to be one's own case manager.

Word to the Wise

Because individuals who receive Skills Training & Development are higher functioning, their training must be more advanced and complex (e.g., maintaining a job, terminating an unpleasant live-in relationship). Skills Training & Development is provided by appropriately credentialed and trained staff. Individuals who receive Psychosocial Rehabilitation are doing less well so their training will be less complex, more basic in nature, (e.g., obtaining employment, negotiating with a neighbor who plays his stereo too loudly) and will be provided by appropriately credentialed and trained staff who are a member of their therapeutic team.

Since the rehabilitative skills training provided to individuals receiving Skills Training & Development (Adult SP's 1 and 2) is clinically different from the rehabilitative skills training provided to individuals receiving Psychosocial Rehabilitative Service (Adult SP's 3 and 4), individuals authorized for SP's 1 and 2 cannot be in rehabilitative skills training groups with individuals authorized for SP's 3 and 4.

Requirements for all Services, Continued

Multiple Diagnoses Confusion may arise when an individual who is dually diagnosed with both Mental Retardation and Serious Mental Illness (SMI) or Serious Emotional Disturbance (SED) presents for services. Because the RDM service packages are specifically designed for aiding the recovery of individuals diagnosed with one of the three major Mental Health disorders, those who have mental retardation with schizophrenia, major depression, or bipolar disorder and have other Mental Health disorders may be served.

However, apart from schizophrenia, bipolar, or major depression, people may be assessed as “not eligible for service” (LOC-R = 9.) These individuals can be over-ridden into a service package if they are members of the Mental Health priority population and have a need for services.

It is important to remember that once an individual is over-ridden into a service package, all the Mental Health rules and performance contract expectations apply (including: adding to over-ride percentages, receiving the services in the packages, and the minimum services as required by the contract).

Co-Occurring Disorders (MH and SA) Individuals who have co-occurring psychiatric and substance use disorders cannot be denied services needed based on current or historical substance use. Often these individuals are assessed to be in need of psychosocial rehabilitative services delivered in service packages 3 and 4 (LOC-R 3 or 4). Medicaid service is delivered in accordance with the service package that is medically necessary.

Dual Diagnosis (MH and MR) Because some individuals with an MR diagnosis may need psychiatric visits and medication only as a supplement to MR services, the clinician and the LMHA must determine whether to provide the individual with the MR services and code the psychiatric services as a supplement (*R054/Grid Code 3210 (Specialized Therapies)*) or to complete a uniform assessment and over-ride the consumer into one of the service packages.

There are a number of comprehensive Medicaid programs available to individuals with mental retardation. The grid on the next page describes the payer source required for the Medicaid services available in the Service Packages.

Requirements for all Services, Continued

Dual Diagnosis Mental Health and Mental Retardation Grid

RDM Service	MR Enrollment Status			
	ICF-MR(1)	HCS(2)	TxHmL(2)	Other
CM (Routine or Intensive)	ICF-MR pays	HCS Waiver pays	MR Service Coordination pays	MR Service Coordination <i>or</i> MH Case Management pays (3)
Psychosocial Rehab	Not applicable (4)	Not applicable (4)	Not applicable (4)	MH Rehab pays (5)
Med Training & Support Rehab	ICF-MR pays	MH Rehab pays	MH Rehab pays	MH Rehab pays
Skills Training & Development Rehab	ICF-MR pays	MH Rehab pays	MH Rehab pays	MH Rehab pays
Crisis Intervention Services Rehab	ICF-MR pays	MH Rehab pays	MH Rehab pays	MH Rehab pays
Day Programs for Acute Needs	ICF-MR pays	MH Rehab pays	MH Rehab pays	MH Rehab pays
Psychopharm Management	Physician card pays	Physician card pays	Physician card pays	Physician card pays

Notes:

- (1) Individuals enrolled in an ICF-MR should be treated as any other third party payer and are not required to be assessed.
- (2) Billing of Day Hab cannot overlap (day and time) with billing of Rehab.
- (3) This is a clinical decision as to whether the individual’s needs will be best addressed by MH Case Management or MR Service Coordination.
- (4) Individuals enrolled in an ICF-MR, the HCS waiver, or the Texas Home Living Program (TxHmL) waiver cannot also receive Psychosocial Rehab as this is a duplication of treatment team functions and case management functions and funding. Waiver individuals whose LOC-R is SP-3 or SP-4 are to be authorized (or over-ridden) as SP-1.
- (5) Individuals receiving Psychosocial Rehab cannot also be receiving MR Service Coordination, as this is a duplication of the case management functions and funding.
- (6) Rehab Counseling and Psychotherapy is restricted to Cognitive Behavior Therapy for individuals age 21 and over.
- (7) Rehab Counseling and Psychotherapy is restricted to Cognitive Behavior Therapy that addresses Mental Health needs. The individual may access “psychological services” under the waiver for other types of psychological services (e.g., behavior management).

Medicaid Issues

Entitlement

Federal regulations require that Medicaid-eligible individuals be given access to the Medicaid services they are eligible to receive. Therefore, Medicaid-eligible individuals may not be placed on waiting lists for case management or rehabilitative services. Case management and rehabilitative services may not be reduced or denied to Medicaid-eligible individuals on the sole basis of either a provider's lack of resources or "limited capacity."

The application of these federal requirements to a service system that uses the concept of service packages requires special attention to the important similarities and differences between the service packages. Particular attention should be drawn to the following two situations:

- 1) Adult SP-3 and SP-4 - These packages include the same Medicaid services. In SP-4, however, the individual receives more units of those services and receives those services from an Assertive Community Treatment (ACT) Team that provides services on a 24-hour basis.

A Medicaid-eligible adult who is determined to be in need of SP-4 may be served in SP-3 due to the provider's limited capacity to provide ACT if the individual still receives the same amount of units of psychosocial rehabilitative services that he/she would have received in SP-4. Since ACT is not a Medicaid service, failing to utilize an ACT Team does not violate federal law.

Word to the Wise

Individuals who are eligible for adult SP-4 but who are served in adult SP-3 due to limited capacity, should be moved to SP-4 as soon as capacity becomes available. The degree of need should determine the order in which these individuals are moved to SP-4, not the funding source. Medicaid-eligible individuals are not to be given priority over non-Medicaid individuals for being moved into the ACT package as space becomes available.

- 2) Child and Adolescent SP-2.1 and SP-2.2 - These service packages include the same case management and rehabilitative services. A child who is determined to be in need of service package 2.1 may be authorized at a 2.2 due to the provider's limited capacity if the child receives the same amount of units of case management and rehabilitative services that he/she would have received in 2.1. The only difference being that a contracted counseling professional outside of the DSHS service system must provide the counseling services ordinarily provided under SP-2.1.

Medicaid Issues, continued

Fair Hearings Medicaid-eligible individuals must be informed of the right to a Fair Hearing under the following three circumstances:

- 1) Denial of Case Management or Rehabilitative Services;
- 2) Reduction of Case Management or Rehabilitative Services; or
- 3) Termination of Case Management or Rehabilitative Services.

The basis of the decision to deny, reduce, or terminate services does not waive the federal requirement that these individuals be informed of their right to a Fair Hearing. Even in situations in which an individual has requested a reduction in or termination of services, the individual must still be informed of the right to a Fair Hearing.

More Information The Medicaid Fair Hearings templates are available at:
<http://www2.hhsc.state.tx.us/CentralOffice/BehavioralHealthServices/MedFairHear.html>

Flex Funds

Flex Benefits Flex Funds, or Flex Benefits, are non-clinical supports that augment the service plan to reduce symptomatology and maintain quality of life and family integration. Examples: For adults, these include rental assistance and transportation assistance and for children, these include respite, mentors, and childcare. For adults, the flexible benefit is limited to \$500.00 per person per month. For children and adolescents, each LMHA is allowed to provide up to an average of \$1500 per child per year.

Service Definitions

Family Training Family Training is training provided to the consumer's primary caregivers for the purpose of assisting them in coping and managing with the consumer's emotional disturbance. It includes instruction on basic parenting skills and other forms of guidance that cannot be considered rehabilitative skills training.

Service Definitions, Continued

Family Partners

The use of Family Partners is mandated in Service Packages 2.1-2.4. The family partner should ordinarily also be a parent or guardian of a child with serious emotional disturbances who has experienced the system firsthand, knows how to navigate through it, and understands the resources available for helping families and their children in similar circumstances. They can be of great service by working with families and helping them to engage and remain in services, by answering questions about the system and available services, and by helping families to understand the critical nature of their involvement in services.

If for whatever reason a particular family does not want to have a Family Partner, this shall not be the basis for moving the family to a lower service package or for discharging the family from services. Education should be provided to the family on the value of the Family Partner and how that individual can serve as a valuable resource to the family. See page 18 for more information on engagement.

Psychiatric Services

Because psychiatric evaluation is included in the definition of Pharmacological management services in the Adult UM Guidelines, time spent administering the psychiatric evaluation counts toward the time allotted for Pharmacological Management.

Services incidental to a physician's visit means that the activity is normally provided as part of the physician's service. "Incidental services" are defined as activities that are ordinarily or routinely provided as part of a physician's services. For example, because it is routine practice for a nurse to weigh a patient and take vital signs prior to a doctor's examination, these activities are regarded as "incidental." Furthermore, because these activities are incidental, they are covered by Medicaid as part of the payment rate for the physician's services and thus billing rehabilitation for these services would be regarded as "double dipping" and a violation of federal statute.

If a person requires more than these ordinary "incidental" services, then the status of the service changes and may qualify for funding under another service category, but the service in question would have to be designated as a planned intervention on the individual's treatment plan and would have to be within the scope of the service definition.

Service Definitions, Continued

Services Beyond the UM Guidelines Generally, supported employment and supported housing services must be provided to adults receiving the team-based service packages of SP-3 and SP-4. However, even when an individual does not meet the criteria for SP-3 or SP-4, the individual may have a need for supported employment or housing services. The Utilization Management Guidelines delineate the TRAG scores (in the section identified as “Add-On Service Criteria”) that are indicative of an individual in need of supported employment or housing services. If the TRAG indicates the need, the adult may receive supported employment or housing services in SP-1 – 4.

More Information The UM Guidelines and additional information are available at: <http://www.dshs.state.tx.us/mhprograms/RDMClinGuide.shtm>

Utilization Management Process

About Utilization Management

UM is the vehicle through which the LMHAs ensure equitable distribution of available resources according to individual need.

