

## BEHAVIORAL HEALTH/DEVELOPMENTAL DISABILITIES SERVICES

### I. INTRODUCTION

This chapter addresses mental illnesses, alcoholism and substance abuse, and developmental disabilities in children and adults. The social and health problems associated with these conditions are of such magnitude that behavioral health ranks as one of the state's priority health issues. Behavioral health services in the state are provided either directly or indirectly by the Office of Behavioral Health Services, regional comprehensive community mental health - mental retardation/developmental disabilities centers and licensed private non-profit and for profit entities. Unless otherwise specified, information contained in this chapter is limited to programs, facilities and services of these entities.

Certain providers in the private sector are exempt from certificate of need review pursuant to W. Va. Code §16-2D-4(a) and are not required to submit data to the HCCRA under the provisions of W. Va. Code §16-5F regarding the amount and type of services they offer. These circumstances limit the determination of the impact that the private sector has in providing behavioral health services.

Standards related to psychiatric inpatient hospitals and ICF/MR group homes are included elsewhere in the Certificate of Need Standards and are not addressed in this chapter. Chemical dependency residential treatment services standards are replaced with only minor modifications. Applications being processed at the time the moratorium was implemented on May 17, 1995, and those received since that time will be reviewed under these standards.

#### A. Intent of Standards

The specific intent of these Standards for Behavioral Health/Developmental Disabilities Services is to provide the Certificate of Need Division of the Health Care Cost Review Authority and CON applicants with guidelines to determine whether applications for new behavioral health facilities and/or services are consistent with that which has been determined to be in the mutual best interests of individuals in need of services, families, providers of services, and the citizens of the State.

## B. Basis for Standards

These standards are based on the following principles:

1. Approved services and settings should promote independence and maximal functioning. Services should promote adaptive skills and enhance the individual's ability to function. Treatment should be participatory and designed to promote/retain integration of these individuals in the community.
2. Care should be provided through a coordinated array of services (integrated continuum of care) which complements and does not duplicate services to accomplish effective and economical care.
3. These standards should encourage the adjustment of the existing array of services to focus less on restrictive, expensive inpatient and residential services and more on the less restrictive, home based and outpatient services. An underlying goal is to encourage a system that provides more effective and appropriate care and more accountability for the outcomes and costs incurred.
4. Services should be accessible to take advantage of community based services. Accessibility of services should accommodate integration into the community and limit disruption of normal living.
5. These standards should be interpreted to complement and coordinate with the programmatic and fiscal plans of appropriate state planning, regulatory and payor (grantor) agencies.
6. These standards should be consistent with the intent of the court orders and consent agreements which relate to services for behavioral health and developmentally disabled.
7. These standards address the conditions and services which state planning and payor agencies have identified as requiring priority attention.
8. These standards should result in project approvals only when a budget neutral position can be maintained by state payor agencies, if the state is projected to be the primary payor.
9. These standards will be reviewed at least annually to assure they are refined with the help of additional data and updated information. Market changes, resulting from the anticipated increase in managed-care arrangements and federal funding changes in Medicaid financing are matters to be studied and the standards adjusted appropriately.

## II. CERTIFICATE OF NEED APPLICATION PROCESS

### A. Determination of Reviewability

Any entity that is not exempt from CON review pursuant to W. Va. Code §16-2D-4(a) must obtain a certificate of need. It is recommended that organizations planning relocation of offices, service changes, acquisitions, and/or addition of any new services, request the HCCRA for a determination of reviewability prior to initiating any action. That request should be concluded with a notarized verification of the signature of the person authorized by the provider organization to sign in its behalf.

### B. Letter of Intent

The initial step in the Certificate of Need process is the submission to the HCCRA of a letter of intent. The letter should include:

1. Name and brief description of the entity applying for the certificate of need;
2. Brief description of the proposed project, including anticipated individuals to be served and services to be provided;
3. Listing of the counties to be included in the proposed service area;
4. Estimate of anticipated capital expenditure associated with the project; and,
5. Signature of individual authorized to sign for the organization.

### C. Application

The HCCRA reviews the letter of intent and determines the type of application which is appropriate. An application form and certain data and materials which should be helpful in its completion are sent to the applicant. The receipt by the HCCRA of a completed application and accompanying application filing fee initiates the CON application review process. For details on time frames, notices, hearings and appeal processes, refer to W. Va. Code §16-2D-1 et. seq. and 65 C.S.R. 7.

### D. Decisions

Decisions of the HCCRA are issued in the form of orders which outline the details of an application, the HCCRA analysis, findings and conclusions, the decision and opportunities for reconsideration and/or appeals. No decision will be issued to an entity which is not in full compliance with the Health Care Financial Disclosure Act (W. Va. Code §16-5F.)

E. Public notices

Actions of the HCCRA, including receipt of letters of intent, applications declared complete, decisions of the Board, scheduled hearings and time frames for hearing requests appear in the "Health Care Cost Review" newsletter published weekly by the HCCRA, in the State Register, and in the Charleston newspapers every Saturday.

III. CERTIFICATE OF NEED APPLICATION REVIEW PROCESS

A. Minimum criteria for review

W. Va. Code §16-2D-6 and 9 contain the statutory review criteria.

B. Recommendations from state regulatory, planning and payor agencies

One aspect of the analysis is a coordinated review by regulatory, planning and payor agencies of state government. The HCCRA takes into consideration in reviewing CON applications, the programmatic and fiscal plans of appropriate state agencies. Each agency is asked for a recommendation on each application. The recommendations are based on the respective agencies' programmatic and/or fiscal plan. The recommendations are sought for "comment only" purposes. The HCCRA has final approval on applications.

The agencies reviewing these standards include:

1. Office of Health Facilities Licensure and Certification (OHFLAC)

OHFLAC licenses and certifies for Medicare and Medicaid Program the participation of all health care agencies, including those providing services to behavioral health and development disabilities clientele. The recommendation made by OHFLAC on CON applications indicates, based on information contained in the application, whether an applicant appears qualified to be licensed and/or certified. For existing agencies, OHFLAC advises the HCCRA on licensure/certification deficiencies which should be taken into account in determining if the applicant should expand its service array or area. The CON review does not replace OHFLAC's responsibility to conduct on site licensure surveys on implemented projects after CON has been issued.

2. Office of Behavioral Health Services (OBHS)

OBHS is the state agency designated to plan and coordinate the delivery of all behavioral health (mental health, alcohol and substance abuse and developmental disabilities) services. Its responsibilities include:

- (a) State-level planning
- (b) Standard-setting and support for community programs
- (c) State liaison with behavioral health/developmentally disabled service agencies and, in particular, the comprehensive regional mental health and developmental disabilities centers
- (d) Operation of the state's mental health hospitals and developmental disabilities facilities

The recommendation made by OBHS on CON applications indicates the consistency of the application with the priorities and goals established by that agency for behavioral health/developmental disabilities services in the state.

3. Office of Social Services (OSS)

Social Services is the state agency responsible for planning and coordination of social services for children. Social services and Medicaid co-fund certain behavioral health related services for children.

The recommendations made by Social Services on CON applications indicate the consistency of the application with the priorities, plans and goals established for childrens' services in the state.

4. Bureau of Medical Services (Medicaid)

Medicaid is the state agency which is the primary payor for health services received by financially needy individuals. Most reimbursement received for the provision of behavioral health/developmental disabilities services in centers, facilities and agencies is paid by the Bureau of Medical Services through the Medicaid Program. Private practitioners, not subject to CON review, also receive Medicaid reimbursement for clinical services only. Other providers, i.e., hospitals, receive reimbursement from many payors in addition to Medicaid. The Office of Maternal and Child Health of the Department of Public Health reimburses agencies for "Early Intervention Program" services.

Recommendations made by the Bureau of Medical Services on CON applications indicate the consistency of an application with the programmatic and fiscal plan of the agency.

5. Court Monitor

The Court Monitor oversees compliance with various court orders and consent agreements in behavioral health and developmentally disabilities related cases. This recommendation is requested on CON applications in which the Court has an official interest.

The Court Monitor's recommendation states whether approval of a particular proposed project is consistent with provisions of the aforementioned court orders and consent agreements.

6. The Children's Regional Summits

The Summits are composed of parents and representatives from comprehensive behavioral health centers, child care agencies, psychiatric hospitals, local DHHR offices, county school districts, and juvenile probation offices. Applicants for CONs to provide services to children may wish to obtain recommendations from their respective summits to accompany their applications.

The opinions of other relevant agencies, such as the Office of Community and Rural Health, may also be requested by the HCCRA during its review of particular applications.

IV. INTRODUCTION TO NEED METHODOLOGY

All CON applicants must demonstrate with specificity: (1) there is an unmet need for the proposed behavioral health services; (2) the proposed services will not have a negative effect on the community by significantly limiting the availability and viability of other services or providers; and(3) the proposed services are the most cost effective alternative.

Five distinct groups comprise the recipients of behavioral health services:

1. Persons age 17 or younger with mental illness, emotional/behavioral problems and/or alcohol/substance abuse in need of behavioral health services.
2. Persons age 18 or older with mental illness and emotional/behavior problems in need of behavioral health services.
3. Persons age 18 or older who abuse alcohol/drugs and are in need of behavioral health services.

4. Persons age 65 or older with mental illness who are in need of behavioral health services.
5. Persons of any age with developmental disabilities who are in need of services.

Applicants must delineate their proposed service area by documenting the expected areas from which individuals will be drawn. The minimum service area will be a county. An entity formerly granted a CON for a county or group of counties will be required to obtain a new CON to expand services into a new county or counties.

Applicants must document expected utilization for the services to be provided for the population within the service area using the population based need methodology contained in these standards. When a population is known to have specific characteristics that affect utilization, these factors may be taken into consideration, and exceptions made.

After establishing expected utilization, applicants must document the existing providers within the service area and the extent to which the need is being met by existing providers in the service area. Providers located outside the service area and the services they provide are considered only if they constitute a major provider of services in the proposed service area.

A. NEED METHODOLOGY FOR CHILDREN AND ADOLESCENTS BEHAVIORAL HEALTH SERVICES (THE BALANCED SYSTEM OF CARE)

Precise data concerning the number of children and adolescents with mental health and addiction disorders is not available. To facilitate planning for these categories of behavioral health services, the West Virginia Office of Social Services and Office of Behavioral Health Services utilize the Balanced System of Care. It is modeled on systems designed in other states and has been modified by considerable local input. The system reflects the number of children needing specific services and the most appropriate setting for those services to be provided.

The Balanced System of Care uses an estimate of 12% of youth between the ages of 0 and 18 who will experience a mental health or addictions disorder. That estimate is consistent with research conducted in 1982 by Knitzer using 25 recognized studies on the prevalence of youth with such problems which showed a consensus of 12%. That percentage applied to the population of youth in this state shows 53,229 potentially needing services. While the total number of youth receiving services in WV in 1994 is not known, approximately 17,000 youth received publicly funded mental health and addiction services. There is an unknown degree of duplication in that figure.

The Balanced System of Care is designed to encourage downsizing (over a period of time) in the overdeveloped inpatient and residential facilities and to encourage

the development of additional foster care, home and school-based and outpatient services. The state's intent is to accomplish the transformation in a budget neutral manner. Additional desired services will be added to coincide with realized savings or with those which can be reasonably anticipated from the decline in both in and out-of-state inpatient and residential services.

