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## Delaware (Group One: State-Developed Guidelines)

- Clinical Services Management Criteria
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### Overview

The Division of Child Mental Health Services (DCMHS) within the Delaware Department of Services for Children, Youth and Their Families operates as a JCAHO-accredited managed behavioral health care organization providing services through a statewide network of public and private providers. Clinical Services Management Teams, currently seven located throughout the state, manage the care of each child in the system by working directly with children and families to plan, authorize, monitor and coordinate care. The Division created its own clinical care guidelines for every level of care in its system, including both mental health and adolescent substance abuse treatment services. The guidelines are used by Clinical Services Management Team Leaders, who are licensed mental health professionals, and their care managers to determine appropriate levels of care. They also are used as referral guidelines for providers in the system. The guidelines are used qualitatively, rather than to create a quantitative score linked to service level.

Delaware's public mental health system is a partnership between commercial managed care organizations (MCOs) under contract to the State Medicaid agency and the Division of Children's Mental Health Services. The MCOs manage physical health care and a basic behavioral health benefit, which is defined as the equivalent of 30 hours of mental health and/or substance abuse outpatient services or its equivalent, renewable annually. The Division's clinical care guidelines apply only to children served by the Division, who essentially are Medicaid-eligible children who need more than 30 hours of outpatient services, as well as children who are without insurance.

### Goals

The Delaware Clinical Services Management Criteria are described by State-level stakeholders as "reasonably broad" by intent, to allow their clinicians a degree of latitude. Exceptions are the criteria for hospitalization, which are fairly strict, and the criteria for partial hospitalization/day treatment, which make clear the Division's policy not to provide these services as an alternative to a public education program. There is some intentional overlap among the criteria for different levels of care, again by intent to create latitude for Clinical Team Leaders. The Division intentionally has made the guidelines very public, uses them as talking points with providers and families, and keeps them published on the Division website.<sup>23</sup> State-level stakeholders indicated that a primary goal of the guidelines is to create equity and fairness in the system by establishing uniform criteria for use statewide.

### Background

DCMHS has used clinical care guidelines for nearly 15 years in its system but established a more rigorous, formalized set of guidelines with the advent of managed care in 1996. When DCMHS first established guidelines, most of the existing examples came from the commercial sector, which covered only brief hospitalization and outpatient services, and state-level

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<sup>23</sup> Delaware's clinical care guidelines can be found at: <http://www.state.de.us/kids/default.shtml> <<http://www.state.de.us/kids/default.shtml>> .

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stakeholders reportedly rejected these as not reflective of their broader array of services or public sector mission. DCMHS stakeholders also reported that they have looked at numerous proprietary instruments over the years, such as the CALOCUS (now CASII), but ultimately decided to develop and stay with their own guidelines to best reflect their array of services and their system. Their current set of guidelines is based loosely on American Psychiatric Association (APA) and National Institute on Drug Abuse guidelines, the latter of which were based loosely on those of the American Society of Addiction Medicine (ASAM). The guidelines also are based on input from Clinical Team Leaders' experience and a general review of the literature.

As the Division has developed new services within its system of care, it also has had to develop new guidelines. In addition, State-level stakeholders indicated that they maintain an ongoing dialogue with their provider network, which operates as an “early warning system” to bring to the Division’s attention problems with the guidelines.

## Description

Clinical care criteria for mental health and substance abuse services have been established for the following levels of care:

- Crisis Intervention Services
- Outpatient Services
- Clinical Care Management
- Intensive Outpatient Service (home-based)
- Aide Service (Wraparound)
- Evening After-School Program
- Day Treatment
- Partial/Day Hospital
- Individual Residential Treatment (e.g., family treatment home)
- Residential Treatment Center (facility-based)
- Psychiatric Hospital

Each set of criteria includes a brief definition of the service and a list of “primary and other” considerations to guide determination of the appropriateness of the service. For example, self harm is one primary consideration in the case of hospitalization, and an example of “other considerations” in the case of hospitalization is “intellectual limitations, such as mental retardation, which are a primary factor in the client’s behavioral problems (that) render the youth incapable of benefiting from interventions offered.”<sup>24</sup>

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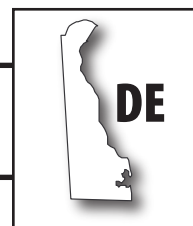
<sup>24</sup> State of Delaware, Department of Services for Children, Youth and Their Families Division of Child Mental Health Services (March 2004). Mental health criteria for hospitalization. Available [www.state.de.us/kids/pdfs/cmh\\_crit\\_mh\\_2003.pdf](http://www.state.de.us/kids/pdfs/cmh_crit_mh_2003.pdf) <[http://www.state.de.us/kids/pdfs/cmh\\_crit\\_mh\\_2003.pdf](http://www.state.de.us/kids/pdfs/cmh_crit_mh_2003.pdf)>.

