Toward A National Standard For Service Intensity Assessment And Planning For Mental Health Care

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PURPOSE:

Recent judicial, public policy and legislative developments have underscored the need for a paradigm shift in the decision-making processes that determine what services and supports will be made available to individuals with behavioral health (BH) needs. While this shift will entail a variety of changes, the top two priorities are:

- These processes should be uniform and standardized so as to optimize equitability and minimize disparities across settings and populations.
- These processes should be transparent and interactive, employing a common and understandable language so as to enhance e□ective collaboration among the key stakeholders, beginning with the persons being served and their families.

The purpose of this white paper is fourfold: 1) to elucidate the background, concepts and best practices for service intensity assessment and planning within this context; 2) to describe the necessary and desirable characteristics of standardized processes to do so; 3) to describe the LOCUS family of tools (LOCUS FT) and the rationale for promulgating these tools as a uniform national standard for service intensity assessment and planning for mental health (MH) care, in conjunction with the American Society for Addiction Medicine (ASAM) Patient Placement Criteria for substance use care; and 4) to delineate next steps for widescale dissemination, training, implementation, evaluation and research on these processes.

Bo : Se ice In en i and Planning Tool de c ibed in hi hi e pape : The LOCUS FT (he h ee in he li) and ASAM C i e ia.

LOCUS: Le el of Ca e U ili a ion S em; de eloped b he Ame ican A ocia ion fo Comm ni P chia (AACP) in he 1990' fo ad l i h BH need .

CALOCUS-CASII: Child and Adole cen Le el of Ca e/Se ice In en i U ili a ion S em; co-de eloped b AACP and he Ame ican Academ of Child and Adole cen P chia (AACAP) fo ho e age 5-18 i h BH need .

ECSII: Ea l Childhood Se ice In en i In men ; de eloped b AACAP in 2009 fo child en age < 5 i h BH need .

ASAM Criteria: De eloped b ASAM in he 1990 fo ad l i h b ance e di o de (SUD).

DEFINING SERVICE INTENSIT ASSESSMENT AND PLANNING:

Service intensity assessment and planning is the process of determining the "correct" amount and types of services and supports that best address an individual's needs at a given point in time. Components of service intensity include, but are not limited to: the setting in which care is delivered (e.g., residential vs. community), the intensity and type of sta□ng (e.g., medical vs non-medical),

H NO ? RECENT JUDICIAL, PUBLIC POLIC AND LEGISLATIVE DEVELOPMENTS USHERING IN A PARADIGM SHIFT

B *B* court decision in 2019, detailed in this report and elsewhere (Appelbaum, 2019; National Council, 2020), directly addressed the potential bias in having service intensity and planning processes developed by entities who stand to benefit financially by having more restrictive criteria for the most expensive services. But who should develop such criteria and what principles should those criteria be based on? The court suggested that these criteria should be drawn from those developed by the relevant professional organizations when available, pointing specifically to the LOCUS FT and the ASAM Criteria as exemplars. The court further articulated a set of eight principles referred to as "Generally Accepted Standards of Care" (see box 2) which should characterize service intensity and planning processes going forward. If these principles were faithfully applied on a large scale, it would reflect the most significant paradigm shift in BH care planning and financing since the rise of managed care in the late 1980s.

Since 2019, several states and other large public entities have enacted policies that require payers of BH services that they oversee to mold their service intensity and planning processes so as to be consistent with the principles delineated in Wit (New York State O ce of Mental Health, 2019). Most significantly, the state of California enacted legislation that requires all commercial payers of BH services to use the LOCUS FT and ASAM Criteria for MH and substance use service determinations respectively (California Insurance Commissioner, 2020). Several other states are in various stages of developing or enacting similar legislative mandates. It is essential to immediately adopt standardized service intensity and planning processes to address long-standing racial and ethnic disparities in mental health care and limit the impact of bias on decisions surrounding health care utilization.