For planning purposes, a proposed Balanced System of Care has been designed for all children in need of mental health/addictions services.

Chart A presents the quantitative need methodology used to project an ideal system of services for children with mental health and addiction disorders. It is anticipated that it would take a minimum of five years to shift the current system of services to more closely resemble the proposed Balanced System of Care.

Applicants will utilize 12% of the population of children and adolescents 0 - 18 years of age in the proposed service area to determine potential need. The number of children in need of a particular service will be based on the percentage for the service noted on Chart A. The same or similar services in the service area is subtracted to determine what unmet need exists for the applicant's proposed services.

The definitions for services indicated on Chart A are contained in Appendix A following this chapter.

#### A. NEED METHODOLOGY FOR CHILDREN AND ADOLESCENTS BEHAVIORAL HEALTH SERVICES

Information in Chart A is available for each county and/or region from the HCCRA.

For simplified application and determination, sequential steps in the process are outlined below.

#### FORMULA FOR ESTIMATING USE OF BEHAVIORAL HEALTH SERVICES

METHOD: (USE CHART A)

##### Proposed Service Area Population:

1. Determine population for persons under age 18 in proposed service area
2. Determine percentage need for the service level (Column A)
3. Multiply 1 x 2 to determine the proposed service area population for the service level
4. Subtract the number of individuals receiving services from existing behavioral health providers in the area to determine the target population

Comparison to State Need:

1. Determine number of slots available by service (Column C)
2. Determine projected area population for under age 18
3. Divide results of number 2 by 53,229 (12% of target population [Chart A]) to determine proposed service area proportionate share of state need
4. Divide number of slots in calculation number 1 for the service by the number of slots available for the service area population (Column C) to determine proposed service area proportionate share of state need
5. Compare results of number 4 to current capacity (Column D) to identify over/under capacity for proposed service area

<b>CHART A</b>				
<b>Balanced System of Care - Projections for Year 2000 - STATEWIDE</b>				
<b>Total State Population under 18 yrs = 443,577</b>				
	12% OF POPULATION (53,229)			CURRENT CAPACITY
SERVICE	% IN NEED (A)	# IN NEED (B)	# SLOTS (C)	# SLOTS (D)
INPATIENT	1.00%	532.29	16	160
RESIDENTIAL TX				
- LEVEL I	4.00%	2129.17	206	183
- LEVEL II	1.00%	532.29	49	0
RES TX				
- LEVEL I	0.90%	479.06	350	171
- LEVEL II	0.10%	53.23	29	22
THER. GP				
- LEVEL I	0.50%	266.15	296	52
- LEVEL II	1.00%	532.29	292	188
FOSTER FAMILY BASED CARE	6.00%	3193.75	3992	749
- LEVEL I				
- LEVEL II				
- LEVEL III				
IND. LIVING	2.00%	1064.58	1121	163
- LEVEL I				
- LEVEL II				
DAY TX				
- LEVEL I	8.00%	4258.34	2100	65
- LEVEL II		0.00	0	
RESPITE	9.50%	5056.78	333	2
H-B SERVICES				
- LEVEL I	10.00%	5322.92	1313	865
- LEVEL II	1.00%	532.29	266	225
CASE MGMT.	20.00%	10645.85	10646	794
OUTPATIENT				
- CRISIS RESP.	5.00%	2661.46	22	37
- D T M P*	65.00%	34599.01	17063	3434

\*DIAGNOSTIC/THERAPY/MED./PSYCH CARE

**B. NEED METHODOLOGY FOR ADULT BEHAVIORAL HEALTH SERVICES**

Adults with serious and persistent mental illnesses have been defined by the West Virginia Office of Behavioral Health Services (OBHS) as "persons 18 years of age or older with a diagnosis of schizophrenia and other psychotic disorders, mood disorders, and borderline personality disorders." OBHS places such persons into two distinct groups based on functional limitations attributable to their illness. Persons with functional limitations in at least two of the following six major life areas comprise one group. Those six areas are vocational, educational, homemaker, social or interpersonal, community, and self care or independent living. The second group is identified as persons with diagnoses of mental illnesses without the functional limitations herein described.

Using Chart C to estimate the age 18 or older population with mental illness, the OBHS has determined that a prevalence rate of 22.1% (298,328 persons) exists in West Virginia. Chart C also indicates that approximately 16% (43,258 persons) will seek the services of a specialized mental health provider (penetration or utilization rate).

Focusing on the number of persons in the State who are seriously and persistently mentally ill with functional limitations, the OBHS estimates a prevalence rate of 10.6% (143,090 persons). The estimated penetration rate at which that group of persons will seek the services of a specialized mental health provider is 24% (34,898 persons) or 2.6% of the total 1,340,000 adults in West Virginia.

Services are classified into four categories although some services fall into more than one category:

<b>CHART B</b>	
STATE NEED FOR POTENTIALLY SERIOUS AND PERSISTENTLY MENTALLY ILL BY LEVEL OF SERVICE	
<b>TYPE OF SERVICE</b>	<b>STATE NEED</b>
RESIDENTIAL SERVICES	700,000 DAYS
TREATMENT SERVICES	900,000 HRS
REHABILITATION SERVICES	1,000,000 HRS
SUPPORT SERVICES	1,700,000 HRS

Applicants will use the 2.6% of the adult population in their service area, and the breakdown of service categories in Chart B to determine whom they propose to serve and how they propose to serve them. If a proposed service covers more or less than one category, calculated adjustments will be made to determine the number of individuals the applicant can reasonably expect to need its service(s). The same or similar services and utilization reported by other providers in the service area will be subtracted to determine whether need for the proposed service(s) can be established.

Preference will be given to applicants who propose services which will diminish overcapacity in residential settings and develop needed capacity in less restrictive and more financially feasible outpatient and community-based settings.

An applicant that proposes to serve persons diagnosed as mentally ill without functional limitations may request the HCCRA to evaluate the need for the project on the basis of the West Virginia low prevalence and low penetration rate from Chart C.

For simplified application and determination using CHART B and CHART C, sequential steps in the process have been outlined below. CHARTS B and C are to be used to determine UNMET NEED.

CHART B identifies NEED BY TYPE OF SERVICE.

CHART C addresses BEHAVIORAL HEALTH UTILIZATION PROJECTIONS.

Applicants anticipating providing services to persons with severe and persistent mental illnesses with functional limitations should use CHART B and CHART C.

Applicants anticipating providing services to persons without functional limitations should use CHART C, COLUMNS A, B, D and E.

Step One - Chart B to determine relationship to State identified need - Behavioral Health Utilization Projections:

1. Identify level of service(s) to be delivered to target population in proposed service area
2. Determine population for proposed service area
3. Divide proposed service area population by State need to determine applicant's proportionate share of State need
4. Multiply adult population by 2.6% to determine target population.

Step Two - Chart C to determine Behavioral Health Utilization Projections - Prevalence:

1. Determine population for proposed service area
2. Apply prevalence epidemiological service area percent for each behavioral health disorder(s) to proposed service area population
3. Determine prevalence average (State range)  
Obtain low range (Column B)

Obtain high range (Column C)

Add low + high, ÷ by 2

4. Apply proposed service area population prevalence (Number 2) to the State average (Number 3) to determine the applicant's proportional relationship to the State prevalence

Step Three - Chart C to determine Behavioral Health Utilization Projections - Penetration:

1. Determine prevalence population for proposed service area
2. Apply specialty mental health provider penetration epidemiological catchment area percent for each disorder to applicant's proposed population (Column D)
3. Determine specialty mental health penetration average (State)  
Low range (Column E)  
High range (Column F)  
Add low + high, ÷ by two to determine average
4. Apply the population (Number 2) to the state specialty mental health penetration average (Number 3) to determine the applicant's proportionate relationship to the State average penetration

Step Four - Target Population

1. Determine penetration population service - Step Three, Number 2
2. Determine the number of persons receiving care from existing behavioral health/mental health providers in proposed service area
3. Subtract the number 1 from number 2 to obtain applicant's target population

The following definitions are to be used by certificate of need applicants who propose to provide services to adults with mental illnesses:

Hospital Services: Those services provided in a facility licensed as a hospital. Hospital services may be provided in a psychiatric unit of a general hospital or in a free-standing psychiatric hospital and will be reviewed under the existing standards for psychiatric services within the acute care standards.

Residential Services: Settings which require licensure as a 24-hour service of a licensed behavioral health center and in which behavioral health center staff are on site work as the primary work site. Such services include, but are not limited to, group homes, personal care homes, board and care homes, and crisis residential units are included.

Treatment Services: Services provided by or supervised by licensed mental health professionals in individual or group settings. They include, but are not limited to, evaluation, intake, individual or group therapy, partial hospitalization, crisis intervention, psychological testing, medication review, medication administration, and medication prescription.

Rehabilitation Services: Those services which are designed to reduce or eliminate skills deficits which facilitate the individual's ability to function as fully and as independently as possible both during and after treatment. Indicators of such services include, but are not limited to, the adoption of a psychiatric rehabilitation model, to the degree to which individuals participate in treatment planning, provision of services outside the individual's work hours or other time commitments, and any linkage to peer support or other supportive services in the community.

Support Services: Those services which provide support to individuals to obtain, maintain, and/or regain maximal functional independence. They include, but are not limited to, personal care supported living, case management, peer support, and are intended to assure treatment access to food, treatment, socialization, employment opportunities, or other elements of integration within the community.

**CHART C**

**Behavioral Health Utilization Projections for West Virginia**

**One Year Prevalence and Penetration for Persons 18 Years and Older with ADM Disorders**

<b>Disorders</b>	<b>Prevalence ECA<sup>1</sup></b> (A)	<b>Prevalence (WV-Low)<sup>2</sup></b> (B)	<b>Prevalence (WV-High)</b> (C)	<b>SMH Penetration ECA<sup>3</sup></b> (D)	<b>SMH Penetration (WV-LOW)</b> (E)	<b>SMH Penetration (WV-HIGH)</b> (F)
Any DIS ADM Disorder	28.1±.5	372,572	386,071	13	47,317	49,031
Any DIS disorder EXCEPT alcohol or drug	22.1±.4	292,928	303,728	15	42,476	44,040
Any mental disorder with comorbid substance abuse	3.3±.2	41,847	47,247	21	8,620	9,733
Any substance use disorder	9.5±.3	124,191	132,290	11	13,909	14,817
Any alcohol disorder	7.4±.3	95,843	103,942	11	10,447	11,330
Any drug disorder	3.1±.2	39,147	44,547	14	5,559	6,326
Schizophrenic or schizophreniform disorders*	1.1±.1	13,499	16,199	46	6,210	7,451
Affective disorders*	9.5±.3	124,191	132,290	23	28,688	30,559
Any bipolar	1.2±.1	14,849	17,549	32	4,811	6,866
Unipolar major depression	5.0±.2	64,795	70,195	28	18,013	19,614
Dysthymia	5.4±.2	70,195	75,594	19	13,648	14,590
Anxiety disorders	12.6±.3	166,038	174,137	15	24,740	25,946
Phobia	10.9±.3	143,089	151,189	14	19,889	21,015
Panic disorder	1.3±.1	16,199	18,899	34	5,443	6,360
Obsessive-compulsive disorder	2.1±.1	26,998	29,698	25	6,830	7,514
Somatization disorder	0.2±.0	2,700	2,700	43	1,147	1,147
Antisocial personality disorder	1.5±.1	18,899	21,598	18	3,307	3,708
Cognitive impairment (severe)	2.7±.1	35,097	37,797	7	2,422	2,608

**NOTES - \* Used to classify as potentially serious and persistent mental illness with functional limitations.**

**ECA is Epidemiological Catchment Area; DIS is Diagnostic Interview Schedule; ADM is alcohol, drug abuse, and mental health; WV is West Virginia; SMH is specialty mental health**

<sup>1</sup> Prevalence is one year prevalence for 100 persons 18 years and older in the community and institutions;

<sup>2</sup> West Virginia prevalence and penetration are based on a 1990 adult population of 1,340,000 and are one year estimates;

<sup>3</sup> Only 40% of individuals with an ADM disorder who seek treatment use SMH; the rest use general medical and other forms of service.