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State-level stakeholders indicated that the criteria are intended to screen children into appropriate services, not keep them out. State-level stakeholders believe that the clinical guidelines help clinicians to do a risk analysis, to review more systematically what has and has not been tried, and to answer the basic question of how to reduce risk. The criteria are not based on a logarithm and do not specify discharge criteria; clinicians use their own judgment regarding absence of the problem that placed a child in a service to begin with, or stabilization, to determine discharge. However, the Division does use peer review monitoring for utilization management. In addition, the Division's management information system, utilized both by Clinical Teams and Division managers, tracks the levels of care in which children are enrolled and provides automatic reminders to care managers about due dates for clinical necessity reviews. Clinical Team leaders can make the decision to go outside of the guidelines (unless it involves a bed). Exceptions to guidelines may be reviewed by senior Division management. In addition, some exceptions end up being reviewed by the utilization review committee retrospectively. For example, at one point, the system experienced an over-use of outpatient combined with behavioral aides for the same children, which led to implementation of additional authorization steps for this combination of levels of care.

### **Individualized, Culturally Competent Family Focus**

DCMHS indicated that there is a formalized process for involving families in clinical decision-making, and that Clinical Team Leaders can implement a wraparound team approach with families. State-level stakeholders pointed out that one of the limitations to the guidelines is that they only cover services available in the network and that some services needed by culturally diverse children and families, for example, children with hearing impairments and Spanish-speaking families, are not available, rendering the guidelines less effective. They also noted limitations with respect to youth who are involved in Delaware's drug court. State-level stakeholders believe that most of the challenges in serving these youth have to do with creating a "drug recovery environment" within the drug culture in which many of these youth live. The clinical care guidelines do not address recovery issues.

DCMHS stakeholders believe that their guidelines do support an individualized approach to care with families because they do not have specific time limits or discharge criteria, and there is no benefit limit. Also, they reported that Team Leaders develop, in effect, strategic plans with families regarding service delivery and that these plans are unique to each child and family.

### **Impact of Service Availability**

As noted above, the clinical guidelines are pegged to available services, that is, to services that the Division provides within its network. Even so, clinicians still identify the need for services that are not available because of capacity limits, or because the service is not available within a certain geographic area, or is not within the Division's network (for example, some services for youth with co-occurring emotional and developmental disorders.) The Division uses a consulting child and adolescent psychiatrist to consult on both program and case-specific needs, which is one resource that Clinical Team Leaders can utilize when a needed service is not available.

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The Division's MIS system actually has a "services gaps" indicator so that the Division can track gaps systematically. The Division uses this MIS data, as well as periodic surveys of Clinical Teams, to identify and try to address gaps. Recently, for example, gaps were addressed with respect to treatment services for youth with sexual offenses.

Among the new services that the state has developed in response to identified gaps are: Individual Residential Treatment (i.e., family treatment homes) as a step down based on an analysis showing that children were remaining too long in facility-based residential treatment; Intensive Outpatient Services (i.e., home-based) for children with mild-moderate mental retardation/developmental delays based on an analysis indicating that these children do not fare well in traditional, office-based settings; and, Intensive Outpatient Services (i.e., home-based) based on an analysis that too many children were being admitted to residential treatment who could be served in the community if in-home services were available.

## **Training, Fidelity and Oversight**

The Division trained Clinical Team Leaders and has conducted training for providers on the clinical guidelines. It relies on Team Leaders (i.e. clinical supervisors) to conduct ongoing training of their care managers. State-level stakeholders indicate that the criteria are very basic to their system and are very much integrated into system operations at this stage. Thus, there is no ongoing, formalized training on the guidelines at this point. However, new Clinical Team Leaders serve an apprenticeship six-month period, in which they are learning the entire system, including the clinical care guidelines.