Each LMHA is responsible for maintaining an infrastructure that supports the implementation of key UM processes and functions, and for incorporating UM data and information into management decisions. Key UM processes include:

- ongoing exchange of clinical information between the LMHA and providers;
 - facilitating access and referral to services; and
 - promoting the most effective use of resources.
-

Effective UM Program

The LMHA must create a comprehensive UM plan, and have enough qualified UM staff to implement it and support the activities of a UM Committee. An effective LMHA Utilization Management program must:

- Recognize the evolutionary nature of Utilization Management and acknowledge the efficiencies that will be gained as managers improve their ability to use data and providers gain trust in UM as facilitating access to care rather than as a barrier;
 - Use data to identify patterns of utilization, work with clinicians to determine if the patterns and variation are desirable or not, and work with providers to make necessary improvements;
 - Ensure that clinically qualified individuals make decisions to authorize or deny services;
 - Capitalize on information management technology that will allow automatic authorization for some services based on provider competence and submission of appropriate clinical data;
 - Reduce concurrent review requirements for providers who demonstrate a consistent ability to follow the UM guidelines and submit appropriate documentation;
 - Conduct retrospective reviews in conjunction with other LMHA functions such as quality management, claims management and data verification to maximize the use of staff resources;
 - Integrate utilization data into various LMHA functions to include strategic and local planning;
 - Be designed to use the least possible resources, require limited infrastructure and be suitable for LMHA contracting with an ASO or other LMHA for this service.
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Utilization Management Process, Continued

Implementation of UM

UM Program

The Utilization Management Program Manual was prepared by the Texas Department of State Health Services Mental Health Resiliency and Disease Management Utilization Management Workgroup to assist the LMHAs to implement the service provisions of the RDM model.

Oversight of LMHA UM Process and Results

DSHS monitors LMHA data entered into WebCARE, CARE, and the Data Warehouse to determine compliance and performance, including the outcomes of service delivery. This incorporates data that reflects patterns of current service utilization and the clinical / assessment decisions used by the LMHA to make those decisions.

Trending

When outliers or trends are detected that reflect unusual or unexpected results, contact with the LMHA will be initiated and the causes explored. DSHS and the LMHA will collaborate on a series of activities to ensure that necessary oversight and improvement occurs in a manner that is the least resource intensive and provides necessary information for management decision-making. On an “as needed” basis and through routine sampling, DSHS will monitor the following:

- **TRAG (Adult & Child):** Oversight of the implementation of the TRAG will be conducted to ensure uniformity of implementation and reliability of results.
 - **UM Clinical Guidelines (Adult & Child):** DSHS will use LMHA WebCARE and CARE data to monitor compliance with the UM guidelines to ensure uniform application and to obtain information to be used in improving the guidelines on the State level.
 - **Complaints, Appeals and Over-rides:** DSHS will monitor the number and nature of complaints and appeals of adverse determinations submitted by the LMHA in order to ensure that the rights of individuals, including due process, are protected. In addition, information obtained from WebCARE about clinical over-rides will be critical to improving the UM Guidelines.
 - **LMHA Utilization Management Program Plan:** DSHS will review the LMHAs UM Plan when indicated to identify best practices.
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Implementation of UM, Continued

Authorizing Services

Authorization and reauthorization are based on the medical necessity of the services requested, Utilization Management Guidelines, and the availability of services and resources.

A Utilization Manager that meets the credential (LPHA or RN) and the competency requirements specified in the Performance Contract can authorize or reauthorize any service package for which there is a medical necessity, provide supervision for other UM staff, and manage, under the direction of the UM Psychiatrist, the activities of the UM Program. Other UM staff may include Utilization Reviewers, the UM Director, or UM Care Managers who meet the credential and competency requirements identified in the Performance Contract.

The UM Program Manual recommends that UM staff begin reviewing the authorizations for individuals whose LOC-R is for one of the less intensive service packages. New UM staff must be carefully supervised by the Utilization Manager until competence has been demonstrated.

<p>Word to the Wise It is essential to use accurate terminology when discussing who may authorize services, for example, neither a QMHP-CS nor a LPHA can authorize services unless they are qualified as UM staff.</p>
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Automatic authorization is a process that is based on a written agreement between the LMHA and its providers that allows automatic authorization only when the recommended LOC is the same as the LOC to be authorized and the providers have been determined through direct oversight to have documented competence in assessment using the UA-TRAG.

Implementation of UM, Continued

Medical Necessity The determination of medical necessity must be appropriately documented. A medically necessary service is defined as a service that:

- A. Is reasonable and necessary for the diagnosis or treatment of a Mental Health disorder or a Mental Health and substance use disorder in order to improve or maintain an individual's level of functioning;
- B. Is in accordance with professionally recognized clinical guidelines and standards of practice in behavioral health care;
- C. Is furnished in the most appropriate and least restrictive setting in which it can be safely provided;
- D. Is provided at a level that is safe and appropriate for the individual's needs and facilitates the individual's recovery; and
- E. Could not be omitted without adversely affecting the individual's mental or physical health or the quality of care rendered.

Tools for Oversight Oversight of the implementation of the TRAG will be conducted to ensure uniformity of implementation and reliability of results. DSHS will use LMHA, WebCARE, and CARE data to monitor application of the UM Guidelines and to ensure their uniform application, while also obtaining information to be used in improving the guidelines.

Complaints, Appeals, and Over-rides DSHS will monitor the number and nature of complaints and appeals of adverse determinations submitted by the LMHA, to ensure that individual rights, including due process, are protected. In addition, information obtained from WebCARE about clinical over-rides will be critical to improving the UM Guidelines.

More Information The Utilization Management Process and the UM Program Manual are available at:
<http://www.dshs.state.tx.us/mhprograms/RDMUMProcess.shtm>

Contracts

Performance Contracts

The Performance Contract	<p>The annual Performance Contract is the vehicle through which DSHS delegates to an LMHA the authority and responsibility for planning, policy development, coordination, including coordination with criminal justice entities, and resource development and allocation for and oversight of Mental Health services in the most appropriate and available setting to meet individual needs in the LMHA's service area.</p> <p>The Contract sets forth service targets, performance measures, and service outcomes that support the assessment and treatment of severe mental illnesses and serious emotional disturbances and are based on scientific evidence and clearly focused on recovery.</p> <p>Failure to meet these and other expectations delineated in the Contract may result in DSHS imposing remedies, sanctions, and penalties.</p>
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Sanctions

State Remedies	<p>Financial sanctions are imposed if an LMHA fails to achieve the service targets and/or the performance measures. Non-achievement of the service outcomes shall result in increased oversight, development of strategies for improvement, and other remedies outlined in the Performance Contract.</p>
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More Information	<p>An example of a standard performance contract is available at: http://www.dshs.state.tx.us/mhcontracts/contractdocuments.shtm.</p>
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Quality Management

Fidelity

What is Fidelity? Fidelity is the degree to which a program is implemented as planned or designed that is, the degree to which a program implementation is “faithful” to the key elements of an Evidence-Based Practice model. Fidelity is accomplished over time through training, supervision, and continuous reassessment to prevent movement away from principles and practices for the duration of the program.

Purpose The purpose of fidelity assessment in RDM is to ensure that all elements deemed critical to the effectiveness of each EBP are appropriately implemented. System measures of implementation and adherence are important to demonstrate the validity of outcome data and to provide DSHS with the ability to replicate the most effective practices throughout the State.

It is expected that high fidelity to the service models will result in improved individual outcomes. The purpose of the fidelity assessment process is to:

- (a) educate providers about service models;
 - (b) assist LMHAs and providers with applying a fidelity monitoring process;
 - (c) identify needs for technical assistance by DSHS and national experts; and
 - (d) allow oversight of individual programs by DSHS.
-

Importance Fidelity is important because:

- (a) Research has shown that programs that implement EBPs with greater fidelity have better outcomes;
- (b) Fidelity measurement provides tools and data for continuous quality improvement;
- (c) Fidelity measurement allows for increased standardization of services across the state;
- (d) Fidelity measurement can increase our understanding of the impact of model variations on outcomes.

Fidelity, Continued

Fidelity Toolkit

A Fidelity Toolkit was created to assist providers, LMHAs, and DSHS in measuring fidelity for each of the primary service models in RDM. The toolkit was based on existing fidelity scales, the consensus-derived "key ingredients" determined at consensus conferences, and input from stakeholders.

The Fidelity Toolkit contributes to the goal of reducing variation by defining with some precision what DSHS expects to receive when contracting for the services included in the RDM service packages. By defining criteria and methods for determining the degree to which the service models are implemented, the Fidelity Toolkit also provides a means for local authorities and providers to demonstrate to the State agency and citizens of Texas that "they are getting what they paid for."

For each of the EBPs or service models, the following have been developed and located in the Fidelity Toolkit:

- manual containing instructions and criteria about the model;
 - an assessment instrument/scale to measure implementation;
 - scoring sheets to record results;
 - Rapid Review self-assessment checklists to quickly determine if key structures are in place.
-

Structure of the Fidelity Scales

Fidelity assessment within the Mental Health field has been accomplished with "fidelity scales" that have evolved into a common format. These scales consist of a limited number of elements or components of the program model that define and distinguish it from other practices. These "key" components reflect, or are a means of objectifying, the underlying program principles and values of the program. An operational definition is provided for each element.

Fidelity, Continued

Assessment Process

The fidelity assessment process is coordinated by Quality Management staff. Depending on the purpose of the assessment, a team may be developed to review the fidelity of a program. This team may include quality management staff, providers of the service from other programs or LMHAs, DSHS staff, state, or national experts in the model. Fidelity assessments generally include a review of multiple information sources, such as medical records/charts, other forms of documentation (e.g., encounter data, group or training attendance lists), interviews with program administrators and staff, and interviews with individuals who have participated in the service package.

The results of a fidelity assessment provide an objective and structured way to provide feedback about program development. Feedback should be provided directly to the program administrators and staff, as opportunities for discussion and consultation are the most likely to result in use of the assessment results for quality improvement.

Rapid Review

One form of fidelity assessment is the Rapid Review. The Rapid Review was developed by DSHS to serve as both a readiness measure and to ensure that critical structural elements remain in compliance on an ongoing basis. Unlike fidelity reviews, where external evaluators review all fidelity elements and use a variety of data collection methods, the Rapid Review elements are scored by use of a self-assessment checklist. For the Rapid Review, rating scales consist of “Yes” for current practice or “No” for not evident.

The Rapid Review process was developed as a self-assessment process for both providers and Local Mental Health Authorities to:

- promote use of the fidelity manual;
 - increase self-initiated improvements based on the review results; and
 - establish a baseline for future comparison.
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More Information

The Fidelity Toolkit and related information are available at: <http://www.dshs.state.tx.us/mhprograms/RDMEval.shtm>

Data Management

Data Collection and Distribution

Mainframe CARE, WebCARE, and EDTS

About CARE

The Client Assignment and Registration (CARE) System registers and tracks Texas Health and Human Services (HHS) individuals throughout the mental health and mental retardation service delivery system. This mainframe system has been in existence for over twenty years. A statewide data communications network links state schools, state hospitals, and community centers to CARE.