C. NEED METHODOLOGY FOR ALCOHOL AND SUBSTANCE ABUSE SERVICES FOR ADULTS (AGE 18 AND OLDER)

An estimated 10% of the West Virginia population age 18 and older have chemical dependency problems. Of this group, 12% will seek help during any given year. The need methodology for residential services are identified in the Acute Care Standards of the "Best Practices" Standards developed by the WVDRR/DADA.

The following Chart D identifies other service settings and their estimated utilization rate:

<b>CHART D</b>	
<b>Alcohol and Substance Abuse Services Utilization</b>	
<b>SERVICE SETTING (A)</b>	<b>Utilization (B)</b>
Low intensity outpatient treatment services	30%
Home/community-based services	10%
Transitional Living Services	7%
Non-Medical Detoxification Services	5%
Intensive Outpatient Treatment Services	10%
Day Treatment Services	10%
Congregate Therapeutic Living Services	5%
Long-Term Residential Rehabilitation Services	5%
Medically Monitored Inpatient/Residential Treatment	7%
Medically Managed Acute Inpatient Treatment	3%
Medically Managed Detoxification Service	3%

Abuse and addiction/dependence are defined as follows:

Abuse: A maladaptive pattern of psychoactive substance use indicated by at least one of the following:

1. Continued use despite knowledge of having a persistent or recurrent social, occupational, psychological, or physical problem that is caused or exacerbated by use of the psychoactive substance; and,
2. Recurrent use in situations in which use is physically hazardous, such as driving while under the influence.

Some symptoms of the disturbance have persisted for at least one month, or have occurred repeatedly over a longer period of time, and has never met the DSM-IV criteria for addiction/dependence.

Addiction/Dependence: According to the DSM-IV, at least three of the following must be present for a diagnosis of addiction/dependence:

1. Substance often taken in larger amounts or over a longer period than the person intended;
2. Persistent desire or one or more successful efforts to cut down or control substance use;
3. A great deal of time spent in activities necessary to get the substance, such as theft, taking the substance or recovering from its effects;
4. Frequent intoxication or withdrawal symptoms when expected to fulfill major role obligations at work, school, or home, or when substance use is physically hazardous;
5. Important social, occupational or recreational activities given up or reduced because of substance use;
6. Continued substance use despite knowledge of having persistent or recurrent social, psychological, or physical problems that cause or exacerbate by the use of the substance;
7. Marked tolerance: need for markedly increased amounts of the substance, at least a 50% increase in order to achieve intoxication or the desired effect with continued use of the same amount;
8. Characteristic withdrawal symptoms; and
9. Substance often taken to relieve or avoid withdrawal symptoms; and, in addition some symptoms of the disturbance have persisted for at least one month or have occurred repeatedly over a long period of time.

It is estimated that 10% of the population age 18 and older have chemical dependency problems and that 12% of that group will seek help during any given year. Approximately 60% of those seeking help will require detoxification services for an average length of stay of five days. Approximately 50% of those receiving detoxification services will volunteer for an inpatient treatment program that will average 21 days. (Derived from WVDHHR/DADA "Best Practices" Standards.) Acute Care (Chapter III) of those Standards contains the need methodology for residential services.

There are, however, many other services and settings used in treating abuse and addiction. A list and definitions for those services and an estimated utilization rate are included in the following:

1. Low intensity outpatient treatment services: Consists of chemical dependency services occurring at a frequency of six hours or less per week. Percent of substance abusing population requiring such services 30%.
2. Home/Community-Based Services: Consists of chemical dependency outpatient services and/or case management services delivered in the client's living environment. Percent of substance abusing population requiring such services 10%.
3. Transitional Living Services: Consists of a minimally supervised group living situation. Percent of substance abusing population requiring such services 7%.
4. Non-Medical Detoxification Services: Refers to helping the client safely eliminate the toxic effects of alcohol and/or other drugs from the body in a 24-hour setting while assessing his/her need for medical care. Percent of substance abusing population requiring such services 5%.
5. Intensive Outpatient Treatment Services: Refers to organized and structured treatment services, non-residential in nature, consisting of 2-5 visits per week with 6 to 20 hours of client contact per week. Percent of substance abusing population requiring such services 10%.
6. Day Treatment Services: Refers to organized and structured treatment services, non-residential in nature, consisting of 21 or more hours of client contact per week occurring 4-5 days per week. Percent of substance abusing population requiring such services 10%.
7. Congregate Therapeutic Living Services: Consists of combined outpatient treatment and a group living situation within a supportive living environment. Percent of substance abusing population requiring such services 5%.
8. Long-Term Residential Rehabilitation Services: Offers 24-hour per day supervised treatment with decreasing intensity of supervision over time

averaging 40 hours per week. Percent of substance abusing population requiring such services 10%.

9. Medically Monitored Inpatient/Residential Treatment Services: Consists of 24-hour per day supervised care, with 50 or more hours of substance abuse treatment services provided per week. Percent of substance abusing population requiring such services 7%.

10. Medically Managed Acute Inpatient Treatment: Consists of substance abuse treatment services delivered in a 24-hour acute inpatient hospital setting. Percent of substance abusing population requiring such services 3%.

11. Medically Managed Detoxification Service: Consists of services offered within an acute care hospital setting designed for the client with the medical conditions warranting a physical examination by a physician within 24 hours of admission. This setting provides 24 hour medical management of detoxification services. Percent of substance abusing population requiring such services 3%.

To justify the need for a particular service, applicants will determine the percentage of the substance abusing population in the proposed service area. To that number, multiply the percentage of the abusing population that will require the specific proposed service(s). To arrive at the current unmet need, subtract the services currently being provided by others in the service area.

A more detailed list of definitions, a description of each service setting and a description of each service is included in Appendix B to this chapter.

For simplified application and determination, sequential steps in the process have been outlined below. Use Chart C and Chart D. Chart D identifies projections. Chart C identifies projections - prevalence.

## C. NEED METHODOLOGY FOR ALCOHOL AND SUBSTANCE ABUSE SERVICES FOR ADULTS (AGE 18 AND OVER)

### Step One - Chart D

Relationship to State Identified Need:

Behavioral Health Utilization Projections:

1. Determine 10% of projected service area population
2. Multiply target population by service level utilization in Chart D by utilization percentage.

### Step Two - Chart C

Behavioral Health Utilization Projections - Prevalence:

1. Determine population for proposed service area (Column A)

2. Apply prevalence epidemiological service area percent for each behavioral health disorder(s) to proposed service area population
3. Determine prevalence average (State range)
  - Obtain low range (Column B)
  - Obtain high range (Column C)
  - Add low + high, ÷ by 2
4. Apply proposed service area population prevalence (Number 2) to the State average (Number 3) to determine the applicant's proportional relationship to the State prevalence

### Step Three - Chart C

#### Behavioral Health Utilization Projections - Penetration:

1. Determine prevalence population for proposed service area
2. Apply specialty mental health provider penetration epidemiological catchment area percent for each disorder to applicant's proposed population (Column D)
3. Determine specialty mental health penetration average (State)
  - Low range (Column E)
  - High range (Column F)
  - Add low + high, ÷ by two to determine average
4. Apply the population (Number 2) to the state specialty mental health penetration average (Number 3) to determine the applicant's proportionate relationship to the State average penetration

### Step Four

#### Target Population

1. Determine penetration population service Step Three, number 2 population
2. Determine the number of persons receiving care from existing behavioral health/mental health providers in proposed service area
3. Subtract the number 1 from number 2 to obtain applicant's target population

## D. NEED METHODOLOGY FOR MENTAL HEALTH SERVICES AMONG THE ELDERLY

According to data reported by the National Institute of Mental Health and other reports covering incidence:

1. 18-25% of older persons experience significant mental health symptomatology that warrants professional intervention. The attached table estimates the prevalence of any alcohol, drug abuse or mental illness at approximately 28 percent of the adult population. Extrapolations of these numbers based on the West Virginia population (1990 census) reflects that as many as 102,000 people 60 years and older could be diagnosed as having some form of mental illness or chemical addiction.

2. Depression and other psychiatric conditions of late life are often particularly acute and debilitating in the context of diminishing social and environmental supports and declining physical status and;
3. Older adults have the highest rate of suicide.
4. Dementing illnesses are now proclaimed the "silent epidemic of the century"; approximately 10% of those over 65 show some signs of dementia.
5. Despite the need for services, use of formal psychiatric services is quite low. Fewer than 20% of the older population experiencing a diagnosable psychiatric condition receive psychiatric treatment and, of this group, only 10% present to mental health specialists. (This strongly suggests availability and accessibility problems within the provider network.)

According to the West Virginia Office of Aging, Commission on Aging (May, 1994), the following data are reported with regard to the functional capacity and disability of West Virginians age 65 and over:

1. 24,286 persons were identified as having 3 or more functional limitations requiring assistance with activities of daily living, including bathing, dressing, eating, getting in or out of bed, walking, traveling and toileting.
2. About 23,000 persons were reported as having 3 or more limitations related to instrumental activities of daily living, including problems with cooking, shopping, conducting business, telephoning, housework and performing chores.
3. The Commission estimates that there are about 73,000 West Virginians 65 years and older who have a diagnosis of Alzheimer's Disease, Phobia, Obsessive/Compulsive Disorder, Schizophrenia, Panic Disorder, Manic Depression or who are Developmentally Disabled.
4. Of the total of the 65+ population, 11,210 are reported to be living in institutions (10,917) or Group Homes (293). Other studies estimate that as many as 65% of all current nursing home residents have at least one condition that could be classified as a mental illness.

The Commission's report contains a county-by-county breakdown of the above data. In addition, the above-referenced table showing prevalence and penetration data for West Virginia can be produced on a county-by-county basis.

A recent study mandated by the New Hampshire Legislature (1995) reports the status of mental health services in that state. The New Hampshire study identifies five

"serious gaps" in the provision of direct mental health services to the elderly. Recommendations are included. This study appears in the Appendix.

Research indicates that the prevalence of mental illness increases markedly after the age of 65. It is estimated that 25% of the elderly population may at some time need mental health services. All elderly persons suffer life stresses such as retirement, death of a spouse, isolation and reduced income that may lead to serious emotional problems. The suicide rate for West Virginians aged 65 and older, based on data collected from 1978 to 1982, was 19.8 per 100,000 population compared with a national rate of 17.8 per 100,000 population in 1980.

In addition to relating the need for services to persons with Alzheimer's disease, the number of elderly persons with a mental illness is increasing. The Plan concludes that pressing needs for community in-home social support services, (i.e., case management, personal care, and day care) need to be addressed in the priority agenda for services for the elderly. The older individual is more likely to develop chronic medical conditions, become functionally impaired and require long term care. Rehabilitation and treatment programs must be available and responsive to an aging population.