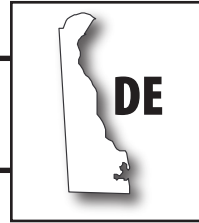
The Division does not have a formal process to monitor the use of the guidelines or their impact. As noted earlier, they rely on provider input, formalized through a quarterly providers' forum, and regular input from Clinical Management teams. In addition, they track impact on access (primarily to outpatient), family satisfaction, appeals and grievances, and cost -- data that they feel gives them some indication of the impact of the guidelines. State-level stakeholders noted that the system has few appeals that go beyond a level-one stage and that consumer satisfaction surveys indicate that 80% of families (out of 2,000 served) are satisfied, particularly with services provided by clinical care managers. Stakeholders also pointed out that their clinical care managers carry caseloads of 1:28-30 compared to the much smaller caseloads in some systems of care (1:10) serving children with intensive needs, yet satisfaction levels with their care managers is high.

State-level stakeholders indicated that they formally review and revise the clinical care guidelines every three years. They review the literature and try to bring a knowledge base into Delaware on an ongoing basis through, for example, quarterly workshops for clinicians. They noted that, to date, the guidelines for mental health and substance abuse have been parallel, but they are re-visiting their assumptions based on their experience with youth involved in drug court and in light of more research in recent years on adolescent substance abuse treatment and recovery issues.

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## Experience To Date

State-level stakeholders indicated that they did not experience a great deal of resistance to the clinical care guidelines by providers. However, they did describe some resistance on the part of child welfare and juvenile justice stakeholders, who view the criteria as a mechanism to reduce access, particularly to beds. DCMHS stakeholders noted that their data show that they are not rejecting youth involved in child welfare and juvenile justice if they are referred for service, and they believe part of the problem is that these systems are not screening and referring youth for behavioral health services. DCMHS feels that the behavioral health system actually has a fairly low threshold for admitting youth, and that they should be getting more referrals from child welfare and juvenile justice. DCMHS argues that the major issue is a lack of a systemic approach and shared responsibility for screening and referring these children and adolescents. DCMHS also points to use of the guidelines as one key reason why they have few instances of judges ordering youth into particular levels of care.

## Major Benefits, Concerns and Lessons Learned

State-level stakeholders believe that the major benefit to using clinical care guidelines is that they support rational decision-making and greater equity in the system. In the past, DCMHS was open to criticism that, when dollars were short, treatment decisions were made based on available dollars. They believe that the guidelines make it more difficult to levy that criticism. State-level stakeholders also pointed out that the guidelines serve to satisfy State Medicaid agency requirements that services provided by DCMHS, which is acting as a managed care entity, are clinically necessary.

DCMHS stakeholders believe that a benefit to these particular guidelines is that they are broad, thereby allowing their Clinical Team Leaders some latitude in decision-making. By the same token, they pointed out that because the guidelines are broad, Team Leaders can make different decisions using the same criteria—a complaint sometimes voiced by providers. State-level stakeholders also pointed out that clinical decision-making is affected as well by availability of services and by Team Leaders' knowledge about which providers are providing quality care.

DCMHS stakeholders indicated that they are still wrestling with what the clinical care criteria ought to be. They struggle, for example, with what the criteria ought to be for youth involved in the foster care system who remain in residential treatment because of lack of a placement in foster care, or what the criteria ought to be for residential treatment in general in light of data questioning its effectiveness. In the substance abuse arena, they struggle over what the criteria should be for youth who are using substances and refusing to show up for treatment; for example, they pose the question as to whether a youth using marijuana, who erratically attends community services, should be considered a “failure” and in need of a more restrictive level of care.

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DCMHS stakeholders offered several “lessons learned” to other states who are interested in implementing clinical care guidelines, which include:

- Make the guidelines transparent and very public (unlike, for example, the clinical care guidelines used in the private managed care world, which are proprietary, shared only with an MCO’s network of providers and care authorizers and not with families and other system stakeholders)
- Maintain very open channels of communication with providers whose experience and knowledge base is important to incorporate into the guidelines
- Be clear what the system is and is not—for example, in the case of Delaware, DCMHS believes it is important to emphasize that they are a mental health and substance abuse treatment system, not, for example, a mental retardation system.<sup>25</sup>

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<sup>25</sup> DCMHS stakeholders noted that they do struggle with children and adolescents who have co-occurring disorders of mental retardation and behavioral health disorders as there is no one system designated to serve this population.