The central mainframe CARE system database is the operational repository for statewide individual information. A separate [Mental Retardation and Behavioral Health Outpatient Warehouse \(MBOW\)](#), formerly Consumer Analysis Data Warehouse (accessed through Business Objects – InfoView) contains completed and static operational information for reporting and analysis purposes.

Mainframe CARE

The mainframe CARE system uses unique, statewide individual identification numbers to maintain descriptive information, such as demographics, county of residence, financial status, diagnostics, commitment status and mental health and mental retardation needs. Client reports, in addition to individual population statistical data, are available through on-line inquiry and standard production report generation.

Major Functions of Mainframe CARE

The mainframe CARE system supports the following major mental health Resiliency and Disease Management (RDM) functions:

- screening and registering individuals
 - recording individual movement (assignment) throughout the service delivery system
 - diagnostics, assessment, and level of care provided for individuals
 - generating reports that profile individuals and components.
-

Mainframe CARE, WebCARE, and EDTS, Continued

About WebCARE When Texas Department of Mental Health and Mental Retardation implemented RDM, the mainframe CARE system was selected as the operational system but required some programming changes. WebCARE was developed to modernize the CARE system and to incorporate RDM requirements. WebCARE's purpose is to improve the integrity and consistency of individual data available for statewide resource management. Following the restructure of the human services system in 2004, WebCARE is operated by the Health and Human Services Commission in cooperation with the Department of State Health Services (behavioral health and Resiliency and Disease Management) and Department of Aging and Disability Services (mental retardation).

WebCARE Functions WebCARE, the web-based front-end to the mainframe CARE system, provides registration, diagnostics, and assessment screens, as well as workflow and data management reporting capability. All data is stored in the same files/database on the mainframe for both CARE and WebCARE. Data may be entered into these files through WebCARE, CARE mainframe screens, or batch files.

WebCARE System Documentation

WebCARE Manuals The following documents are available to help one use the WebCARE system.

Note: Some documents require Adobe Reader (pdf files).

Manual	Description
WebCARE Manual	The WebCARE manual explains how one can use the WebCARE system's Resiliency and Disease Management (RDM) functions. It contains descriptive information about how the WebCARE system functions, procedural information about using WebCARE, and WebCARE Screen Field Tables, Error Codes, and Related Business Rules.
CARE Reference Manual	The manual contains detailed information that you may occasionally need to use in working with mainframe CARE or WebCARE screens. It contains, for example: <ul style="list-style-type: none"> • Decode Tables – codes and values used in WebCARE • Component Codes – codes and values sorted differently • County and Local Service Area Codes – codes, names and LSA's • AMD Classifications – codes and values • DSM IV Codes – codes and values • Glossary – alphabetical list of mainframe CARE and WebCARE system terms and definitions.

WebCARE Forms

Introduction

When entering a new individual in WebCARE, the process is to enter:

1. a registration record,
2. a diagnostics record,
3. an assessment record,
4. an assignment record in mainframe CARE, and
5. monitor the individual record for needed updates via reports until the individual has been discharged and the record has been completed.

Note: Individuals are identified as “Clients” in the mainframe CARE and WebCARE system.

WebCARE Forms

To facilitate the entry of information into WebCARE, forms were created. WebCARE has the following data entry modules with associated forms:

- [Client Registration](#)
 - [Client Diagnostics](#)
 - [Adult Uniform Assessment](#) and [Instructions/Schedule](#)
 - [Child/Adolescent Uniform Assessment](#) and [Instructions/Schedule](#)
-

WebCARE RDM Module

Uniform Assessment

The Uniform Assessment is an instrument designed to assist in the selection of a benefit package and financing methodology for public mental health services in the State of Texas. The WebCARE system is designed to record the individual’s assessment data, with the primary goal of using standard, quantifiable measures to guide the choice of service needs and to make appropriate “level of care” decisions.

Workflow / Reports

Sequence of Assessment Types

The expected sequence of completed assessment types is:

1. One Crisis (if individual is in crisis before an Intake or following a Discharge). No Discharge assessment is required.
 2. One Intake (If Intake Non-Admission – LOC-R=9 and LOC-A=9, then no Update or Discharge assessment is required) – used for initial admission into services, after a Discharge, or for Crisis Follow-up services after a hospital discharge.
 3. One or more Update(s) – used for periodic reassessments, usually every 90 days.
 4. One Discharge – used when services will no longer be provided.
-

WebCARE
RDM Menu

Data Entry		Workflow / Reports	
325	Client Registration	246	Incomplete/ Provider Complete Assessments - Adult
330	Diagnostics	247	Assessments Expiring By Section - Adult
164	MH Child Uniform Assessment for RDM	248	Assessments to Expire - Adult
346	MH Adult Uniform Assessment for RDM	251	Completed Assessments - Adult
		252	Autoclosures - Adult
		264	Incomplete/ Provider Complete Assessments - Child
		265	Assessments Expiring - Child
		267	Completed Assessments - Child
		268	Autoclosures - Child

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Managing

The Workflow / Reporting modules in the WebCARE system allows one to display or print specific individual information and component information. These reports are provided to assist centers in reducing partially completed records and to help identify assessments requiring updates, resulting in timely and sequential completion of assessments. These reports may also be used for files batched to WebCARE and for Electronic Data Transfer System (EDTS) files created by WebCARE.

Batch Processing – Incoming Data

Enter Data Into CARE

There are two methods for entering data into the CARE system:

1. Direct data entry into the mainframe CARE system through a 3270 terminal emulator or through WebCARE using a web browser. R&DM *Adult and Child/Adolescent Uniform Assessments* for new and/or ongoing consumers may only be entered via WebCARE.
2. Batch submittal of data using File Transfer Protocol (FTP) to the mainframe. For *Adult and Child/Adolescent Uniform Assessments* information, batch files will be accepted into the CARE system after the center completes the Batch Certification process. Reports may be generated for centers and viewed through JHS Exporter. For more details, see the following documents:
 - [Batch Information](#)
 - CARE X/PTR Report Listing
 - ◆ [CARE XPTR Numeric List](#)
 - ◆ [CARE XPTR by Directory](#)

Electronic Data Transfer System – Outgoing Data

EDTS

An EDTS transactional file is created on a daily scheduled basis. When data is entered into WebCARE (either by batch or online data entry), it will be copied to the extract file. That file is placed in a directory specifically for the center submitting the data and may be transferred to the center for reporting or updating the local system. The files are part of the Electronic Data Transfer System (EDTS). For more information on EDTS, see the following documents:

- [General Information About EDTS Files](#)
- [Adult EDTS Layout](#)
- [Child EDTS Layout](#)
- [Diagnosis EDTS Layout](#)
- [Registration EDTS Layout](#)

More Information

More information about mainframe CARE, WebCARE, and EDTS is available at:

<http://www2.hhsc.state.tx.us/655/CIS/Training/care.html>

Cost Accounting Methodology (CAM)

Service Cost Determination

While the CAM was created prior to RDM, a basic understanding of RDM cost estimates is essential. The standardized CAM, which is consistent with industry norms for the determination of cost, makes it possible for the LMHA to determine the cost of providing services. Each LMHA should analyze its CAM report, review the statewide CAM summary, and use that knowledge to facilitate relevant decisions (*e.g.*, to provide or contract a service, to expand, downsize, or maintain a program, or to evaluate staff performance).

While management decisions are based on several factors, CAM information may clarify some situations by providing objectivity. In order to demonstrate objectivity, it is imperative that cost findings for services provided by the LMHA be objective and determined according to accepted accounting practices.

LMHAs may choose to complete CAM reports more frequently (on a quarterly or monthly basis) than required by the State to facilitate local management decisions.

Standard Cost Methodology

The Cost Accounting Methodology was designed to utilize a standardized format to provide LMHAs and the State uniform and comparable cost data. The standardized cost methodology provides a means of demonstrating objectivity and provides the LMHA with a powerful local management tool.

A key component in the costing model is a consistent service classification recognized by LMHAs and DSHS. The Service Grid was developed to work with the CAM and thereby ensure that services are consistently defined across the state.

Performance Contract

Beginning September 2001, LMHAs were required through their Performance Contracts to report all Mental Health and Mental Retardation cost data to the appropriate State agency.

How to Use CAM Data

Using Cost Data

CAM data has been used by LMHAs in several ways. Examples include:

1. Sharing the cost per individual hour with the direct care worker.
 2. Looking at variations in the cost per server hour and analyzing these variations with servers relative to their peers.
 3. Analyzing range of billable hours per server amongst peers, and comparing to the LMHAs benchmark for billable hours.
 4. Reviewing cost per server hour, looking at patterns and trends related to efficiency, direct service time, and no-show rates.
 5. Analyzing individuals who have the highest service costs and looking for trends or relationships between costs and levels of need, diagnoses, etc.
 6. Analyzing differences in costs between services of internal providers and those of external providers.
 7. Establishing productivity benchmarks for staff.
 8. Implementing incentive programs relative to staff performance.
 9. Analyzing CAM data reported to monthly Encounter Data submitted.
 10. Analyzing CAM data from year to year for changes/trends.
-

Viewing CAM Data

Summarized CAM data for all LMHAs is published in the Mental Retardation and Behavioral Health Outpatient Warehouse (MBOW) under the category CA Financial/CAM. In addition, there are a variety of reports in MBOW that apply the service costs from the CAM to actual service activity reported in encounter data. Most reports of this nature are found in the CA Financial category.

CAM Reporting Requirements

CAM Data

Requirements for submission of the CAM documents are outlined in the performance contracts between the LMHAs and DSHS. CAM Reports shall be provided to DSHS for the six-month period ending February 28th and for the twelve-month period ending August 31st of each fiscal year.

CAM Reporting Requirements, Continued

More Information MBOW Technical Support, MBOW (Business Objects) Training, and MBOW Access information are available at:
<http://www2.hhsc.state.tx.us/applications/datawarehouse/>

More information about CAM is available at:
<http://www2.hhsc.state.tx.us/655/CommunitySystemsManagement/CamGrid.html>

Encounter Data Collection and Validation

Overview of Encounter Data An encounter is a single medical service, a period of examination, or treatment provided to an individual. The contract requires LMHAs to provide all encounter transactions when a service is delivered. The encounter data is used as detailed information for the RDM contract reports and also as an allocation base for reported CAM dollars..