Consistent with the trend in the planning and implementation of new behavioral health services for all persons with a mental illness, chemical addiction or developmental disability, the following array of services are needed by the elderly mentally ill.

Certificate of Need applications should state that one or more of the following services will be provided:

Acute Inpatient: Twenty-four hour hospitalization is used when all other interventions are inappropriate to the specific needs of the patient. In most cases, inpatient care will be needed only when the patient demonstrates medical necessity for continuous observation and treatment for a brief period of time.

Residential Services: These services include:

1. Specialized Psychiatric Nursing Home Care
2. General Nursing Home Care
3. Group Homes
4. Specialized Foster Care
5. Supported Living Arrangements

Community Based Care: Services in this category of care include:

1. Specialized Home Behavioral Health services such as psychiatric nursing
2. Partial Hospitalization Programs
3. Outpatient Treatment including individual, group and family treatment

4. Crisis Intervention
5. Specialized Consultation and Treatment for elderly persons with severe behavior problems, regardless of diagnosis
6. Day Treatment
7. Day Care
8. Respite Care
9. Case Management

Family, Community and Outreach Services: These services include:

1. Family Support and Education Services
2. Community Outreach and Case Finding

Applications for behavioral health services to the elderly should follow the existing HCCRA guidelines for CON application and include a plan for:

1. Integrating and coordinating the proposed service with other services to this population group.
2. Demonstrating the impact and the contribution of the proposed service to fill existing gaps in care to the elderly mentally ill.
3. Demonstrating awareness of the potential adverse effects of relocating elderly mentally ill persons from one setting to another. This plan should specify steps to be taken to assess the patient's desire and ability to make a transition in residential settings.

Proposed Standards:

1. Proposals should use existing population-based prevalence and penetration data to demonstrate need, as presented in this document and adapted to the county or region to be served. In addition, applicants shall conduct a survey to determine to what extent other organizations in the service area are meeting the needs of the persons he/she proposes to serve.
2. Programs shall describe proposed services in terms of their consistency with prevailing knowledge regarding the need for specialized services, similar to the array described above, for the elderly with an emotional, addictive or developmental disability.
3. Applicants shall demonstrate that the proposed service promotes accessibility, affordability, and acceptability of the service by the elderly person with a behavioral health problem.

4. Applications shall contain a description of how the proposed service contributes to the development of less intense services and settings for the elderly person.
5. Applicants shall demonstrate how they will coordinate their care with other providers and agencies serving or having an interest in services to elderly persons with a mental illness.
6. Applicants shall indicate their anticipated sources of revenue. It is expected that private payors and Medicare will be the primary source of revenue and Medicaid will be less than 10%.
7. Applicants need to promote integration/reintegration with the larger community.

#### D. NEED METHODOLOGY FOR MENTAL HEALTH SERVICES AMONG THE ELDERLY

For simplified application and determination, sequential steps in the process are outlined below.

Chart E identifies behavioral health utilization projections for West Virginians--60 years and older.

##### Step One - Chart E

Behavioral Health Utilization Projections - Prevalence:

1. Determine population for proposed service area
2. Apply prevalence epidemiological service area percent for each behavioral health disorder(s) to proposed service area population (Column A)
3. Determine prevalence average (State range):
  - Obtain low range (Column D)
  - Obtain high range (Column E)
  - Add low + high, ÷ by 2
4. Apply proposed service area population prevalence (Number 2) to the State average (Number 3) to determine the applicant's proportional relationship to the State prevalence

##### Step Two - Chart E

Behavioral Health Utilization Projections - Penetration:

1. Determine prevalence population for proposed service area
2. Apply specialty mental health provider penetration epidemiological catchment area percent for each disorder to applicant's proposed population (Column F)
3. Determine specialty mental health penetration average (State)
  - Low range (Column G)
  - High range (Column H)

- Add low + high, ÷ by two to determine average
4. Apply the population (Number 2) to the state specialty mental health penetration average (Number 3) to determine the applicant's proportionate relationship to the State average penetration

### Step Three

#### Target Population

1. Determine population in specialty mental health provider in Step Two, Number 2, results in the SMH penetration
2. Determine the number of persons receiving care from existing behavioral health/mental health providers in proposed service area
3. Subtract the number of existing behavioral health provider recipients from Step One to determine the applicant's target population

**CHART E**

**Behavioral Health Utilization Projections for West Virginia - 60 Years and Older**

<b>Disorders</b>	<b>Prevalence ECA  (A)</b>	<b>Prevalence WV-Low all adults (B)</b>	<b>Prevalence WV-High all adults (C)</b>	<b>Prevalence WV LOW (60 &amp;Over) (D)</b>	<b>Prevalence WV HIGH (60 &amp;Over) (E)</b>	<b>% SMH Penetration (F)</b>	<b># SMH-LOW Penetration (G)</b>	<b># SMH-HIGH Penetration (H)</b>
Any DIS ADM Disorder	28.1±.5	372,572	386,071	98,808	102,388	12.7	12,549	13,003
Any DIS disorder EXCEPT alcohol or drug	22.1±.2	292,928	303,728	78,402	79,834	14.5	11,368	11,576
Any mental disorder with comorbid substance abuse	3.3±.2	41,847	47,247	11,098	12,530	20.6	2,286	2,581
Any substance use disorder	9.5±.3	124,191	132,390	32,936	35,084	11.2	3,689	3,929
Any alcohol disorder	7.4±.3	95,843	103,942	25,418	27,566	10.9	2,771	3,005
Any drug disorder	3.1±.2	39,147	44,547	10,382	11,814	14.2	1,474	1,678
Schizophrenic or schizophreniform disorders	1.1±.1	13,499	16,199	3,580	4,296	5.0	165	215
Affective disorders	9.5±.3	124,191	132,290	32,936	35,084	23.1	7,608	8,104
Any bipolar	1.2±.1	14,849	17,549	3,938	4,654	32.4	1,276	1,508
Unipolar major depression	5.0±.2	64,795	70,195	1,074	2,506	27.8	299	697
Dysthymia	5.4±.2	70,195	75,594	18,616	20,048	19.3	3,593	3,869
Anxiety disorders	12.6±.3	166,038	174,137	44,034	46,182	14.9	6,561	6,881
Phobia	10.9±.3	143,089	151,189	37,948	40,096	13.9	5,275	5,573
Panic disorder	1.3±.1	16,199	18,899	4,296	5,012	33.6	1,443	1,684
Obsessive-compulsive disorder	2.1±.1	26,998	29,698	7,160	7,876	25.3	1,811	1,993
Somatization disorder	0.2±.0	2,700	2,700	716	716	42.5	304	304
Antisocial personality disorder	1.5±.1	18,899	21,596	5,012	5,728	17.5	877	1,002
Cognitive impairment (severe)	2.7±.1	35,097	37,797	9,308	10,024	6.9	642	692

**NOTES**

ECA is Epidemiological Catchment Area; DIS is Diagnostic Interview Schedule; ADM is alcohol, drug abuse, and mental health; WV is West Virginia; SMH is specialty mental health

Prevalence is one year prevalence for 100 persons 60 years and older in the community and institutions

West Virginia prevalence and penetration are based on a 1990 adult population of 1,340,000 (60+ population of 358,000) and are one year estimates

## E. NEED METHODOLOGY FOR PERSONS WITH DEVELOPMENTAL DISABILITIES

A developmental disability is a long-term condition that occurs before the age of twenty-two that results in substantial limitations in at least three of the following areas: self-care, language, learning, mobility, self-direction, capacity for independent living and economic self-sufficiency. The term may also be applied to infants and young children through age five who experience a significant delay or specific condition with a high probability of resulting in a developmental disability if services are not provided.

A number of different conditions can cause developmental disabilities including cerebral palsy, mental retardation, autism, epilepsy and brain injuries.

Most West Virginians with developmental disabilities live with their families or some other natural arrangement. Only 6% live in alternative arrangements (institutions, group homes, supervised apartments ) financed by the state.

It is estimated by the Developmental Disabilities Planning Council and the Office of Behavioral Health Services persons with developmental disabilities comprise an estimated 1.8% or 32,523 of the state's population. Approximately 90% of this number who receive services do so through the public sector support. While it is recognized that services need to be available proportionate to the demographics of the state, people with disabilities tend to cluster in areas where infrastructure exists, such as public transportation, specialized medical care and specialized services for persons with developmental disabilities. (Excerpted from "Paths to Equality; published by the Developmental Disabilities Planning Council, August 1994).

West Virginia has made remarkable progress in changing the service system for persons with developmental disabilities from a reliance on institutional care to one of community based services. More than 90% of those living in institutions have moved into community living since 1977. With recent legislation mandating the relocation of the remaining residents of Colin Anderson Center into community living, the state has further committed itself to home and community based services for persons with developmental disabilities.

Approximately 280 persons with developmental disabilities continue, however, to reside in state and private nursing facilities-- 489 in ICF/MR group homes and 30 in an intensive habilitation center. The goal of the state is to gradually develop alternatives in order that residents can be moved to homes typical for the community and supported, if appropriate, by home and community based services. An exception to this goal may be the need to temporarily add 30 ICF/MR beds and 10 habilitation beds to accommodate the transfer of some Colin Anderson residents. It is anticipated that savings realized from utilizing less institutional, nursing home and ICF/MR care can be diverted to fund additional home and community based services. The availability of these services makes possible the moving of persons with developmental disabilities from those settings. The goal of public sector expenditures is to maintain an essentially budget neutral position.

Following are the array of services used by persons with developmental disabilities and a brief description of each. It should be noted that apartment, condominium and houses in which persons with developmental disabilities live is listed on the array as an important component, but would not be subject to certificate of need review if the following circumstances exist:

- (1) the setting is typical housing stock for the community;
- (2) three or less persons with developmental disabilities are living there;
- (3) the persons with developmental disabilities living there pay their own rent or mortgage from SSI, Social Security or other personal resources;
- (4) services required by the residents are either imported to the home or the resident leaves the home to obtain services. (The provider of the imported or services provided out of the home is subject to certificate of need review.)

<b>CHART F</b>	
<b>Developmental Disabilities Service Capacity Maximums (Proposed for December 1, 1996)</b>	
<b>Facility/Program</b>	<b>Capacity</b>
Institution (Colin Anderson Center)	25 beds <sup>1</sup>
ICF/MR Group Homes	519 beds <sup>2</sup>
Other Group Homes (4+ persons)	XX beds <sup>3</sup>
Crisis/Intensive Habilitation Centers	40 beds <sup>4</sup>
Day Habilitation Centers	2700 slots
<b>Services</b>	<b>Capacity</b>
Case Management/Svc. Coordination	12,950 slots
Personal Care Services	1614 slots
Day Habilitation ("off site")	200 slots
Crisis Support Services ("off site")	130 persons to be served in a year

**Prevalence Information**

WV Population: 1,793,477 (1990 Census)

DD Population: 32,283 (1.8% of the general population per study by Gollay, et al.) [Adults: 24,298]  
[Children: 7,984]<sup>1</sup> Based on closure date of Dec. 31, 1996.<sup>2</sup> Includes 30 CAC related additional beds.<sup>3</sup> Information unavailable as of November 8, 1995.<sup>4</sup> Potomac Center plus 10 community beds associated with CAC closure.