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HAT OULD INTENSIT PLANNING CONSISTENT ITH THE GENERALL ACCEPTED STANDARDS OF CARE PRINCIPLES LOOK LIKE?

Applying the principles delineated in Wit (see box 2 above) as intended requires a very di□erent approach to BH care planning and financing. Rather than a series of discrete dichotomous decisions about whether someone currently meets a particular payer's

IMPLEMENTATION AND TRAINING

For the LOCUS FT to be used e□ectively and e□ciently, both payers and providers need to systematically implement and apply them. Governmental agencies should implement the LOCUS FT throughout their region of responsibility to ensure uniformity and objectivity of benefits and to facilitate communication between all elements of the system. Insurance organizations should implement the LOCUS FT because their simplicity and clarity will facilitate utilization reviews and monitoring of treatment plans and better address the underlying conditions as opposed to just the acute crisis. Since the LOCUS FT were developed by clinical specialty organizations and published evidence of clinical validity, they provide a transparent alternative to proprietary criteria for payers to make service intensity decisions as part of utilization management while minimizing the risk of prioritizing financial considerations over fiduciary duties to meet patient care needs. Provider organizations should implement the LOCUS FT because they increase the e□ciency and consistency of clinical interactions and/or to facilitate the incorporation of patient-centered and recovery-oriented care. Comprehensive training is essential to ensure demonstrable fidelity to the tool and to meet regulatory questions about consistent use of the tool. Training should be obtained from approved sources as certified by AACP and/or AACAP. Implementation should include establishing continuous quality improvement processes focusing on interrater reliability, the use of readings for treatment and transition planning, the availability of the full continuum of recommended services and the longitudinal monitoring of outcomes and service utilization at each level of care.

CONCLUSION: The need for standardized clinically driven service intensity assessment in the MH field is long overdue. A confluence of recent events has created urgency for a widely recognized and accepted standard of practice to do so. The LOCUS FT is well positioned to become the national standard for service intensity assessment across the age range for the MH field, along with ASAM Criteria for addiction treatment to serve that role. Opportunities exist to expand the appropriate utilization of these clinical decision support processes by creating broad strategies for implementation across providers, payers and state systems, along with continued research, evaluation and quality improvement.

Recent judicial, public policy and legislative developments have underscored the need for a paradigm shift in the decision-making processes that determine what services and supports will be made available to individuals with behavioral health (BH) needs. While this shift will entail a variety of changes, the top two priorities are:

services and supports that would help people thrive over the long term rather than limiting the focus to acute symptomatology (principles 1 and 5). It should be fundamentally person-centered and individualized, avoiding a one-size-fits-all approach (principle 6). And while the overall process would ideally be common across the full range of ages, it should be sensitive to the reality that the types of services and supports needed for children are often quite di□erent than those for adults (principle 7). Overall, for a specific clinical presentation service, an intensity assessment provides guidance about the intensity of a range of clinical and

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This section discusses how the concepts of needs assessments, medical necessity and UM are all components of best practices in service intensity assessment and planning.

A. GOALS OF MULTIDIMENSIONAL ASSESSMENT

To be e□cient, e□ective and fair, multidimensional assessment should achieve the following goals, starting with a focus on a common language for persons served and service providers:

- Allowing individualized, person-centered service planning and monitoring of progress in treatment.
- Using standards that are broadly acceptable and uniformly applied.
- Not requiring significant additional time or expense.
- Allowing integrated management by service providers.
- Informed by evidence or outcomes.
- Operating with a full array or continuum of services.
- Maintaining a balance between quality and cost concerns.

T ea men Planning: These tools help identify an individual's strengths and needs, and the assessment profile helps support the creation of an individualized service plan within the array of services and supports aveo1,abe ha2 (t the)eaeomene pinvoensity

and informal supports including peer supports and other natural supports in the community supports such as faith-based organizations, etc.

F e enc and Leng h of Con ac : Daily for multiple hours to quarterly single sessions.