Encounter Schedule The Encounter data submission process consists of two schedules:

Production Encounter Submission Schedule:

LMHAs must submit their encounter data on a monthly basis. The production schedule range is from the 9th of each month to the 16th. The first 7 submissions are trial runs to test submission against validation criteria and the 16th is the final publishing run each month. Failure to submit complete encounter data during the production schedule is a contract violation.

Tentative Encounter Submission Schedule:

The Tentative schedule allows LMHAs to submit their most recent encounters daily. It is not contractually required. The benefits for submitting daily encounter data are:

- The ability to test encounter submissions daily;
 - The ability to submit current encounter data in order to see the effects of the tentative encounter data in the contract reports;
 - By looking at the tentative data in the reports, LMHAs can identify missing encounter data or make corrections to the current tentative file before the final publishing run.
-

Encounter Data Collection and Validation, Continued

Encounter Data Validation and Process

DSHS has defined an array of what services may be reported in the encounter submission. Details describing all of the validation criteria are located in the MBOW under the “General Warehouse Information / Specifications” category. Data that does not meet criteria is rejected during the validation process and not loaded into MBOW. If more than 1% of the encounter data is rejected on a production validation run, the entire file will be rejected. (This 1% criterion does not apply to the tentative data process.)

The encounter validation process consists of these steps:

1. LMHAs FTP their submission files to the State encounter “landing” directory.
2. The automated encounter process picks up these files and runs them through a validation process.
3. The results of the validation process are posted in the Encounter Exception Log reports that are available to the LMHAs.
 - a. Production Encounter Submission reports are located in “CA Encounter Exception Log” category.
 - b. Tentative Encounter Submission reports are located in the “CA Encounter Exception Log / Tentative Exception Log” category.
4. LMHAs correct their submissions based on the error log reports. Files are then resubmitted for the next processing cycle.
5. Automated emails alert LMHA users whether a submission met or failed the validation criteria

More Information

MBOW Technical Support, MBOW (Business Objects) Training, and MBOW Access information area available at:

<http://www2.hhsc.state.tx.us/applications/datawarehouse/>

Information about Encounter Data can be found in the MBOW.

Data Reporting and Analysis

About the Mental Retardation and Behavioral Health Outpatient Warehouse

The MBOW is an integrated database for analysis, decision support, and historical reporting of Mental Health and Mental Retardation services and their individuals. Primary sources of data for this warehouse are service encounters, CAM reporting, Medicaid eligibility, and CARE registration, assignment, and uniform assessment data. These data are assembled via a collection of rules for integration and representation and presented using advanced reports in Business Objects. This approach renders the following benefits:

- Information requests can be made in business terms.
- There are consistent business rules for integration & representation of data.
- Information can be retrieved regardless of data location.
- Analysis that is dynamic & responsive.
- Technical expertise is not required to answer business questions.

A comprehensive set of pre-constructed reports is available in the MBOW, which makes the system very easy to use. These reports are available to DSHS and its business partners (LMHAs).

MBOW Load Cycle

MBOW loads daily with the most up-to-date information available. Reports are scheduled to refresh commencing at 7:00 AM and generally are up to date before 8:00 AM.

Though it loads daily, the sources for MBOW have independent schedules and therefore the timeliness of the data is dependent on its source as follows:

- Encounter data - Up to the close of the prior business day depending if the LMHA submits via the tentative process. (The tentative encounter submission process allows LMHAs to report encounter data voluntarily for representation in the MBOW before the final processing cycle.)
- Assessment and Authorization Data - Completed records daily. Incomplete records are not loaded into the data warehouse.
- Medicaid Eligibility - Weekly on Tuesdays.
- Consumer Registration & Demographic data (Name, gender etc.) - Weekly on Saturdays. This delay primarily affects newly registered individuals.
- CAM data - Six months after the close of the year. The last reported CAM is used as a proxy for costs until the current cost data is available.

Data Reporting and Analysis, Continued

About Business Objects

Business Objects is the data reporting and presentation tool for information in the MBOW. Business Objects web intelligence can be accessed through the HHSC Intranet at the following URL:

<http://www2.hhsc.state.tx.us/applications/datawarehouse/>

Business Objects has the following features:

- Viewed via the web (the only software needed is a standard internet browser)
 - Data visualization (graphs)
 - Drilling / Pivoting reports for extended analysis
 - The ability to save reports and data in a variety of formats
-

Applying MBOW to RDM

Overview

With the MBOW, LMHAs and State Program Managers have access to standardized, reliable, and quantifiable assessment data linked to the actual services received by the individual. The net effect is the data warehouse can present a picture of need and use of services, which is invaluable in the management of RDM.

MBOW Related to RDM Goals

The MBOW can be used to answer questions directly related to the RDM goals.

Goal 1:

Periodic assessments of individuals using appropriate and objective measuring tools

Questions answered:

- What percent of the served population has an up to date assessment?
- Which Individuals are being served without an assessment?
- When do my assessments expire?

Goal 2:

Consumer participation in proven-effective services tailored to their individual needs

Questions answered:

- What percent of the population is in a service package that their assessment recommends?
- What kinds of over-rides are happening?
- What is the rate of crisis for those under-served?
- What is the served population broken out by service package?

Goal 3:

Consumer participation in services of adequate intensity to aid in recovery from mental illness and the development of resiliency

Questions answered:

- What percent of the population is getting the minimum number of service hours?
- How does the average number of service hours per consumer compare with the number forecasted?
- Which individuals are receiving a high volume of service in low intensity service packages?
- What types of services are being delivered in each service package?
- How many days does it take an individual see a service provider after their intake assessment?

Goal 4:

Provision of services with fidelity to key elements of the evidence-based practices

Fidelity is not addressed by MBOW Reports.

Goal 5:

Substantial improvement in measurable quality of life indicators leading toward the ultimate goal of full recovery

Questions answered:

- What percentage of the overall population served indicates an improvement in functional abilities?
 - How frequently do consumers access crisis services?
-

Applying MBOW to RDM, Continued

MBOW – Getting Help

The MBOW home page can be found at:

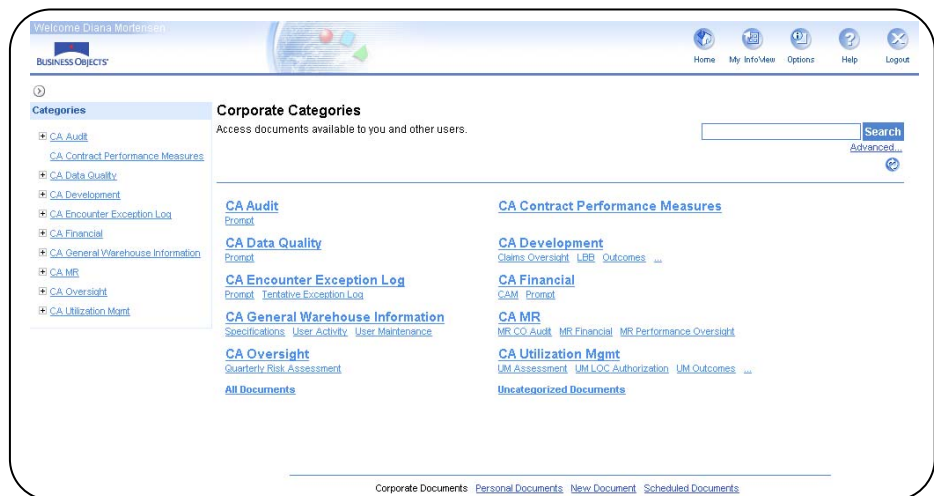
<http://www2.hhsc.state.tx.us/applications/datawarehouse/>

This page contains:

- A link to the Web intelligence portal from which one can access reports;
- Information on how to get access to the MBOW;
- A schedule and sign-up process for MBOW training;
- A change log of modifications and upgrades to the MBOW; and
- Information on how to open a trouble ticket to obtain support for MBOW (e.g., a password reset).

Report Categories

MBOW: Corporate Categories Menu



Primary RDM Report Categories

The report categories that are most frequently used for RDM-related information are:

- **CA Contract Performance Measures**
This category contains reports that directly relate to the performance contract items. These reports compare the performance of each LMHA with its obligations under its respective service level contract. In general, this should be the first category of reports to be analyzed by LMHAs since it monitors of their contractual obligations. Supporting details for contract measure reports (e.g. client list) are available in the CA Utilization Management category.

Report Categories, Continued

- **PM Outcomes**

This subcategory has detailed reports that pertain to primary clinical outcomes, such as functional improvement and crisis avoidance.

- **CA Utilization Mgmt**

This category contains all supporting detailed reports for the CA Contract Performance Measures. It contains four subcategories representing each RDM process.

- **CA General Warehouse Information**

This category functions as the MBOW news page. Check this directory regularly to stay up-to-date. It contains an orientation for new users, contact information for each of the LMHAs, a report catalog, and specifications for reporting data for inclusion in the data warehouse.

UM Subcategories

Within the CA Utilization Management (UM) category, the following subcategories are listed:

- **UM Assessment**

This subcategory holds detailed reports that pertain to the Assessment phase of the RDM process. These reports support the Contract Performance Measure - Completion Rate report.

- **UM LOC Authorization**

This subcategory has detailed reports that pertain to the Authorization phase in the RDM process. These reports support the Contract Performance Measure – Appropriateness of Service report.

- **UM Service Delivery**

This subcategory details the Service Delivery phase of the RDM process. These reports support the Contract Performance Measure - Average Hours and Service Package Minimum Hours reports.

- **UM Waiting List**

This subcategory contains reports on waiting lists. Individuals in this subcategory are either waiting for services (assigned to LOC-A=8) or are assigned to a lower than recommended service packages (i.e., they are under-served).

Report Categories, Continued

Other Report
Categories

Other reports that are available through MBOW that are relevant to RDM are:

- **CA Audit**

This category was created in order to enable QM to perform its audit of the LMHAs. Reports are primarily detailed encounter listings that show which services were provided to which consumers on which day by which provider.

- **CA Financial**

This category contains reports related to CAM costs, projections of the dollar value of GR services, and Medicaid reimbursement reports.

Funding Strategies

Rules: Rehabilitative Services, Case Management, & Community Standards

How To Read A Rule

Rules are Different from Manuals and Guides

Often when a person first begins to look at technical rule language, they may feel a sense of confusion and/or a sense of being overwhelmed. Rules must be written in a prescribed manner, in both format and content, to ensure that legal staff are able to cite and defend the actions of the State. Quality management and oversight staff also need the precise wording and structure of the rule to assist them in determining compliance with Federal and State requirements. The result of the prescriptiveness of rule language causes rules to be written in a manner that is not “user-friendly.”