Applicants will first determine the number of persons with developmental disabilities in the proposed service area either using the 1.8% factor or evidence that the area has a disproportionate number of persons with developmental disabilities. Using that number of persons with developmental disabilities, applicants can then estimate, based on the proposed service, the number of persons in the proposed service area in need of that particular service. Once that is calculated, the persons already receiving such services in the proposed service area are subtracted to determine the unmet need.

There are services which cannot be expected to be allocated throughout the State on a proportionate basis. In those situations, applicants must justify need on a regional or statewide basis.

The following definitions are to be used by certificate of need applicants who propose to provide services to those with developmental disabilities.

Case Management/Service Coordination: Services which assist individuals to gain access to needed medical, behavioral health, social, educational and other services. Case Management services include arranging for initial assessments, linkage and referral, coordinating needed services, conducting Interdisciplinary Team meetings, writing individual Program Plans, evaluating services and advocating for the person's rights and protection.

Crisis & Intensive Habilitation Center: A facility for persons with developmental disabilities who need behavioral and/or psychiatric assistance, support and intervention that will lead to the resolution of the crisis and return to the community.

Crisis Support: Face-to-face contact with an individual in need of emergency behavioral and/or psychiatric intervention to resolve an acute crisis.

Day Habilitation: A program of skills instruction and supervision designed to assist an individual in achieving increased independence and productivity or maintaining current skills in his/ her activities of daily living. Day Habilitation services take place away from a person's home and include activities in the natural community environment.

Day Habilitation Center: A facility licensed by the Office of Health Facility Licensure and Certification to provide skills instruction and supervision designed to assist individuals in achieving increased independence and productivity or maintaining current skills in their activities of daily living.

Group Home: A residential facility licensed by the Office of Health Facility Licensure and Certification to serve four or more individuals with developmental disabilities.

ICF/MR Group Home: An Intermediate Care Facility for the Mentally Retarded licensed by the Office of Health Facility Licensure and Certification and certified by the Bureau for Medical Services to serve four or more individuals with developmental disabilities.

Individualized Supportive Residential Setting: A personalized living arrangement developed to serve no more than three individuals with developmental disabilities who need long term residential support, in homes that are typical for the community in which they are located, in which the residents pay for their rent or mortgage and in which services are brought from outside of the home. (There is no "live in" staff.)

Institution: A large, congregate residential facility for individuals with developmental disabilities.

Personal Care: Medically oriented activities or tasks that enable persons to meet their physical and/or health related needs and be treated as outpatients in community living arrangements. Services include to personal hygiene, dressing, feeding, nutrition, environmental support functions and health-related tasks and must be ordered by a physician and supervised by a registered nurse.

Specialized Family Care Home: A surrogate family residence serving two or fewer individuals with developmental disabilities that is certified by the Office of Social Services.

Other Services: Services not described in this list which an applicant proposes shall be defined by, and the need justified by, the applicant.

For simplified application and determination, sequential steps in the process have been outlined below.

## E. NEED METHODOLOGY FOR PERSONS WITH DEVELOPMENTAL DISORDERS

### Step One - Chart F

#### Relationship to State Identified Need

##### Behavioral Health Utilization Projections:

1. Identify level of service(s) to be delivered to target population in proposed service area
2. Determine population for proposed service area

3. Divide proposed service area population by State need to determine applicant's proportionate share of State need

#### THE FOLLOWING STANDARDS APPLY TO ALL APPLICATIONS

#### V. QUALITY

Applicants seeking a certificate of need approval for the development of a behavioral health/developmental disabilities service, or for a renovation project or replacement facilities, shall demonstrate compliance with applicable licensing, certification, and/or accreditation standards, or submit a substantive and detailed plan to come into compliance with applicable licensing, certification and/or accreditation requirements. All staff of the facility shall be in compliance with applicable standards.

All behavioral health/developmental disabilities entities shall document written plans for the development and implementation of a quality assurance program which meets acceptable standards as specified by any applicable accrediting organizations.

All behavioral health/developmental disabilities entities shall demonstrate:

1. Suitability of physical plant, if applicable;
2. Sufficient and appropriately qualified staff;
3. Effective treatment environment documented by written protocol;
4. Recognition of individual rights to include participation of the individual or his or her designee to develop the treatment plan (except as delineated by Hartley), the right to informed consent to accept or refuse treatment, and to have access to an advocate. Furthermore, individuals under voluntary commitment have the right to refuse experimental treatment that may include medications; and,
5. An administration/evaluation process.

#### VI. CONTINUUM OF CARE

Behavioral health/developmental disabilities entities will develop referral relationships and cooperative agreements with other health care providers, behavioral health community services, and volunteer and support groups.

A continuum of care and services should be available to all individuals in need of behavioral health services. Individuals must be treated in the least restrictive setting which allows appropriate treatment. Each individual should have a case manager, if indicated, to review and monitor the treatment; to serve as an advocate to ensure the treatment plan is carried out; and to maintain communication between the treatment team and the guardian as applicable or with the individual's consent, throughout the treatment process.

## VII. COST

A. The applicant must demonstrate the financial feasibility of the project. The factors to be considered must include:

1. Utilization by payor classification.
2. Current and projected rates.
3. Statements of (a) revenues and expenses, (b) balance sheets, (c) statements of changes in fund balances, and (d) statements of cash flow for each of last two fiscal years. Audited financial statements, if prepared, must be submitted. If 10-K Reports are required to be submitted to the Securities Exchange Commission by either the applicant or a related entity, these must be submitted for the preceding three (3) years.
4. A preliminary financial feasibility study which must, at a minimum, include: (a) revenues and expenses, (b) balance sheets, (c) statements of changes in fund balances, and, (d) statements of cash flow for each of the last two fiscal years, the current fiscal year and future fiscal years prior to the project's implementation, and the first three years after the project's implementation. The financial feasibility study must also include all assumptions used, including projected payor mix, charges and/or revenues for each category of payor.
5. Sources of revenue/reimbursement by payor classification. The applicant must demonstrate the proposal is consistent with applicable payors' fiscal plans.
6. If the ongoing financial feasibility of the proposed project depends in part on funding from state programs (including but not limited to Medicaid and PEIA), the applicant must either: (a) describe why the proposed project can reasonably expect to receive such financial support in the future or (b) describe where alternative sources of funding will come from to support the project.

B. The applicant must demonstrate that the costs and charges associated with the project are comparable to the cost and charges of similar providers offering similar services.

C. The applicant must demonstrate compliance with W. Va. Code §16-5F-1 et seq., "The Health Care Financial Disclosure Act," and 65 C.S.R. 13, the "Financial Disclosure Rule."

## VIII. ACCESSIBILITY

Geographical access to services is quite important to individuals in obtaining services and with regard to their costs in obtaining them. Economy of scale is a factor in the provider's location of services, as well as service and convenience. Generally, however, the following guidelines serve to express expectations regarding access:

1. Routine ambulatory services and crisis intervention - Service providers should be located within 30 - 40 minutes of the individual in need of service for respite, day treatment, diagnostic services, counseling, psychopharmacology, crisis intervention services, behavior management specialist, counseling, in-home services, etc.
2. Crisis residential services - Service providers should be located within 90 minutes of persons to be served. These services would be crisis respite or stabilization.
3. Long-term care facilities - Service providers should cover the following sub-populations: the medically fragile or medically involved; behaviorally challenging; geriatric, and general populations. These providers should be within 60 minutes of family members.

Entities shall comply with all applicable state and federal laws regarding accessibility to persons with disabilities.

Preference will be given to applicants who demonstrate intent to provide services to patients, without regard to their ability to pay.

## IX. ALTERNATIVES

Alternatives to new construction should be explored and applicants must demonstrate the need for any new construction proposed for the development of a behavioral health/developmental disabilities entity. That exploration should include the evidence that unused space in hospitals, ICF/MR, and other existing facilities cannot be acceptably and cost-effectively converted before non-residential beds are constructed.

Alternatives which can assure the availability of a service at a lower or comparable cost with improved accessibility shall be addressed.

## X. EXECUTIVE SUMMARY

These standards have been developed at a time of considerable change and uncertainty in health care. Consequently, these standards represent a work in progress

to be further enhanced as pending developments in health care take place, more complete data become available, and additional time permits more in-depth research. It is not anticipated that the principles outlined in these standards will change. Methodologies and procedures, however, are expected to become more specific and better defined.

The Bureau of Medical Services (Medicaid) is the primary payor for most services provided by the behavioral health agencies subject to certificate of need review. Expenditures by Medicaid for behavioral health services have increased considerably in recent years. As reimbursement sources for behavioral health services were reconfigured, services and eligibility were expanded; fees were raised and utilization increased. Medicaid, following the lead of an increasing number of private, third-party payors and the Public Employees Insurance Agency, is planning a managed care arrangement for behavioral health and other health care services. The effect of that change on service availability, utilization, reimbursement and Medicaid expenditures is uncertain. Additionally, Medicaid has initiated program changes, fee reductions, utilization review and program monitoring in recent months. The effect of these initiatives is not yet clear.

Congress is considering proposals to change the manner and degree to which the federal government participates in the financing of Medicaid and other state administered programs. The approach that will be implemented, if any, is uncertain. Thus, the consequences cannot be estimated.

A panel appointed by the Governor to provide recommendations to the Medicaid Program continues to meet. The panel's final report was not released prior to the drafting of these standards.

Licensure regulations for behavioral health services are currently being revised and will be released upon legislative approval and after these standards have been implemented.

These standards will be reviewed by the Health Care Cost Review Authority routinely to assure their consistency with the plans of appropriate agencies and to assure they reflect current and anticipated developments in behavioral health care.

## APPENDIX A

### Definitions - Children and Adolescents Behavioral Health Services

The following definitions and charts from the Balanced System of Care serve as the quantitative population-based need methodology to be utilized by Certificate of Need applicants who propose to provide behavioral health services to children.

Acute Psychiatric Inpatient Hospitalization: Provides intensive, 24-hour psychiatric care, including crisis stabilization and diagnostic assessment, in a hospital setting, for

30 days or less. Offers a full array of psychiatric services to children, adolescents and their families, and ensures the availability of accredited educational, medical and recreational activities.

Residential Crisis Support: Provides short-term response (no longer than 30 days, utilization review and prior authorization required for up to an additional 30 days) to a crisis situation. Services include: group/individual counseling; basic needs (food, clothing and shelter); group/individual problem-solving; medication administration; 24-hour awake staff; and the availability of 1:1 supervision. Assessment, treatment planning, case management, and family intervention services are also available. Maximum staff:client ratio = 1:5.

- A. Level I: Refers to a level of supervision and medical/psychiatric intensity required to serve children with mild to moderate behavior problems. Services are delivered in a residential or foster family setting. Services are delivered in a community-based setting, such as an emergency shelter, emergency foster family, or residential facility, which has the potential to provide 1:1 supervision for up to 72 hours. The goal is to achieve stabilization and safety in emergency situations and return to the family or community. Residential Crisis Support should only be used after intensive interventions are employed in the home to reduce the crisis and keep the family intact.
- B. Level II: Refers to a level of supervision and medical/psychiatric intensity required to provide intensive treatment in response to a crisis situation for children with severe behavior/emotional problems. Services are facility-based (non-secure). The goal is to provide intensive treatment to promote rapid stabilization in emergency situations and return to the family and community.