These elements of service intensity, while conceptually independent, are combined in specific service "packages" or programs in any community, ranging from inpatient hospitalization, various types and levels of residential treatment, partial hospitalization, various types and levels of intensive community based services (including home-based) and various types and levels of routine ambulatory services, each of which may include various types and LOCs coordination or case management to address multiple types of services or agencies addressing a variety of human service needs.

Applicabili : Service intensity assessment and planning can be utilized for individuals and families across the lifespan for persons served with mental and substance use disorders in addition to other complex health and social service needs. Service intensity assessment and planning are also relevant for individuals with intellectual, developmental and physical disabilities. Cultural considerations and social determinants of health impact all of these considerations. A service intensity assessment tool may be used for initial service intensity (placement) recommendations or for determination of continuing care needs. The continuing process of assessing service intensity is based on dynamic understanding of the way service intensity needs fluctuate during the course of illness, so the assessment should be repeated with frequency of review varying with the LOC and whenever there is change in clinical status that a ects scoring. In general, ratings should be repeated most frequently during periods of greatest acuity and instability. If the service intensity score remains relatively high, the level of care and treatment package should be reevaluated. In addition to individual clinical applications, service intensity assessment tools can be used to characterize the range and capacity of services for a given population, for "acute care determinations" in crisis service settings and for "continuing care determinations" to monitor and plan service intensity needs for individuals and populations over time. The independence of

Severity Rating Scale for suicidality (commonly known as the C-SSRS) and the Clinical Institute Withdrawal Assessment Scale for measuring alcohol withdrawal severity. These scales contribute helpful information for both service recipients and service providers for determining which best practice interventions to use, at what “dosage” and at what level of urgency. They also allow for the objective measure of improvement in syndromic severity.

Comp ehen i e Need and F nc ional A e men : Individuals of all ages with BH conditions commonly experience needs and challenges from functional impairments in multiple life domains. These needs and functional impairments must be identified in the process of assessment in addition to diagnoses and symptoms and addressed appropriately in the context of service planning. The needs identified arise from a combination of the individual’s functional impairments and factors in their social environment (including Social Determinants of Health). Frequently (though not universally) used tools that provide a common language to identify and quantify service needs and functional impairments include the Child and Adolescent Needs and Strengths, Adult Needs and Strengths, Child and Adolescent Functional Assessment Scale (CAFAS), Multnomah Community Assessment Scale (ref 24), Daily Living Activities-20 (DLA-20) and others. These tools assess functional impairments and factors that can support individuals or make functioning more di cult for them but do not independently define or predict the service intensity needed for maximizing an individual’s successful community tenure. Tools that bridge those areas have the benefit of helping both providers and the person served access a range of services that will support their needs.

D. CREATING A COMMON LANGUAGE FOR SERVICE INTENSIT ASSESSMENT FOR ALL STAKEHOLDERS

Structured service intensity assessment tools are vital components of standardizing the assessment process that create a common and transparent language for use by individuals and families receiving services, providers, payers and population health managers. The current tremendous variability among payers, providers and service recipients in how service intensity determinations are made creates confusion and dispute, while potentially impacting inequities in service delivery and access. A shared framework from a family of tools for service intensity assessment and planning allow uniform clinical, fiscal and regulatory functions to be accomplished in a person- and family-centered manner. This is particularly beneficial for individuals and families with complex needs. A common language across the lifespan helps bridge discontinuities of care that can occur at times of transition, such as from the child and adolescent system of care to the adult system of care. For children and adolescents, it also facilitates treatment planning and the coordination and continuity of care among involved child serving agencies (e.g., child welfare, MH, education, juvenile justice, etc.).

The needs of major stakeholders are better served in the following ways: •RecipieC B •Pw service (omplext (em o)7 (f.1 (ed nd 12 (e aiz allod func

The preceding sections focused on prioritizing service intensity assessment and planning as a clinical task. Systematic application of service intensity assessment tools can also allow providers to make decisions about both care and resource use to promote e□ciency because they eliminate costly redundancies and micromanagement. This section focuses on the relevance of service intensity assessment and planning to payers and population health managers and delineates the relationship of service intensity assessment as a clinical function to the concepts of resource management, medical necessity determination and UM.