Manuals and guides, on the other hand, may be written with the primary purpose of conveying the content of the rule in a more informal style with language that is more familiar to the audience. Manuals and guides allow the authors to provide additional details and examples that the dictates of rule language do not allow. Manuals and Guides may also provide the authors with an opportunity to tie the content from multiple rules into a more comprehensive picture than what would be as easily gleaned from reading the separate rules. While manuals and guides may be less of a drain on the brain than rule language, manuals and guides lack the precision of rule language.

Applicability

Every rule has a specific focus or application. The entities to which a rule applies are found in the body of the document – usually in the first few pages of the rule. A common mistake is to take a rule that applies only to one entity (such as to a State Hospital) and to assume it has application to other entities (such as a State School). A second mistake is to assume that because a rule does apply to one entity that it must not apply to others. You must check each rule to see the scope of application – for some apply to single entities and some apply to multiple entities.

How To Read A Rule, Continued

Definitions are Critical

Because of the legal nature of rules, terms that are used in technical ways require specific definitions. Sometimes a definition is used to elaborate on a term that is unique to the rule or the Texas Public Health system; for example, “uniform assessment” which has no meaning outside of the MHMR service system. Other times a definition is used to clarify what is meant by the term to ensure consistency in application across the state. For example, the definition of “child” varies from rule to rule dependent upon which legal definition of “child” impacts the rule.

Thus, it is essential to know the definitions of the terms used within the rule. A frequent error is to assume a term has a common meaning when it has been defined more precisely in the definitions section of the rule; for example, the requirement that each individual have a “treatment plan.” This may seem like a very straightforward requirement, but you cannot know if you are in compliance with the rule unless you know how the term “treatment plan” is defined in the rule. If any of the elements identified in the definition of a treatment plan are missing, then the requirement that each individual have a treatment plan has not been met.

Treatment Plan - A written document developed by the provider, in consultation with the individual (and LAR on the individual’s behalf), that is based on assessments of the individual and which addresses the individual’s strengths, needs, goals, and preferences regarding service delivery. The treatment plan includes:

- (A) measurable goals targeted to the individual’s symptoms, needs, and functioning;
- (B) the types of Mental Health community services to be provided;
- (C) a schedule for service delivery, including amount, frequency, and duration of services to be provided;
- (D) the staff responsible for the service(s) to be provided;
- (E) time frames for achieving the goals; and a projected schedule for re-evaluation of the treatment plan.

How To Read A Rule, Continued

Understand the Entire Rule

Read the
Entire Rule

Often, people can run into difficulty by reading only one section of a rule and assuming that the single section is all that the rule has to say on a particular topic. While sometimes this is a correct assumption, many times the rule has additional language outside of a particular section that nonetheless has applicability to the subject matter of a particular section. For example, one rule specifies the requirements for access to services, treatment planning, service delivery, and quality management in specific sections of the rule. However, later in the rule there is another section entitled “Additional Standards of Care Specific to Mental Health Community Services for Children and Adolescents.”

Even if a person was in full compliance with a particular section of the rule, the failure to understand that there are additional requirements for children and adolescents could result in findings on non-compliance if the person is served as a child or adolescent.

Check the References

Read All
Documentation

Many times a rule will refer to other rules, documents or laws. These references are provided intentionally and should not be ignored. For example a rule on Rehabilitative Services may refer to the Medicaid MH Rehabilitative Services Billing Guidelines. The failure to refer to those guidelines could result in inappropriate billing for services, which in turn could result in a financial loss to the service provider.

More Information

You can find the Medicaid Mental Health Rehabilitative Services at:
[http://info.sos.state.tx.us/pls/pub/readtac\\$ext.ViewTAC?tac_view=5&ti=25&pt=1&ch=419&sch=L&rl=Y](http://info.sos.state.tx.us/pls/pub/readtac$ext.ViewTAC?tac_view=5&ti=25&pt=1&ch=419&sch=L&rl=Y)

You can find the Mental Health Case Management Services at:
[http://info.sos.state.tx.us/pls/pub/readtac\\$ext.ViewTAC?tac_view=5&ti=25&pt=1&ch=412&sch=I&rl=Y](http://info.sos.state.tx.us/pls/pub/readtac$ext.ViewTAC?tac_view=5&ti=25&pt=1&ch=412&sch=I&rl=Y)

You can find the Mental Health Community Services Standards at:
[http://info.sos.state.tx.us/pls/pub/readtac\\$ext.ViewTAC?tac_view=5&ti=25&pt=1&ch=412&sch=G](http://info.sos.state.tx.us/pls/pub/readtac$ext.ViewTAC?tac_view=5&ti=25&pt=1&ch=412&sch=G)

Glossary

A B C D E F G H I J K L M N O P Q R S T U V W X Y Z

Access	An individual's ability to obtain the mental health community services needed to achieve the expected outcomes described in Outcomes for Mental Health Community Services. Access depends upon components such as availability and acceptability of services to the individual (or the individual's Legally Authorized Representative (LAR) on the individual's behalf), transportation, distance, hours of operation, language, and the cultural competency of staff members. Barriers to access may be structural, financial, or specific to the individual.
ACT (Assertive Community Treatment) – Urban	A self-contained Mental Health program made up of a multi-disciplinary team that works to provide the majority of treatment, rehabilitation, and support services an individual needs to achieve life goals. The individuals served have severe and persistent mental illnesses and have not successfully accessed or integrated traditional Mental Health services. The individuals served generally have a history of multiple hospitalizations and may have a higher incidence of homelessness, jail involvement, and substance use. ACT services are unique to the individual. The ACT team is mobile and delivers services in community locations. Eighty-five (85%) percent or more of the services are provided in vivo. Note: There should be no more than ten individuals to one team member. Some providers will, therefore, not have a high enough ACT census in a given geographic area to warrant a full ACT team. In these cases, DSHS may grant a waiver known as an ACT Alternative. Under the waiver, those individuals identified as needing ACT services may receive intensive services outside of the recommended ACT model.
ACT (Assertive Community Treatment) – Rural	
Adolescent	An individual who is 13 through 17 years of age.
Adult	An individual who is 18 years of age or older.
Adult Uniform Assessment	An assessment promulgated by DSHS to assess the individual's service needs. The result of the assessment is a LOC that corresponds to a service package. The Adult UA includes the Adult Texas Recommended Assessment Guidelines (TRAG), the Texas Implementation of Medication Algorithms (TIMA) scales, and Community Data.
Administrative Service Organization (ASO)	An entity that provides administrative services, through written agreement, such as credentialing of staff or utilization review of services.

Glossary

Adverse Action

Any action taken or proposed by DSHS against a provider in which the provider may request an administrative hearing under Chapter 406 of this title (relating to ICF/MR Programs) or this chapter, concerning Medicaid Programs.

Adverse Determination (Denial)

Any decision by the LMHA or its review agent to:

1. deny eligibility for services;
2. deny a request for a specific service, procedure, support, or extension of stay to a consumer whose eligibility has been approved; or
3. terminate or reduce a consumer's services, procedures, or extension of stay.

Appeal

A mechanism for an individual (or LAR on the individual's behalf) or provider to appeal adverse determinations made by a local mental health authority (LMHA), with which they disagree. This includes determinations in which consumers:

1. Are found ineligible for services during the eligibility determination process;
2. Have been terminated from services and/or supports;
3. Have had an involuntary reduction in their level of service and/or support; or
4. Have been denied access to a service and/or support they wish to receive.

Assignment

Identifies where a person is receiving services and tracks a person's movements throughout the MHMR service delivery system. Assignments consist of a combination of the following: component, program, activity, location, and assignment/absence code. Assignments are entered into mainframe CARE using a terminal emulator such as Quick Window Sockets 3270 Telnet Application (QWS3270).

Authorization

The LMHA utilization management process endorsing that the amount, duration, and type of services are medically necessary and appropriate based on available clinical information, and that the provider may proceed with service provision.

B

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(Total) Brief Bipolar Disorder Symptom Scale (BDSS) Bipolar Algorithm

Individuals with a diagnosis of Bipolar I disorder will be evaluated using the Brief Bipolar Disorder Symptoms Scale, or BDSS. This scale is derived from items included on the 24-item Brief Psychiatric Rating Scale. The 10-item version utilized for TIMA includes items assessing hostility, elevated mood, grandiosity, excitement, motor hyperactivity, depressed mood, anxiety, emotional withdrawal, blunted affect, and unusual thought content.

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(Total) Brief Negative Symptom Assessment (BNSA) Schizophrenia Algorithm	The BNSA is a 4-item instrument utilized to assess a subset of DSM-IV negative symptoms (Alogia, Amotivation, Flat Affect, and Asociality). The BNSA provides quick assessment of distinct negative symptoms, takes less than five minutes to administer, and is based largely on observation. These items are from the Brief Psychiatric Rating Scale (BPRS).
Brief Psychiatric Rating Scale (BPRS)	A method of determining clinical severity of psychiatric symptoms. A high BPRS implies severe symptoms.
Business Objects	A business intelligence platform that provides a web portal data presentation layer for any data warehouse. This software allows statewide informational access via reports and charts.
C	Return to beginning of Glossary
Child	An individual who is 3 through 12 years of age.
Child and Adolescent - Texas Implementation of Medication Algorithm Scales (CA-TIMA)	CA-TIMA is an evidence-based process for providing psychiatric care to children and adolescents. CA-TIMA involves consensus-derived guidelines for medication treatment, training and support for physicians, standardized documentation, and patient and family education.
Child Protective Services (CPS)	The public agency that is responsible for investigating cases of suspected abuse or neglect of children and for providing services and supports to children and families. CPS is a division of Department of Family and Protective Services (DFPS) and provides an array of services and supports that are set up to assess and address the safety of a child. These services and supports are provided when it is determined that the child is at risk or has been abused or neglected.
Child/Adolescent Uniform Assessment (CUA)	An assessment promulgated by DSHS to assess the individual's service needs. The result of the assessment is a LOC that corresponds to a service package. The Child UA includes the Child and Adolescent Texas Recommended Assessment Guidelines (TRAG) and Community Data.
Client Assignment Registration System (CARE)	DSHS's centralized, confidential database that registers and tracks individuals receiving services funded by or through the Texas Department of Health and Human Services.

Glossary

Cognitive Behavioral Therapy (CBT)

A psychotherapeutic approach that emphasizes the importance of thought patterns on feelings and behaviors and provides guidance in altering thought, feeling, and behavioral patterns. CBT is provided in order to resolve a concrete problem in daily functioning (problem focused, solution oriented) or symptoms resulting from maladaptive thoughts, feelings, interpersonal disturbances, and/or experiences consistent with a DSM-IV diagnosis. Psychotherapy is intended to be brief, time-limited, and focused.