Residential Treatment Services: Provides a highly structured and intensively staffed 24-hour (awake) group care setting targeting youth with a confirmed DSM-IV mental health diagnosis who exhibit severe disturbances in conduct and emotions and, as a result, are unable to function in multiple areas of their lives. The focus of intensive residential treatment is returning the child to an adequate level of functioning. A full array of services, including individual, group and family counseling, psychiatric services, on-site education, recreation, instruction in daily living, and crisis services are provided in a self-contained environment. Staff:client ratio = 1:3 with capability of 1:1 or 2:1 in situations of danger to self or others.

- A. Level I: Refers to a residential treatment model with a psychiatric or addictions treatment overlay.
- B. Level II: Refers to an intensive psychiatric model (e.g., Barboursville School).

Therapeutic Group Home: Structured, therapeutic group living targeting youth with a confirmed DSM-IV or ICD-9 diagnosis. The goal of this service is to help youth to overcome their problems to the degree that they can live in a less restrictive environment. Youth typically attend public school or a day treatment program outside the residence. A comprehensive array of supportive and therapeutic services is available: assessment, case management, treatment planning, supportive individual and group counseling, behavior monitoring and interventions, and enhancement of basic living skills.

- A. Level I - Supportive Residential Programs: Refers to level of supervision and program intensity required to serve children who are able to attend public school and interact in other community (social and recreational) settings with a minimal amount of adjustment problems. Emotional problems are not part of a persistent, long-term pattern and generally respond to logical/natural consequences and supportive counseling interventions.

Staff:client ratio - 1:6 during awake hours, with capability to provide higher ratio as programmatically needed.

- B. Level II - Intermediate Residential Programs: Refers to a level of supervision and program intensity required to serve children who demonstrate moderate to severe adjustment difficulties in school, home and/or community. They display a persistent pattern of challenging behavior which has persisted for at least one year and is not a reaction to a single precipitating event. Multiagency treatment planning and intervention is usually required. Services include a comprehensive array of supportive and therapeutic interventions, including assessment, case management, treatment planning, supportive individual and group counseling, behavioral interventions, basic living skills, crisis management, and individual/group/families therapies.

Staff:client ratio = 1:5 during awake hours, with capability to provide higher ratio as programmatically needed. Twenty-four hour crisis intervention capacity required.

Foster Family Based Care: Individualized service in an alternative family setting for a dependent child who is unable to live at home.

- A. Level I: Placement is designed for children with no to mild behavioral or emotional problems who are best served in a family setting pending a more permanent living arrangement. Duration of care may vary from weeks to years. (For purposes of documenting current capacity, this level refers to DHHR foster families.)
- B. Level II: Individualized, therapeutic foster homes with specially recruited, trained and supported foster parents, in which children are individually placed. Clinically trained professionals provide crisis support, case

management and treatment services throughout the child's length of stay. The purpose of this service is to enable children to overcome their problems in a highly supportive, individualized and flexible placement which will assist them to move to a less intensive out-of-home setting or return to their families. Level II refers to level of supervision and intensity of services required to serve the child who presents moderate emotional and/or behavior management problems.

- C. Level III: Refers to level of supervision and intensity of services required to manage and treat the child who has severe emotional and/or behavior management problems. High management care may include two adults as foster parents or supplemental assistance in the form of support personnel for one foster parent. Typically, only one child is served per treatment family.

Transitional Living: Adolescents aged 17 - 21 using this service live in an apartment setting in preparation for community living. Under varying degrees of supervision, youth are given increasing responsibility for managing their own living situations, including planning, purchase and preparation of meals; cleaning and maintaining the home; financial management; caring for self in areas of health and safety; developing constructive use of leisure time. "Doing" is integrated with learning as youth are trained in all aspects of independent living. Activities focus also in areas of emotional, cognitive and physical development; social integration; and vocational training. The goal of independent living is to teach clients the skills needed to achieve personal, social and economic self-sufficiency while providing a transition from other more restrictive residential environments.

- A. Level I - Transitional Living: Youth rents an apartment in the community and has contact with a support staff person up to three times per week to help with problem resolution, skill development and access to a range of community services. The goal of the service is to gradually phase out support as the youth demonstrates acquisition of skills needed to live independently.
- B. Level II - Supervised Transitional Living: Youth shares an apartment or house in the community with two to three other youth. Staff support may be live-in or shift, or, depending on the needs of the youth, may be provided only in the evening and overnight. Staff assist with problem resolution, skill development and access to a range of community services.

Day Treatment. Day treatment services are the most intensive form of nonresidential services for children and youth. They are indicated for youth who demonstrate severe impairment in conduct and emotions and who require intensive treatment services which can be provided in a community setting to allow the youth to return home each day. Day treatment is provided through an integrated set of educational, counseling and family interventions (primarily case coordination) that engage the youth for typically

four to six hours a day. These services are designed to strengthen individual and family functioning and to prevent more restrictive placement.

- A. Level I - Day Treatment: This level is designed for youth who require intensive but not restrictive services. The approach is typically psychoeducational. Service components are provided through a multi-disciplinary approach and include education (with an emphasis on individualized instruction), therapy and counseling (individual and group), family services, crisis intervention, and skill building (emphasizing interpersonal, problem-solving, and basic living skills), behavior management, recreation and leisure, and periodic psychiatric management and consultation.
  
- B. Level II - Partial Hospitalization: Typically provided in a hospital-based or hospital-like setting, this level of day treatment serves as a transition from in-patient services or to prevent in-patient admission. Youth requiring this service exhibit severe impairment and require ongoing assessment, protected monitoring, and structure and supervision under the direction of a physician to prevent or minimize exacerbation of symptomology. They require medication and/or psychiatric stabilization and receive the same service components as Level I, with the exception of psychiatric management, which is more frequent (24-hour capability) and intensive.

Respite Care: A planned break for primary caretakers (parents or relatives) who are in challenging situations. Trained respite parents or providers assume the duties of caregiving and supervising for a brief period of time in order to allow the caregivers a break. Services include: basic needs (food, clothing, shelter); diagnostically and developmentally age-appropriate supervision; and continuation of services as identified in the treatment plan. Respite can be provided in a home other than the child's own or with a trained respite care provider coming to the home to assume the duties of caregiving and supervision. (Training will include crisis intervention training, CPR, first aid, disability-specific knowledge. Respite may occur for up to 24 days or 576 hours annually, with utilization review and prior authorization required for additional time. Documentation should include CARF, CAFAS or PECAFAS scores indicating the medical necessity of additional respite, a treatment team review and physician's signed approval.

Intensive Home-based Services: A package of services designed to strengthen families and help them avoid unnecessary out-of-home placement of children. Services are provided in the family's home; service response is immediate; a blend of therapeutic and concrete support services are offered, and services are available during non-traditional work hours. Interventions are based on family systems theory and focus on the family as a whole. Service components include clinical evaluation, treatment planning, intensive individual therapy, family therapy, supportive individual and group counseling, behavior management planning and implementation, basic living skills, case management, crisis intervention, and case consultation.

- A. Level I: This level of intervention requires 20 hours or more per month of treatment services provided face-to-face by degreed professional staff with 70% of the treatment provided in the home.
- B. Level II: This level of care is designed as an alternative to residential treatment for children with a confirmed DSM-IV diagnosis who exhibit severe disturbances in emotion and conduct and, as a result, are unable to function in multiple areas of their lives. The focus of treatment is returning the child to an adequate level of functioning. A full array of services, including individual, group and family counseling, psychiatric services, education, recreation, instruction in daily living, and crisis services are provided. Must have capability of 1:1 or 2:1 staffing in situations of danger to self or others.

Case Management: Services to assist youth and their families in accessing and coordinating needed medical, behavioral health, social, educational, and other services at a necessary and appropriate level of intensity to meet service need. The service is distinguished by the following characteristics.

Intensity: provided a minimum of 8 hours per child/family per month.

Independence: service is delivered independent of direct services (i.e., is not part of a home-based services package), but case manager may work for a direct service provider.

Continuity: the case manager is consistent across source of services.

Outpatient Services: Includes crisis intervention services provided at the site of the crisis; screening and referral; diagnostic assessment for youth and families; individual, group and family therapy; other specialized treatment services (e.g., play therapy, art therapy); short-term problem-oriented counseling; life skills enhancement; and medical/psychiatric care.

- A. Crisis Response: Assessment, stabilization and referral provided to an individual or families at a location at the site of the crisis. Twenty-four hour face-to-face capacity required.
- B. Diagnostic Services:
  - 1. Evaluation: A systematic appraisal of a child's functional level in various domains, such as educational, social, family, and psychological to determine the nature and extent of services and treatment which may be required.
  - 2. Medical/Psychiatric Evaluation: A systematic appraisal performed on an outpatient basis in accordance with generally accepted medical practices for the following purposes: specialized medical and/or psychiatric review

of physical symptoms; psychiatric diagnostic evaluation; medical or psychiatric therapeutic evaluation; psychotropic medication evaluation.

C. Treatment Services:

1. Counseling: Regularly scheduled goal-oriented intervention by a competent professional responsive to the needs of the child, for the purposes of assisting the child and family in solving problems related to educational, vocational and social issues.
2. Therapy: Psychological or psychiatric intervention aimed at behavioral, attitudinal or emotional change. Therapy is more treatment-oriented than counseling and is conducted by a professional with clinical training. The three modalities within psychotherapy referred to in this service are individual, family and group therapy.
  - a. Activity Therapy: Therapeutic interventions focused on the development of socialization skills, activities of daily living, appropriate self-expression and leisure awareness designed to improve or preserve the child's level of functioning. These interventions fall into the following categories:
    - (1) Experiential Therapy: Activities, both physically active and passive in nature (e.g., ROPES), designed to assist children in self-expression, social interaction, self-esteem enhancement and entertainment as well as to develop skills and interests leading to enjoyable and constructive use of leisure time. These activities must be planned and supervised by professional recreation therapists but may be conducted by paraprofessional assistants.
    - (2) Expressive/Adjunctive Therapies: Therapeutic activities which are designed and conducted to assist children in self-expression and feelings expression through nonverbal, non-threatening media. These may include modalities such as art, music, dance therapy, etc., which provide opportunities for self-expression and awareness.
  - b. Behavior Management: Interventions employed to change specific dysfunctional behaviors which interfere with the child's ability to function optimally in social, educational, recreational or home settings. Behavior management interventions can be categorized as formal and informal according to the following descriptions:

- (1) Planning: Interventions in which behavioral modification techniques are employed by a clinician to analyze the dysfunctional behavior and to design specific techniques which will reduce or eliminate undesired behaviors. Such planning techniques customarily involve: extended observation of the child's overall functioning for a period of time to properly identify and assess the frequency of dysfunctional behaviors; identifying precipitating factors which cause the behavior to occur, increase or decrease; developing a specific behavior management plan to modify the dysfunctional behavior; instructing paraprofessionals, teachers and family in the application of special techniques; implementing and/or supervising the implementation of the plan and evaluating progress.
  - (2) Implementation: Special strategies used to change, control or manage dysfunctional behavior. Behavior management intervention would be planned and supervised by a mental health professional and implemented by a paraprofessional. Examples might include: one-on-one supervision for a child when placed in a group setting of less intensity than he/she requires, shadowing a "runner," special monitoring, prompting and reinforcing targeted behaviors, temporary crisis intervention support during episodes of acting out while in a community setting.
3. Basic Living Skills Development: Individualized support and structured group activities offered to youth who have basic skill deficits due to such factors as a history of abuse/neglect or years spent in institutional settings which did not allow development of daily living skills. The purpose of the service is to improve or preserve a youth's level of functioning. Services include, but are not limited to, learning and demonstrating personal hygiene skills, parenting skills, social appropriateness, and daily living skills.
  - a. Mentoring Services: A service that provides the opportunity to acquire new social behaviors or alter existing ones by reproducing a distinct response or series of responses that have been demonstrated by a model. The purpose is to assist the child to relate and function more effectively within his/her personal, social, and physical environment. This is accomplished through a structured one-on-one relationship between a child and a role model as they participate in a variety of activities which serve as media for the social learning to occur.