Payers (e.g., Medicaid agencies, managed care organizations (MCOs), commercial insurance plans) and population health managers (e.g., Veterans Administration, state administrators, accountable care organizations) are regularly faced with the challenge of achieving high quality outcomes for persons served while having limited resources available for populations with complex needs. This requires payers and population health managers to be constantly engaged in seeking mechanisms for e□ective resource management, ensuring that people are neither underserved nor overserved with respect to the community standard of care. Payers and population health managers also must ensure that resources expended and insurance payments disbursed are clinically appropriate and consistent with professional standards and the generally accepted standard of care for the individuals or families served to meet their legal and contractual requirements. Service intensity assessment and planning and appropriately matching resources to objectively determined service intensity determinations (which generally impact service cost) are essential elements of e□ective resource management.

The LOCUS FT o□er a common language and opportunities for provider/payer alignment in pursuing goals with the Quadruple Aim to enhance patient experience, improve population health, control costs and improve the work life of health care providers, including clinicians and sta□. "Patient experience" may be improved by more consistently and objectively matching services to needs. Access and population health may be improved by using LOCUS FT to understand where additional service levels need to be developed for a given community. Costs may be reduced by controlling inappropriate overutilization and underutilization. Health care providers' work-life may be improved by facilitating more transparent discussions about service intensity planning, thereby reducing friction and conflict with payers.

MEDICAL NECESSIT CRITERIA AND SERVICE INTENSIT PLANNING

For a person to be eligible for third party payment for a given service, standards of medical necessity must be met. These standards are either set by law or contract, but in practice are determined first by the provider of record and then potentially by a third-party reviewer for final authorization or a decision of an appeal for services that were not authorized.

For example, the U.S. government defines "medical necessity" as "Health care services or supplies needed to diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine." https://www.healthcare.gov/glossary/medically-necessary/

The American Medical Association (AMA) and American Psychiatric Association (APA) both define medically necessary services as follows:

> Health care services or products that a prudent physician would provide to a patient for the purpose of preventing, diagnosing or treating an illness, injury, disease or its symptoms in a manner that is:
>
> (a) in accordance with generally accepted standards of medical practice.
>
> (b) clinically appropriate in terms of type, frequency, extent, site and duration.

(c)

UTILI ATION MANAGEMENT AND SERVICE INTENSIT PLANNING

UM is related to both medical necessity and service intensity assessment, but also is distinct.

Commonly, however, UM is understood and defined by its role in helping payers manage health care costs (See textbox). While this is only a subset of the intended purpose of UM, it takes on enormous weight in determining which services will be paid for. Service intensity assessment is an important component of UM. Payers and population health managers utilize UM for both individual persons/families served – as well as for populations – as a methodology for constantly assessing whether "service intensity planning" matches severity of illness. This constant review process allows for continuing scrutiny to ensure that individuals and populations are not overserved or, ideally, underserved. UM relies on structured tools to determine whether the services provided are "medically necessary" in relationship to both matching interventions to diagnoses and needs, as well as ensuring that service intensity is neither too much, or theoretically too little.

In BH services, UM is usually operationalized by payers to emphasize processes to control overutilization of more expensive services (Bailit, 2002; Wickizer, 2002). UM may be done prospectively, retrospectively or concurrently. BH (2; W)1(2 (t, but a a/0(tly)58 (. BH (2; W)13 nec/(pr)12 (ly)58 (. BH (2; W)13 nec/(plW)13 nec/(

individuals with complex and multi-dimensional BH conditions that must influence accurate service intensity determination for ongoing treatment through a continuum of services over time. These complex conditions require more intensive services for longer periods of time for e□ective treatment that ameliorates disability and dysfunction and promotes a high quality of life.