Community Services

Mental Health, co-occurring substance use, and mental retardation services required to be available in each local service area pursuant to the Texas Health and Safety Code, §534.053(a), for which DSHS contracts through the performance contract as well as all other services specified in the performance contract.

Community Services Specialists (CSSP)

A staff member who, as of August 30, 2004:

(A) received:

(i) a high school diploma; or

(ii) a high school equivalency certificate issued in

accordance with the law of the issuing state;

(B) had three continuous years of documented full-time experience in the provision of mental health rehabilitative or case management services; and

(C) demonstrated competency in the provision and documentation of mental health rehabilitative or case management services in accordance with Chapter 419, Subchapter L of this title (relating to Mental Health Rehabilitative Services) and Chapter 412, Subchapter I of this title (relating to Mental Health Case Management Services).

Complaint

Any dissatisfaction expressed orally or in writing by a complainant to the LMHA regarding any aspect of the LMHA's operation, including but not limited to, dissatisfaction with benefit administration, unsatisfactory behavior/treatment by a provider, unsatisfactory behavior/treatment by representatives of the LMHA, the environmental conditions of treatment/service sites, and concerns about the quality of services provided. The term includes dissatisfaction relating to procedures related to review or appeal of an adverse determination (*e.g.*, denial, reduction, or termination of a service), the manner in which a service is provided, and a disenrollment decision. The term does not include:

1. a misunderstanding or a problem of misinformation that is resolved promptly by clearing up the misunderstanding or supplying the appropriate information to the satisfaction of the enrollee; or
2. a provider's or enrollee's oral or written expression of dissatisfaction or disagreement with an adverse determination.

Glossary

Component (Code)	An entity of the MHMR service delivery system. A component can be a facility of Texas Health and Human Services, such as a state hospital, state school, or community LMHA. Each entity has a unique identifying code that is used in mainframe CARE or WebCARE.
Consumer Analysis Data Warehouse (CADW) Previous name for the MBOW	See M ental retardation and B ehavioral health O utpatient W arehouse (MBOW).
Consumer-operated Services (COS)	Services provided by consumers for the benefit of consumers. Consumer-operated service programs are designed to assist consumers in becoming healthy, independent, and productive members of the community; increase consumer utilization of and satisfaction with mainstream mental health services; decrease consumer utilization of crisis and inpatient mental health services; and decrease consumer involvement with criminal justice system.
Continued Stay Review	A review conducted by an external or internal auditor to determine if the current place of service remains the most appropriate to provide the LOC required by the consumer.
Continuity of Services	LMHA responsibilities to ensure the continuity of services as the individual moves between facilities, providers, and/or LMHAs. Continuity of Services must be provided in accordance with the <i>Mental Health Services – Admission, Continuity, and Discharge</i> rule.
Co-Occurring Psychiatric Substance Use Disorder (COPSD)	COPSD is the co-occurring diagnoses of psychiatric disorders and substance use disorders. COPSD services provide intensive case management for those individuals who have both a psychiatric disorder and a substance abuse disorder. The case manager works with the individual to ensure that appropriate services are scheduled and attended. This specialist will also engage the individual in intensive motivational counseling and education on an individual basis, as well as specialized groups.
Cost Accounting Methodology (CAM)	The Cost Accounting Methodology is a standardized report that provides LMHAs and the State consistent and comparable cost data. The standardized CAM, which is consistent with industry norms for the determination of cost, makes it possible for the LMHA to determine the cost of providing services.
Counseling	Individual, group and family cognitive behavioral therapy provided by a licensed practitioner within the scope of his or her professional license that is focused on the reduction or elimination of a person's symptoms of emotional disturbance and increasing the person's ability to perform activities of daily living

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Credentialing

A process to review and approve a staff member's educational status, experience, and licensure status (as applicable) to ensure that the staff member meets the departmental requirements for service provision. The process includes primary source verification of credentials, establishing and applying specific criteria and prerequisites to determine the staff member's initial and ongoing competency and assessing and validating the staff member's qualification to deliver care. Re-credentialing is the periodic process of reevaluating the staff's competency and qualifications.

Crisis

A situation in which:

(A) because of a mental health condition:

(i) the individual presents an immediate danger to self or others; or

(ii) the individual's mental or physical health is at risk of serious deterioration; or

(B) an individual believes that he or she presents an immediate danger to self or others or that his or her mental or physical health is at risk of serious deterioration.

Crisis Services

Mental health community services provided to an individual in crisis. Interventions provided in response to a crisis in order to reduce symptoms of severe and persistent mental illness or serious emotional disturbance and to prevent admission of an individual to a more restrictive environment. Crisis intervention services include:

- an assessment of dangerousness of the individual to self or others;
- the coordination of emergency care services in accordance with §412.314 of this title (relating to Crisis Services);
- behavior skills training to assist the individual in reducing stress and managing symptoms;
- problem-solving;
- reality orientation to help the individual identify and manage their symptoms of mental illness; and
- providing guidance and structure to the individual in adapting to and coping with stressors.

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Day Programs for Acute Needs

Day programs for acute needs providing short-term, intensive treatment to an individual who requires multidisciplinary treatment in order to stabilize acute psychiatric symptoms or prevent admission to a more restrictive setting. Day programs for acute needs are:

- provided in a highly structured and safe environment with constant supervision;
- ensure an opportunity for frequent interaction between an individual and staff members;

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- are services that are goal-oriented and focus on reality orientation;
- symptom reduction and management;
- appropriate social behavior;
- improving peer interactions; and
- improving stress tolerance and the development of coping skills.

Department

Texas Department of State Health Services (DSHS)

Diagnostic and Statistical Manual of Mental Disorders (DSM)

The current edition of the *Diagnostic Statistical Manual of Mental Disorders* published by the American Psychiatric Association. A diagnostic tool used to promote effective diagnosis, treatment, and quality of care. Information is included about the associated features, culture, age, and gender features, prevalence, course, and familial pattern of mental disorders.

Dual Diagnosis; Dually Diagnosed

The co-occurring diagnoses of psychiatric disorders and mental retardation.

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Electronic Data Transfer System (EDTS)

EDTS is the system that provides data to LMHAs. A daily extract of all new, successfully entered RDM CARE records is placed in a directory accessible to LMHAs and can be transferred to the LMHA via Electronic Data Transfer System (EDTS) for record verification and use by the provider's local system.

Evidence-Based Practice (EBP)

Clinical practices and interventions proven by evidence to produce optimal outcomes at the highest level of efficiency and effectiveness.

Exception

The authorization of additional amounts of services based on medical necessity when the individual has reached the maximum service units of their currently authorized level of care (LOC).

External Provider

A service provider that is not employed directly by the LMHA.

Externalizing Disorders

Disorders that are characterized by behaviors directed outward, typically toward other people. These types of behaviors typically involve conflict with other people. Externalizing disorders include Oppositional Defiant Disorder (ODD), Attention Deficit Hyperactivity Disorder (ADHD), Conduct Disorder (CD), and substance abuse disorders. ODD is a recurrent pattern of negativistic interpersonal behavior characterized by disobedience and defiance toward benevolent authority figures. CD is a more serious behavior disorder characterized by aggressive and antisocial behavior and major community rules violations.

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Face-to-Face

A contact with an individual that occurs in person. Face-to-face does not include contacts made through the use of video conferencing or telecommunication technologies.

Family Member

Any person who an individual identifies as being a member of their family (e.g., parent, spouse, child, sibling, significant other, partner).

Family Partner

Experienced parent (i.e. parent of an individual with a serious emotional disturbance) who provides peer mentoring, education, and support to the caregivers of a child who is receiving mental health community services.

Family Training

Training provided to a child or an adolescent's primary caregivers to assist the caregivers to cope and manage with the client's emotional disturbance. This includes instruction on basic parenting skills and other forms of guidance that cannot be considered rehabilitative skills training.

Federally Qualified Health Center (FQHC)

An entity may qualify as an FQHC if it:

- is receiving a grant under §330, of the Public Health Service (PHS) Act. The Health Resources and Services Administration (HRSA) within HHS recommends, and the Secretary determines that, the facility meets the requirements for receiving a grant under §330 of the PHS Act;
- is receiving funding under a contract with the recipient of such a grant and meets the requirements to receive a grant under §330 of the PHS Act;
- is determined by the Secretary to meet the requirements for receiving such a grant (look-alike) based on the recommendation of HRSA within PHS;
- was treated by the Secretary as a federally funded health center (FFHC) for purposes of Part B Medicare as of January 1, 1990; or,
- is an outpatient health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act or by an urban Indian organization receiving funds under title V of the Indian Health Care Improvement Act as of October 1, 1991.

Fee-For-Service

Payment for services is on a per service basis.

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General Revenue (GR)

Money provided to local authorities by the state authority to provide services for both insured and indigent Mental Health clients. The funds are provided before the services are rendered. This money originates from state tax revenues and fees and is deposited into either a non-dedicated GR fund (legislators have discretion over how to spend these funds) or a dedicated GR fund (money for a specific purpose).

Global Assessment of Functioning (GAF)

A clinical assessment instrument to evaluate overall functioning in several domains. A low GAF indicates poor functioning.

Good Faith Effort

Documentation of multiple attempts (2 or more) and multiple methods (2 or more) using traditional methods (phone calls and letters), mobile methods (home, job-site or school visits) or systems alerts (program alerted to be on the lookout for the child or adult) to contact every person to determine the continued need for services. This term relates to individuals currently on a wait list to receive services.

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Health Insurance Portability and Accountability Act of 1996 (HIPAA)

The Health Insurance Portability and Accountability Act, 42 U.S.C. 1320d et seq. Title II requires the US Department of Health and Human Services to establish national standards for electronic health care transactions and national identifiers for providers, health plans, and employers. It also addresses the security and privacy of health data. HIPAA is a federal law intended to improve the availability and continuity of health insurance coverage that, among other things, places limits on exclusions for pre-existing medical conditions; permits certain people to enroll for available group health care coverage when they lose other health coverage or have a new dependent; prohibits discrimination in group enrollment based on health status; guarantees the availability of health coverage to small employers and the renewability of health insurance coverage in the small and large group markets; and requires availability of non-group coverage for certain individuals whose group coverage is terminated.

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Intensive Case Management

Primarily community-based services that assist an individual in gaining and coordinating access to necessary care and services appropriate to the individual's needs. Intensive Case Management is available only to children and adolescents.

Intermediate Care Facility for Persons with Mental

Facility that provides Medicaid-funded residential services to individuals with mental retardation or a related condition.