- b. Supported Employment: Specialized employment in a structured and supervised work program for individuals with limited or underdeveloped potential for competitive work in the marketplace. Usually client reimbursements are based upon an approved reduced payment scale.

Outpatient Medical/Psychiatric Care: Medical treatment for physical illness or impairment which is usually provided through a clinic or private physician.

- A. Medical management and monitoring.
- B. Detox.
- C. Direct care.

Source Document for Needs Methodology for Children's Mental Health/Substance Abuse Services Standards

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## APPENDIX B

### Definitions - Alcohol and Substance Abuse Services for Adults

The following definitions are to be used by certificate of need applicants who propose to provide adults with alcohol and drug abuse services and include a list of definitions, a description of each service setting, a description of each service and the utilization percentage of the substance abusing population requiring such services.

#### Low Intensity Outpatient Treatment Services:

- A. Definition: Low intensity outpatient services consist of chemical dependency services occurring at a frequency of six hours or less per week.
- B. Setting: By definition, low intensity outpatient treatment is nonresidential in nature. Settings may range from formal agency settings (e.g., community behavioral health centers) to private practice office settings.
- C. Description: Low intensity outpatient treatment is designed to accommodate the client whose active relationship with substances does not immediately jeopardize any major life areas such as health, relationships, employment, school, or legal status. The low intensity experience provides the needed education, information, insight, practice with recovery tools and techniques, and ongoing evaluation and referral services. These services assist individuals in initiating and maintaining permanent changes in alcohol and/or drug using behavior. Services are provided with regard to least restrictive alternative for those clients who find more intensive services to be a major cause of disruption to financial status, employment status, or ability to meet family obligations.

The programmatic elements of low intensity outpatient treatment generally include a psycho-educational approach along with 12 step work, problem solving, coping skill enhancement, relapse prevention, and ongoing evaluation, referral, and case management services.

- D. Utilization: Percent of substance abusing population requiring such services 30%. (Sources for population need based upon national statistic to the State of WV.)

#### Home/Community-Based Services:

- A. Definition: Home/community based services consist of chemical dependency outpatient services and/or case management services delivered in the client's living environment.

- B. Setting: Most often, these services occur in a client's residence. However, depending upon the individual needs of the client and his or her family or significant others, services may also be delivered in the home of a family member or friend or in such community-based settings as homeless shelters, independent groups homes, or independent living facilities.
- C. Description: Home/community based services are targeted to individuals who are unable to gain access to services provided in traditional milieus such as community behavioral health centers or private offices. These settings may be inaccessible due to a number of factors, including the illness of the client, caretaking responsibilities for other family members, lack of transportation, or residence in a rural area which is located at too great distance from available providers.

Typically, the substance abuse treatment services provided in the home or community-based settings are identical to the low intensity outpatient services described above. Although clients requiring intensive outpatient services may under some circumstances be served in this setting, such would be the exception rather than the rule.

Compared to the "typical" low intensity outpatient client, clients requiring home/community based services may be in greater need of active case management.

- D. Utilization: Percent of substances abusing population requiring such services 10%. (Sources for population need based upon national statistics to the State of WV.)

#### Transitional Living Services:

- A. Definition: Transitional living is a minimally supervised group living situation.
- B. Setting: The service should be provided in a house or apartment complex approved by the Department of Health and Human Resources. Clients live together in small groups, with each individual having his/her own room or apartment or sharing accommodations with other clients. Some facilities serve only males or only females, while others serve both.

Some facilities providing transitional living services are owned and operated by individuals or organizations unaffiliated with substance abuse treatment programs, while others are operated directly by community behavioral health centers which provide a continuum of treatment services.

- C. Description: In the transitional living setting, clients are encouraged to focus on self-directed recovery with minimal treatment support. Residents are involved in daily community-focused activities within an environment that fosters independent living skills. Support and guidance are available from facility staff, and compliance

with house rules is necessary for continued stay. The primary goal of the program is to foster the residents' return to an independent living style while fostering his or her ongoing involvement in recovery systems that can be supportive of long-term successful recovery from addiction.

- D. Utilization: Percent of substance abusing population requiring such services 7%. (Sources for population need based upon national statistic to the State of WV.)

#### Non-Medical Detoxification Services:

- A. Definition: The objective of non-medical detoxification is to help the client safely eliminate the toxic effects of alcohol and/or other drugs from the body in a 24-hour setting while assessing his/her need for medical care. At the same time, this level of care can serve as a non-medical entry point into the treatment system.
- B. Setting: Non-medical detoxification occurs in a non-medical facility. However, the client should have access to medical evaluation and intervention at the earliest evidence of signs and symptoms of severe withdrawal.
- C. Description: The range of service is narrow, targeting simply the intoxicated or incapacitated individual who is medically and psychiatrically stable and who needs to reach a basic state of sobriety. Frequently, non-medical detoxification functions as an entry point to medically monitored residential treatment for clients. Treatment modalities provided within this level of care include monitoring of clients from withdrawal and global assessment. This particular level also provides a period in which intervention and engaging skills can be used to encourage the client's further involvement within the treatment process. If opportunities for further engagement in treatment are to be used effectively during non-medical detoxification, it is important for case management services to be available and for staff to be knowledgeable of appropriate referral sources for the continued treatment of the client.
- D. Utilization: Percent of substance abusing population requiring such services 5%. (Sources for population need based upon national statistic to the State of WV.)

#### Intensive Outpatient Treatment Services:

- A. Definition: This level of care refers to organized and structured treatment services, non-residential in nature, consisting of 2-5 visits per week with 6 to 20 hours of client contact per week. This program is designed to initiate and maintain permanent changes in an individual's alcohol and/or other drug using behavior. It is utilized as an initial treatment option for individuals with adequate support and minimal complications or as a continuation of treatment for those individuals requiring further structured intervention and support.

- B. **Setting:** Intensive outpatient treatment is a term describing day and evening treatment programs which employ an integrated, comprehensive and complementary schedule of therapeutic activities. Intensive outpatient treatment programs may either be free standing or part of a broader mental health or medical facility. Programs may also be a part of education or residential facilities. However, intensive outpatient services should be provided in a separate, identifiable, and organized unit representing a significant part of the treatment continuum.

Clients should have access to medical evaluation and intervention at the earliest signs of withdrawal or other medical complications. Other complementary services should be available to clients as needed.

- C. **Description:** Most intensive outpatient services operate as evening programs with treatment hours ranging from approximately 6 to 20 hours per week. This allows the client to maintain employment, family interaction and other normal activities of daily life.

Intensive outpatient programs are part of the continuum of care and function to provide therapeutically intensive services through active treatment in a coordinated and structured environment. The program may function in one or more of the following ways:

1. As an acute care facility in order to avert an inpatient admission; or
2. As transitional care following inpatient status in order to facilitate return to the community, and to reduce the length of an inpatient stay; or
3. As a more intensive form of outpatient therapy when traditional office visits are not sufficient to meet client needs; or
4. As a therapeutic setting for comprehensive assessment.

There should be a minimum of 6 hours with a maximum of 20 hours a week of scheduled treatment. It should be carried through 2-5 days a week. A minimum of two hours programming per day is ideal. This should be provided at all times.

The program structure should include the following support systems:

1. Availability of medical and other specialized professional consultation and supervision;
2. Direct affiliation with more/less intensive levels of care;

3. Ability to conduct and/or arrange for needed laboratory and toxicology tests;
  4. Ability to obtain psychiatric consultation as indicated.
- D. Utilization: Percent of substance abusing population requiring such services 10%. (Sources for population need based upon national statistic to the State of WV.)

Day Treatment Services:

A. Definition: This level of care refers to organized and structured treatment services, non-residential in nature, consisting of 21 or more hours of client contact per week occurring 4-5 days per week. This program is designed to initiate and maintain permanent changes in an individual's alcohol and/or other drug using behavior. It is utilized as an initial treatment option for individuals with minimal support and moderate complications or as a continuation of treatment for those individuals requiring further structured intervention and support.

B. Setting: Day treatment is a term describing programs which employ an integrated, comprehensive and complementary schedule of therapeutic activities. Day treatment programs may either be free standing or part of a broader mental health or medical facility. Programs may also be a part of educational or residential facilities. However, they should constitute a separate, identifiable, and organized unit representing a significant part of the treatment continuum.

Clients should have access to medical evaluation and intervention at the earliest signs of withdrawal or other medical complications. Other complementary services should be available to clients as needed.

C. Description: Most day treatment programs operate with treatment hours ranging from approximately 21-40 hours per week. This gives the client the opportunity to maintain family interaction and other normal activities of daily life.

Day treatment is part of the continuum of care and functions to provide therapeutically intensive services through active treatment in a coordinated and structured environment. The program may function in the following ways:

1. As an acute care facility in order to avert an inpatient admission; or
2. As transitional care following inpatient status in order to facilitate return to the community, and to reduce the length of an inpatient stay; or

3. As a more intensive form of outpatient therapy when traditional office visits are not sufficient to meet client needs; or
4. As a therapeutic setting for comprehensive assessment.

There should be a minimum of 21 hours with a maximum of 40 hours a week of scheduled treatment, with treatment occurring 4-5 days a week. A minimum of five hours of programming per day is ideal. This should all be done on a pre-determined schedule.

There should be specific written plan for the provision of emergency medical and mental health services. Emergency services should be provided at all times.

The program structure should include the following support systems:

1. Availability of medical and other specialized professional consultation and supervision;
2. If outpatient detoxification is appropriate, physician availability and nursing care an observation are available as warranted based on clinical judgement.
3. Direct affiliation with more/less intensive levels of care;
4. Ability to conduct and/or arrange for needed laboratory and toxicology tests;
5. Ability to obtain psychiatric consultation as indicated.

- D. Utilization: Percent of substance abusing population requiring such services 10%. (Sources for population need based upon national statistic to the State of WV.)

#### Congregate Therapeutic Living Services:

- A. Definition: Congregate therapeutic living services consist of combined outpatient treatment and a group living situation within a supportive living environment. Staff monitoring to facilitate the individual's reintegration into the community is provided, and clients participate in outpatient addiction rehabilitation services.
- B. Setting: Small groups of clients reside together in a house or apartment complex. A client may be assigned an individual room or apartment, or he or she may share accommodations with a roommate. Some residence serve only males or only females, while others serve both.

Most often, the residence is operated and maintained by an agency which also offers outpatient treatment services, thus providing coordination and continuity of care between the therapeutic living and outpatient components of the clients' treatment.