This demonstrates the need for tools that can avoid both underutilization and overutilization of a level of service and supports

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The LOCUS FT was designed consistent with the principles and goals of service intensity planning described previously in this report.

The LOCUS FT ha e fo main objec i e :

Provide a system for assessment of service needs based on six evaluation parameters.

Describe a continuum of service intensity levels, characterized by the amount and scope of resources available at each LOC, in each of four categories of service.

Create a methodology for quantifying and objectifying the assessment of service needs to permit reliable determinations for placement in the service continuum and to mitigate the e□ects of bias in decision-making.

Facilitate clinical management and documentation.

Each of the LOCUS FT has six dimensions of assessment with specific scoring anchors for each dimension that generate a recommendation for a service intensity, or LOC, for individuals with mental illness, including those with co-occurring medical, developmental or substance use conditions. The six service intensity levels range from recovery management or basic services to medically managed intensive services, which is conceptually equivalent to hospitalization but can be provided in other settings. Each service intensity level supports care planning in four service areas: clinical, support, crisis stabilization and prevention and the care environment. The LOCUS FT are instruments designed to be recovery oriented by including consideration of recovery environment, history and engagement.

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THE DIMENSIONAL ASSESSMENT

The dimensional assessment systems used by LOCUS FT determine the most appropriate level of service intensity for a client's needs. They accomplish this by requiring the selection of a numeric rating in each of six dimensions. The dimensional framework operationalizes most of the factors experienced clinicians would normally consider in making decisions about required service intensity and assures that those factors are considered consistently and in an unbiased manner.

In the dimensional assessment, there are six evaluation dimensions:

- **Ri k of Ha m:** This rating reflects the degree to which a person is at risk for harming themselves or others. This risk may be due to suicidal or homicidal ideations or to impaired judgment or impulse control resulting from intoxication or otherwise altered mental states. Criteria for this rating include factors such as suicidal or homicidal thoughts, intentions, ambivalence, history of attempts, impulsivity and availability of means. Criteria are also included that indicate the degree to which one's ability to keep themselves safe is impaired.
- **F nc ional S a :** This rating measures a person's level of function relative to their baseline functional status. The criteria consider the ability to interact with others, to maintain hygiene and activities of daily living and to fulfill role responsibilities and physical functions, such as sleep and weight fluctuations.
- **Medical, Addic i e and P chia ic Co-mo bidi :** This rating measures potential complications to the course of the presenting or most prominent condition due the coexistence of additional disorders, such as SUDs and IDDs. The criteria specify the degree to which the presence of additional disorders prolong the course, increase the severity of or impede the ability to recover from the presenting condition. Withdrawal syndromes are considered as medical comorbidity in this context.
- **Reco e En i onmen :** This dimension assesses social determinants of health using two subscales – level of stress and level of support. Criteria for ratings on the stress scale include interpersonal conflicts or harassment, life transitions, interpersonal or material losses, environmental threats and perceived pressures to perform. On the support scale, criteria delineate the degree to which support is available from family, friends and professional sources and the likelihood that these supports will be able to participate in care.
- **T ea men and Reco e Hi o :** This scale considers past experience and response to treatment and the durability of any recovery achieved. Criteria for this rating include the intensity of treatment experienced, the degree of success and the extent and durations of recovery periods. Recent experiences and responses are weighed more heavily than more remote episodes.
- **Engagemen and Reco e S a :**

In the CALOCUS-CASII there are two subscales in Dimension 6, one for the child and one for the caregiver, to recognize that active engagement in services is important for both the child and the caregiver. Only the scale with the highest numeric rating is

IMPLEMENTATION TASKS FOR PA ERS AND PROVIDERS

The following principles can guide the process put in place to implement use of these instruments. First, the LOCUS FT three components (the LOCUS FT standardized assessment of needs and risks, standardized levels of service intensity and standardized crosswalk that matches individual needs to service intensity) cannot be separated or independently implemented. Second, although implementation may proceed in a piecemeal fashion in some cases, the vision of systemwide usage should be kept in mind. Organizational leaders should have these fundamental principles in mind before attempting to introduce these tools:

applying LOCUS FT guidelines to individual cases. Training may be developed locally and tailored to the specific circumstances encountered there. Concepts underlying the establishment of these tools must be presented as well as the conventions of scoring. Training may take a variety of forms, including live in-person training, live online training, asynchronous web-based training and sessions combining aspects of each of these. Advanced training programs should be developed to create a cadre of "experts" or "super users" to provide supervision and additional support.