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Retardation (ICF-MR)

Internalizing Disorder

Disorders that are introversive and intrapersonal in nature. Depression and Anxiety are the most prevalent of the internalizing problems. Internalizing behaviors refer to behaviors such as anxiety, inhibition, shyness, immaturity, sadness, and social withdrawal. According to the DSM-IV, internalizing behavior problems are equated with anxiety and mood disorders. DSM-IV anxiety disorders include separation anxiety disorder (the only anxiety disorder specific to childhood), social phobia, specific phobia, generalized anxiety disorder, agoraphobia, panic disorder with and without agoraphobia, obsessive-compulsive disorder, posttraumatic stress disorder, acute stress disorder, anxiety disorder due to a general medical condition, substance-induced anxiety disorder, and anxiety disorder not otherwise specified. DSM-IV mood disorders include major depressive episode, dysthymic disorder, depressive disorder not otherwise specified, bipolar disorders, cyclothymic disorder, mood disorder due to a general medical condition, and substance-induced mood disorder.

International Classification of Diseases, Clinical Modification (ICD-CM)

Published by the U.S. National Center for Health Statistics, this is the official system of assigning codes to diagnoses and procedures associated with morbidity for indexing medical records, medical care reviews, ambulatory or other medical care, as well as for basic health statistics. This is the Clinical Modification (CM) of the World Health Organization's International Classification of Diseases (ICD), since the codes must be more precise to describe the clinical assessment of the individual.

In-vivo

An individual's natural environment, (e.g., the individual's residence, work place, or school).

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Legally Authorized Representative (LAR)

A person authorized by law to act on behalf of an individual and who may be a parent, guardian, or managing conservator.

[Legislative Budget Board \(LBB\)](#)

The LBB is a permanent joint committee of the Texas Legislature that develops recommendations for legislative appropriations for all agencies of state government. The LBB ensures that state resources are appropriately distributed among the various state agencies.

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Level of Care (LOC)	A designation given to the Department's standardized packages of mental health services, based on the uniform assessment and the utilization management guidelines, which specify the type, amount, and duration of mental health community services to be provided to an individual.
Licensed Medical Personnel	A physician, an RN, pharmacist, vocational nurse, or physician assistant.
Licensed Practitioner of the Healing Arts (LPHA)	A person employed by a Medicaid provider, under arrangement with a Medicaid provider, or employed by a professional association or institution of higher learning under arrangement with a Medicaid provider who is: (A) a physician; (B) a licensed professional counselor; (C) a licensed clinical social worker; (D) a licensed psychologist; (E) an advanced practice nurse; or (F) a licensed marriage and family therapist.
Local Case (Number)	Unique identifier given to distinguish an individual's records at a component. An individual is given a local case number when he or she is first assigned to a component. If an individual is assigned to more than one component, that individual will have a unique local case number at each component.
Local Mental Health Authority (LMHA)	An entity designated as the local mental authority by DSHS in accordance with the Texas Health and Safety Code, §533.035(a).
Local Service Area (LSA)	Geographic area composed of one or more Texas counties delimiting the population that may receive services from the local MH or MR Authority.
Location (Code)	Code used to identify community-based programs and units associated with a single component.
M	Return to beginning of Glossary
Management Information System	An information system designed to supply an LMHA or MCO with information needed to plan, organize, staff, direct, and control their operations and clinical decision-making.
Medicaid Eligible	An individual who qualifies to receive assistance through the state's Medicaid program. This term includes individuals who qualify but have not yet completed the required paperwork or are awaiting enrollment.
Medicaid Fair Hearing	A federally required process that ensures Medicaid-eligible

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individuals are not denied access to medically necessary services. If a Medicaid-eligible individual is receiving services, the individual must be notified of the right to request a fair hearing if services are to be suspended, reduced, or terminated.

Managed Care Organization (MCO)

An entity that has a current Texas Department of Insurance certificate of authority to operate as a Health Maintenance Organization (HMO) under Chapter 843 of the Texas Insurance Code or as an approved nonprofit health corporation under Chapter 844 of the Texas Insurance Code and that provides mental health community services pursuant to a contract with the department.

Medical Record

The systematic, organized account, compiled by health care providers, of information relevant to the services provided to a consumer. This includes an individual's history, present illness, findings on examination, details of care and services, and notes on progress.

Medication Training and Support Services

Training based on curricula promulgated by DSHS to assist an individual in understanding the nature of an adult's severe and persistent mental illness or a child/adolescent's serious emotional disturbance; understanding the role of the individual's prescribed medications in reducing symptoms and increasing or maintaining the individual's functioning; identifying and managing the individual's symptoms and potential side-effects of the individual's medication; learning the contraindications of the individual's medication; understanding the overdose precautions of the individual's medication; and learning self-administration of the individual's medication.

Mental Health and Mental Retardation (MHMR)

An abbreviation for the Texas Department of Mental Health Mental Retardation (TDMHMR). In September of 2004, TDMHMR was reorganized into separate state agencies. MH services were transferred to the Texas Department of State Health Services (DSHS) and MR services were transferred to the Texas Department of Aging and Disability Services (DADS).

Mental Health Community Services

All services medically necessary to treat, care for, supervise, and rehabilitate individuals who have a mental health or emotional disorder or a COSPD. These services include services for the prevention of and recovery from such disorders, but do not include inpatient services provided in a state facility.

Mental Retardation (MR)

A developmental disability characterized by significant limitations both in intellectual functioning and in adaptive behavior as expressed in conceptual, social, and practical adaptive skills. MR is onset prior to age 18. An assessed Intelligence Quotient (IQ) score must be at 70 or below.

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Mental Retardation and Behavioral Health Outpatient Warehouse (MBOW)

Represents an integrated database for analysis, decision support, and historical reporting of Mental Health and mental retardation services and the individual clients. Primary sources of data for this warehouse are service encounters, Cost Accounting Methodology reporting, Medicaid eligibility, and CARE registration, assignment, and uniform assessment data. These data are assembled via an assortment of rules for integration and representation and presented using advanced reports in Business Objects.

Mental Retardation Services

Texas Department of Aging and Disability Services (DADS) under the responsibility of the DADS Deputy Commissioner. MR services are concerned with (1) research, prevention, and detection of mental retardation, and (2) all services related to the education, training, habilitation, care, treatment, and supervision of people with mental retardation.

Multi-Systemic Therapy (MST)

A comprehensive in-home and community-based treatment model provided to children and adolescents with externalizing disorders who are involved in the juvenile justice system

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Ohio Youth Functioning Scale Score (OYFS)

The "Functioning Scale" is comprised of 20 items designed to rate the youth's level of functioning in a variety of areas of daily activity. Each item is rated on a five-point scale (0 "Extreme troubles" to 4 "Doing very well"). Although the problem severity scale is similar to many other existing symptom rating scales that focus on the severity of behavioral problems, the functioning scale provides a broader range of ratings including "OK" and "Doing very well". This provides an opportunity for raters to identify areas of functional strength. A total functioning score is calculated by adding the ratings for all 20 items. Higher scores are indicative of better functioning.

Ohio Youth Problem Severity Scale Score (OYPSS)

The "Problem Severity Scale" is comprised of 20 items covering common problems reported by youth who receive behavioral health services. Each item is rated for severity/frequency (0 "Not at all" to 5 "All the time") on a six-point scale. A total score is calculated by summing the ratings for all 20 items.

Outlier

A recognized service need outside of the standard service(s) determined appropriate for a given service package. The outlier service must be assessed and authorized as being medically necessary.

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Over-ride

An authorization that results in a higher or lower LOC than is recommended by the uniform assessment.

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Parent Support Group

Routinely scheduled support and informational meeting for the primary caregivers of a child or adolescent with serious emotional disturbance.

Peer Provider

A staff member who:

(A) has received:

(i) a high school diploma; or

(ii) a high school equivalency certificate issued in accordance with the law of the issuing state;

(B) has at least one cumulative year of receiving mental health community services for a disorder that is treated in the target population for Texas; and

(C) is under the direct clinical supervision of an LPHA.

Pharmacological Management Services

Supervision of administration of medication, monitoring of effects and side effects of medication, and assessment of symptoms generally performed by an M.D. or other professional licensed to diagnose mental illness and to prescribe medications. This service includes psychiatric evaluations performed in accordance with the Utilization Management guidelines for each service package.

(Total) Positive Symptom Rating Scale (PSRS) Schizophrenia Algorithm

The 4-item PSRS assesses positive symptoms of schizophrenia (suspiciousness, unusual thought content, hallucinations, and conceptual disorganization). These items are from the Brief Psychiatric Rating Scale (BPRS).

Primary Caregiver

An adult with whom a person is living and who has assumed responsibility for the care of the person.

Prior Authorization

The process of obtaining coverage approval for a service or medication, prior to that service or medication being rendered. Without such prior authorization, the service or medication is not covered or is reimbursed at a lower level.

Priority Population

Those groups of individuals with mental illness, co-occurring substance disorders, and mental retardation identified in DSHS current strategic plan, and operationally defined in the performance contract, as being most in need of mental health services.

Productivity

The percentage of time that staff members are engaged in direct face-to-face service delivery with a consumer.

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Protected Health Information (PHI)	The name, address, social security number, or any information by which the identity of an individual can be determined either directly or by reference to other publicly available information. The term includes medical records, graphs, and charts; statements made by the individual either orally or in writing while receiving Mental Health community services; videotapes, photographs, etc.; and any acknowledgement that an individual is receiving or has received services from a state facility, LMHA, MMCO, provider of rehabilitative services that are reimbursed by Medicaid, or provider.
Provider Network	A group of providers that will accept referrals from the LMHA for persons who need Mental Health services.
Provider Profiling	<p>An essential mechanism by which LMHAs use aggregate data and information about providers in their networks. The collection of data associated with profiling allows the LMHA to assess the performance of clinicians, programs and services. The intent of such a process is not to point out “bad” or “good” performers, but to identify areas for questioning or further study and to potentially facilitate processes by which the provider modifies their practice so that services are more efficient and effective. Profiling covers multiple areas of care delivery such as:</p> <ul style="list-style-type: none">A. Competency of providers to provide care.B. Accessibility to services.C. Safety of the environment in which services are provided.D. Continuity of care.E. Effectiveness and efficiency of treatment.F. Satisfaction of consumers and family members with services. <p>Psychiatric clinical diagnostic interview performed by a qualified physician.</p>
Psycho-social Rehabilitation Services (PSR)	Psychological, social, educational, vocational, behavioral, and cognitive interventions provided by members of an individual’s therapeutic team that address deficits in the individual’s ability to develop and maintain social relationships, occupational or educational achievement, and independent living skills that are the result of a severe and persistent mental illness in adults. Psychosocial rehabilitation services may also address the impact of co-occurring disorders upon the individual’s ability to reduce symptomology and increase daily functioning. Psychosocial rehabilitation services consist of the following component services: (1) independent living services; (2) coordination services; (3) employment related services; (4) housing related services; (5) medication related services; and (6) crisis related services.