- C. Description: There are many similarities between congregate therapeutic living services and transitional living services (Level 1-III). Both services provide group support, opportunities to participate in self-help groups such as Alcoholics Anonymous and Narcotics Anonymous, assistance with obtaining employment, and linkage with agencies providing ancillary or complementary services.

The primary difference between the two services lies in the relatively greater amount of structured support and professional intervention required by clients at the congregate therapeutic living level. These individuals typically require either intensive outpatient or day treatment services in addition to a structured living environment in order to achieve and maintain abstinence and recovery.

- D. Utilization: Percent of substance abusing population requiring such services 5%. (sources for population need based upon national statistic to the State of WV.)

#### Long-Term Residential Rehabilitation Services:

- A. Definition: Long-term residential rehabilitation services offer 24-hour per day supervised treatment with decreasing intensity of supervision over time. Long term residential treatment combines chemical dependency services and community ancillary services averaging 40 hours of service per week.
- B. Setting: It is cost-effective to provide long-term residential rehabilitation in a free-standing facility rather than a hospital setting, since long-term clients are unlikely to suffer from acute withdrawal symptomology or acute medical/behavior problems which necessitate the extensive medical support available in a hospital. The provision of both short-term and long-term treatment within the same setting offers several advantages. For example, as the long-term client enters the final stages of treatment, he/she may provide peer counseling to short-term program clients. Peer counseling would provide a positive influence on those clients who have difficulty with authority figures. For the long-term clients, such a "mentoring role" would raise self-esteem. For both types of clients, such interaction would further the treatment for isolating behaviors which should be changed in order to provide a positive recovery. Such a combination of short-term and long-term treatment also promotes individualized program tracks.
- C. Description: The most significant characteristic which differentiates the long-term residential program from other levels of care is time. This factor, along with the

highly structured programming provided, allows the individual to maintain abstinence.

The client who requires long-term treatment in many instances also requires vocational rehabilitation. This training would include, for example, how to write a resume that would not reflect long periods of work lapses. A work program would provide the opportunity to instill good work habits and teach skills for positive working relationships. Participation in a work program reinforces the philosophy that the structure of a long-term residential program would decrease over time and increase client choices and responsibilities.

Case management services focus on teaching the client to become self-sufficient in accessing services from outside sources. A strong emphasis should be placed on utilizing half-way houses, intensive outpatient programs, and women's treatment programs as appropriate step-down units from structured treatment programs. Case managers will guide the long-term client, as applicable, to contact aftercare service such as outpatient counseling. The case manager will also interface with the client's continuing care coordinator to ensure continuity and outcome of care.

Long-term treatment can be addressed in a three phases. Again, variable lengths of stay need to be emphasized. For the most part, clients entering long-term treatment need an intensive structured program. The first phase of treatment included addiction education, basic living skills, individual therapy, and intensive group therapy. The second phase increases client responsibility and focus on vocational aspects of rehabilitation. Phase III increases work program hours and focus on peer counseling and increased independence, with clients being encouraged to take overnight passes. The program schedule for all three phases would allow for individualized program tracks such as anger, management, relapse prevention, etc. Depending upon their individual needs, clients could be discharged at Phase II or Phase III.

Although group therapy is the preferred modality in substance abuse treatment, it is most beneficial in individual therapy is included as well. Individual therapy gives clients an opportunity to raise certain sensitive and embarrassing issues before addressing them in a group setting. The individual sessions would them be greater in number in the earlier stages of treatment and would decrease over time. Family therapy would be offered on the weekends. Multiple family therapy and educational groups would be utilized.

- D. Utilization: Percent of substance abusing population requiring such services 10%. (Sources for population need based upon national statistic to the State of WV.)

## Medically Monitored Inpatient/Residential Treatment Services:

- A. Definition: Medically monitored inpatient/residential treatment services consist of 24-hour pre day supervised care, with 50 or more hours of substance abuse treatment services provided per week. The client's medical condition is such that a physical examination by a physician is required within 72 hours of admission.
- B. Setting: Medically monitored inpatient/residential treatment services may be based wither in a free-standing appropriately licensed health care facility or a specialty unit within a general or psychiatric hospital or other licensed facility. Clients served at this level of care require a secure environment, providing 24 hour nursing support and medical consultation.

Programs providing medically monitored residential care should be responsive to the special needs of physically challenged clients. Facilities should be accessible to nonambulatory individuals so that all clients can participate fully in all programming. Programs should have the capability, either directly or through contract with other agencies, to adapt treatment services to address the needs of special populations such as the deaf or hearing impaired. Also, depending upon the client's level of intellectual functioning, additional assistance with understanding the concept of recovery from addiction may be needed.

- C. Description: This level of care provides daily treatment services based upon the individual needs of the client. This includes the availability of medical, individual, and group services. Multi-disciplinary individualized assessments and a treatment plan based on the this assessment are provided. Therapy, either within an individual or group setting, is conducted. Also, health education programming is offered, as well as clinical program activities designed to increase the client's knowledge and insight regarding addiction. In recognition of the important role played by families and significant others in the client's recovery, family therapy and codependency sessions are provided.

Continuing care following a client's discharge from this level depends upon the coordination of services facilitated by the continuing care coordinator. All services should be in close physical proximity to increase the likelihood that aftercare/relapse prevention services will be used. Participation in such services, in turn, increases the likelihood of continued recovery. If a client relapses, then the assessment skill s of the continuing care and the client can be assigned to the appropriate level of care. The temptation of the referral source to give false, misleading or inaccurate information just to the facility providing this level of care will admit the client should be avoided so that the proper level of care is offered based upon the client's individual needs.

- D. Utilization: Percent of substance abusing population requiring such services 7%. (Sources for population need based upon national statistic to the State of WV.)

Medically Managed Acute Inpatient Treatment:

- A. Definition: Medically managed acute inpatient treatment consists of substance abuse treatment services delivered in a 24-hour acute inpatient hospital setting. The medical condition of acute inpatient clients is such that they require physical examinations within 24 hours of admission, and medical management and/or skilled nursing care is required on a 24 hour basis. Unlike the typical medically monitored inpatient/residential setting, the acute inpatient setting is under the direction of a physician, and intensive efforts are directed toward managing and stabilizing medical conditions which may complicate the provision of substance abuse treatment services.
- B. Setting: Medically managed acute inpatient treatment occurs in a hospital setting. Services are most appropriately provided in a unit which is discrete from other units within the hospital, including acute psychiatric units.
- C. Description: The substance abuse treatment offered within the acute inpatient setting is very similar to that offered in the medically monitored short-term inpatient/residential setting. Each client undergoes an individualized assessment, and a comprehensive treatment plan based upon that assessment is developed. Individual therapy and group therapy are provided, along with related services such as recreation therapy. An internal case manager coordinates with the individual's continuing care coordinator to identify and secure the services needed by the client following discharge from the acute inpatient setting.
- D. Utilization: Percent of substance abusing population requiring such services 3%. (Sources for population need based upon national statistic to the State of WV.)

Medically Managed Detoxification Services:

- A. Definition: Medically managed detoxification services consist of services offered within an acute care hospital setting designed for the client with the medical conditions warranting a physical examination by a physician within 24 hours of admission. This setting provided 24 hour medical management of detoxification services.
- B. Setting: Medically managed detoxification may occur in any licensed acute care setting with intensive medical services and a defined detoxification unit. Such a setting needs to be capable of providing services aimed at alleviating acute emotional/behavioral/physical distress resulting from addiction. Life support care must also be available. This acute service is often provided as a regiment prior

to medically managed inpatient residential treatment services within a general or acute care hospital setting.

- C. Description: This level of care provides treatment approaches which include daily clinical management to provide highly individualized physical/emotional/behavioral detoxification protocol of an acute nature for life threatening symptomology. A comprehensive biosocial assessment of the client and the nature/intensity, duration and tolerance level is begun upon admission. A comprehensive nursing assessment is conducted upon admission. Detoxification protocols are established upon individual need.

In most cases, this type of care would precede Medically Managed Acute Inpatient Treatment Services or Medically Monitored Inpatient/Residential Treatment Services.

- D. Utilization: Percent of substance abusing population requiring such services 3%. (Sources for population need based upon national statistic to the State of WV.)

## APPENDIX C

### New Hampshire Status of Mental Health Services

A recent study mandated by the New Hampshire Legislature (1995) reports the following status of mental health services in that state.

1. "The State of New Hampshire is poised on the brink of a massive increase in the need for public services for the elderly.
2. Between the years 1990 and 2015, the elderly population in New Hampshire is expected to increase by more than 80%.
3. The percentage of elderly who are mentally ill and receiving public support has been increasing faster than the elderly population in general.
4. The number of individuals with Alzheimer's disease, not formally seen as mentally ill, has been increasing at a rapid pace, and 30-40% have major psychiatric symptoms such as depression, delusions, and hallucinations, with service demands and care needs that are similar to the elderly mentally ill.
5. Demographic trends give NH less than five (5) years to prepare for this inevitable and unprecedented need for elderly services of all kinds before service demands escalate".

The New Hampshire study identified five "serious gaps" in the provision of direct mental health services to the elderly. These gaps are in the areas of:

1. Psychiatric nursing---only 32% of the hours of needed service are being provided.
2. Family Services--to support those caring for the elderly.
3. Counseling Services--including individual, group and family counseling.
4. Partial Hospitalization--where most are receiving the service who need it, but more services are needed for those receiving them. NOTE: We could not make this statement in WV where practically no specialty partial hospitalization programs exist for the elderly mentally ill.
5. Substance Abuse Treatment--where twice as many need the service and they need almost three times as much service as they are getting.

Other gaps include:

1. A significant gap in the quantity of home health services.
2. Gaps in the availability of day care and recreational opportunities, meals and transportation services, and physical therapy.

The following recommendations were made:

1. To correct the imbalance in available residential settings. Most elderly mentally ill patients live in institutions or group home, similar to the distribution of living arrangements for elderly West Virginians with a mental illness. The NH report recommends decreasing the reliance on the most intensive levels of care in favor of less restrictive settings such as group homes or supported residential care coupled with day treatment, elderly day care, partial hospitalization and home care options.
2. To develop community-based alternatives. These services would include home-based mental health services and skilled psychiatric nursing care. Emphasized are the development of integrated systems of care that create collaborative relationships between home-health providers and mental health centers. Also stressed as a needed community based service were specialized partial

hospitalization or rehabilitation programs. These services should, according to the report, "emphasize community living skills and adult day care options to help support elderly in the community, as a preferred alternative by many consumers to residing in a nursing facility".

3. Development of need-based support services to family members caring for the elderly mentally ill.
4. Development of a statewide training program for front-line health care workers.
5. Improvement in existing pilot programs that stress educational and community outreach to address the issue of under utilization of mental health services by the elderly living in the community.
6. Development of mental health services for severe behavioral and psychiatric disorders in Alzheimer's and other brain disorders in the elderly.
7. Development of a coordinated service delivery system. Such interagency activity should include at least the development of "immediate and long-term solutions in defining levels of need and eligibility, access to care, coordination and provision of care, sharing of financial responsibility and funding".
8. The development of standardized information and outcomes assessment in implementing model programs.
9. Closing existing information gaps in the areas of:
  - a. Longitudinal follow-up of the current study sample.
  - b. Study of family preferences and abilities in care-giving.
  - c. An examination of home and community-based delivery options.
  - d. The service needs of elderly with Alzheimer's and other related disorders complicated by severe problem behaviors.