Quality Monitoring and Improvement are Essential

The final part of the plan will be putting in place a method to monitor use and develop a process to improve the quality and scope of LOCUS FT use. Continuous quality improvement (CQI) initiatives may address a variety of process indicators, such as:

- Time to complete ratings.
- Use of ratings for treatment and transition planning.
- Inter-rater reliability.
- Raters' knowledge of services associated with each LOC.
- Availability of recommended services.
- Longitudinal monitoring of outcomes and service utilization.

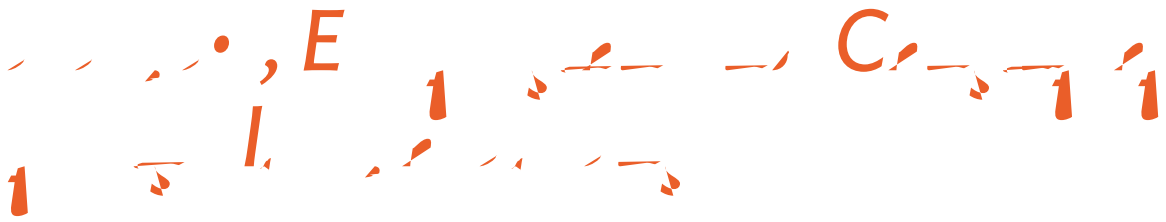
Recording of successive ratings over the long term will provide a record of the coursuy, sucuj/Span#A0 578.AQTm[(seStu)48alln0 (ariety5 (oring

IMPLEMENTATION CONSIDERATIONS FOR LARGER S STEMS AND MANAGED CARE ORGANI ATIONS

Although traditional utilization review processes are recommended during the early phases of implementation, the goal should be to gradually shift responsibility for service intensity decisions to the provider. MCOs can validate that providers understand and use LOCUS FT correctly before delegating full responsibility for level of care decisions by implementing a system of certification related to reaching a threshold of "accurate" ratings (i.e., 95%), or using a similar threshold for individual clinicians or an entire provider organization. Once providers are certified, periodic audits would be required to ensure inter-rater reliability arises. When ongoing di erences arise regarding the correct LOCUS FT scoring between users and di erent organizations, a joint committee should be formed to improve inter-rater reliability and resolve di erences in individual cases.

Data Collection

Aggregate utilization data should inform programming and payment policies. The use of the "LOCUS Data Set" (Sowers, 2003) will allow MCOs to access information about their own provider network and their regional, national and global utilization. This data analysis will allow them to identify both underutilization and overutilization for individuals and populations. Unnecessary expenses are generated when clients are assigned LOCs that are more intensive than LOCUS FT recommendations due to lack of available services at the recommended level. Often service gaps exist when there are financial disadvantages for providers to fill them. Creating adequate reimbursement revenue streams will encourage providers to develop services that fill out the continuum



CURRENT RESEARCH

Early in their development, both LOCUS and CALOCUS/CASII were tested for reliability and validity. In a study published in 1999, LOCUS-familiar raters with various backgrounds and exposure to training scored 10 case vignettes. The study found close agreement between the three placement methods (grid, decision tree and computer-assisted). Intraclass correlation coe□cients were calculated and showed good (> 0.4) reliability with regard to dimensional ratings and level of care recommendations, with all scores above 0.5. Validity was measured by comparing Re, with

intensity assessment and planning: refinement of the tools and the training that supports their reliable use, impact of the use of

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