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Qualified Mental Health Professional-Community Services (QMHP-CS)

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A staff member who is credentialed as a QMHP-CS who has demonstrated and documented competency in the work to be performed and:

- (A) has a bachelor's degree from an accredited college or university with a minimum number of hours that is equivalent to a major (as determined by the LMHA or MCO in accordance with §412.316(d) of this title (relating to Competency and Credentialing)) in psychology, social work, medicine, nursing, rehabilitation, counseling, sociology, human growth and development, physician assistant, gerontology, special education, educational psychology, early childhood education, or early childhood intervention; or
- (B) is a registered nurse.

Quality Management

A program developed and implemented by the LMHA by which organizational performance and services are assessed and evaluated to ensure the existence of those structures and processes necessary for the achievement of consumer outcomes and continuous quality improvement.

Quick Inventory of Depressive Symptomatology (QIDS) Self-Report (QIDS-SR) Clinician (QIDS-C)

A brief 16-item scale measuring depressive symptomatology. Items represent a subset of the items from the Inventory of Depressive Symptomatology and are useful in assessing change in depression symptoms over time. Both self-report and clinician-completed forms are available.

R

Reasonable, Documented Effort

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See “Good Faith Effort”.

Recovery

Refers to the process by which a person becomes able or regains the ability to live, work, learn, and participate fully in his or her community.

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Rehabilitative Case Management

Provision of a variable level of integrated support, including:

- A. Assistance in accessing medical, social, educational or other appropriate support services as well as linkage to more intensive services if needed, in addition to monitoring (monthly or weekly as needed), assessment of service needs, service planning and coordination, administration of TIMA scales and other TIMA medication management functions;
- B. A basic level of rehabilitative services addressing daily and independent living skills to persons on their case load;
- C. Supported housing;
- D. Patient & family education: includes education on diagnosis, medications monitoring and management of symptoms and side effects, and
- E. Co-Occurring Psychiatric and Substance use Disorder services.

Rehabilitative Counseling and Psychotherapy

Cognitive behavior therapy focused on the reduction or elimination of an individual's symptoms of severe and persistent mental illness and increasing the individual's ability to perform activities of daily living.

Rehabilitative Services

Individualized age-appropriate training and instructional guidance, that addresses functional deficits due to mental illness or emotional disturbance that is designed to improve or maintain the individual's ability to remain in the community as a fully integrated and functioning member of that community, and is one of the following types of rehabilitative services:

- A. Crisis intervention services;
- B. Medication training and support;
- C. Psychosocial rehabilitative services consisting of the following component services:
 - a. Independent living services;
 - b. Coordination services
 - c. Employment related services;
 - d. Housing related services; and
 - e. Medication related services;
- D. Rehabilitative counseling and psychotherapy;
- E. Skills training and development;
- F. Crisis intervention; and
- G. Day programs for acute needs.

Rehabilitative services are provided in a consumer-driven, integrated systemic delivery approach that meet the needs and choices of individuals with mental illness that gives equal priority to:

- A. Assisting and supporting the individual in managing the symptoms of his/her mental illness;
- B. Training the individual in the skills needed to cope with the

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demands of the individual's chosen environments;

C. Modifying characteristics of the environments when necessary;
and

D. Strengthening or developing social support networks.

Resilience

The personal and community qualities that enable people to rebound from adversity, trauma, tragedy, threat, or other stresses, and to go on with life with a sense of mastery, competence, and hope.

Review: Concurrent

A routine review by a utilization reviewer, during the course of an individual's treatment, to determine if continued treatment is medically necessary.

Review: Prospective

Pre-admission review for appropriateness of admission to service.

Review: Retrospective

Review following service provision to assess the appropriateness, necessity, quality, and reasonableness of health care services provided. Usually conducted on a case-by-case or aggregate basis.

Routine Case Management

Primarily site-based services that assist an adult, child or adolescent in gaining and coordinating access to necessary care and services appropriate to the individual's needs.

Rural ACT (Assertive Community Treatment)

See ACT - Rural

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Service Package (SP)

A standardized set of services that are available to an individual authorized to receive them. See *Level of Care*.

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Skills Training and Development Services

Training provided to an individual and the LAR or primary caregiver of a child or adolescent. Such training addresses severe and persistent mental illness or serious emotional disturbance and symptom-related problems that interfere with the individual's functioning and living, working, and learning environment; provides opportunities for the individual to acquire and improve skills needed to function as appropriately and independently as possible in the community; and facilitates the individual's community integration and increases his or her community tenure.

Supplemental Nursing Services

Services provided by a licensed nurse or other properly qualified and trained person working under the supervision and delegation of a physician or registered nurse (RN) as provided by state law to ensure the direct application of a psychoactive medication to the individual body by any means (including handing the client a single dose of medication to be taken orally) and to assess target symptoms, side effects and adverse effects, potential toxicity and the impact of psychoactive medication for the client and family in accordance with the client's treatment plan. This service includes such activities as monitoring an individual's vital signs during a home visit, refilling pill packs, monitoring self administration of medications, pill pack counts and evaluating the severity of side effects during a home visit. This service does NOT include physician's services, nursing services incidental to a physician services, case management or rehabilitative services.

Supported Employment Services (SE)

Individualized assistance in choosing and obtaining employment, at integrated work sites in regular community jobs, and long-term supports provided by staff members who assist individuals in keeping employment and/or finding another job as necessary. These services are for individuals who have significant functional impairments or increased symptoms but who have stabilized to the point where they are able to fully participate and benefit from intensive specialized vocational services.

Supported Housing Services (SH)

Supports and services to assist individuals to live in ordinary living arrangements typical of what is available to the general population. Integrated supported housing is achieved when individuals with serious mental illnesses choose ordinary, typical housing units that are located among units for individuals who do not have mental illness. Housing without supports or services is not supported housing.

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Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI)

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A 29-member collaborative council that addresses the needs of juvenile and adult offenders with mental illness, mental retardation or developmental disabilities. TCOOMMI may contract with LMHAs to provide services. TCOOMMI ensures that individuals in the criminal justice system receive necessary medical and Mental Health services.

Texas Implementation of Medication Algorithm Scales (TIMA)

An evidence-based process for providing psychiatric care to adults with severe and persistent mental illnesses, consisting of consensus-derived guidelines for medication treatment, training and support for physicians, standardized documentation, and patient and family education.

Texas Recommended Assessment Guidelines (TRAG)

A clinical assessment instrument designed to quantifiably assess dimensions of mental health needs and assist clinicians in making decisions about appropriate levels of care within the DSHS Resiliency and Disease Management service delivery model.

Texas Youth Commission (TYC)

Provides for the care, custody, rehabilitation, and reestablishment in society of Texas' most chronically delinquent or serious juvenile offenders. Texas judges commit these youth to TYC for mostly felony-level offenses committed if they are at least age 10 and less than age 17 at the time of the arrest. TYC can maintain jurisdiction over these offenders until their 21st birthdays.

Transportation Benefit

Compensation to individuals or services to transport clients from their home to a clinic.

Travel (Service)

A provider traveling to an individual to perform a service.

U

Uniform Assessment (UA)

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An assessment tool developed by the department that includes, but not limited to, the Adult Texas Recommended Assessment Guidelines (TRAG), the Texas Implementation of Medication Algorithms (TIMA) Scales for Adults, and the Children and Adolescent Texas Recommended Assessment Guidelines.

Urban ACT (Assertive Community Treatment)

See ACT – Urban.

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Utilization

Extent to which enrollees of a managed health care plan use health care services.

Utilization rates are established to help in comprehensive health planning, budget review, and cost containment. Utilization can be expressed in a variety of ways:

- A. Patterns or rates of use of a single service or type of service, e.g., hospital care, physician visits, and prescription drugs.
- B. The extent to which the members of a covered group use a program or obtain a particular service, or a category of procedures, over a given period of time. Usually expressed as the number of services used per year or per numbers of persons eligible for services.

Utilization Management (UM)

The planning, organizing, directing, and controlling of the healthcare product/service that balances cost-effectiveness, efficiency, and quality to meet the overall goals of the LMHA. Use of systematic data-driven processes to influence consumer care and decision making to ensure an optimum level of service is provided consistent with consumer diagnosis and level of functioning within the financial restraints of funding. Includes but is not limited to service authorization, concurrent review, retrospective review, discharge planning, and utilization care management.

Utilization Management Committee

LMHA standing committee that consists of LMHA UM physicians, utilization and quality management staff, financial staff, and others as indicated. Meets at least quarterly to evaluate and monitor service utilization patterns and trends and clinical practices, provide information for agency resource planning and allocation decisions, and ensure ongoing improvement in the utilization management process. Committee functions also include ensuring that resources are channeled to the services that are needed by individuals and that a balance between crisis and routine services is achieved.

Utilization Management Guidelines (UM Guidelines)

Evidence-based guidelines developed by the Department that establish the type, amount, and duration of mental health community services for each LOC. Descriptions of evidence-based clinical practices that are configured into Service Packages which describe the type, amount and duration of services for each level of care and also provide admission, continued stay and discharge criteria for all services and levels of care for the mental health service system. They are functionally integrated into treatment processes.

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Utilization Review

A formal review of consumer utilization of health care services to assess efficiency, and/or appropriateness of services and treatment plans on a prospective, concurrent or retrospective basis. Utilization review may be accomplished by a peer review group or a public agency. Utilization review (UR) is part of the utilization management process.

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WebCARE

WebCARE is the web-based front-end to the mainframe CARE System. The mainframe Client Assignment and Registration (CARE) System registers and tracks individuals served by Texas Health and Human Services Commission (HHSC) throughout the Mental Health and mental retardation service delivery system.

Wraparound Plan

A collaborative planning process that is family-focused and community-based. The planning process is family-driven and focuses on a strength-based approach to service/support plan development. The individualized plan contains strategies that are tailored to the strengths, needs, values, norms and preferences defined by the child and family. Traditional services, formal supports, and informal and natural supports are included in the plan. Services and supports are culturally competent. Wraparound planning is a commitment to unconditional care for the child and family regardless of difficult circumstances. Wraparound planning is intended to assist the child and family in the development of community supports that will allow the child to remain in or to return to the preferred living or day care environment.

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