

Discharge/Transfer Service Criteria (ASAM Criteria) (cont.)

4. Has experienced intensification of his or her problem(s), or has developed new problem(s), and can be treated effectively only at a more intensive level of care

(The ASAM Criteria, 2013, p.303)



A Word About Terminology

Treatment Compliance vs Adherence

Webster's Dictionary defines:

- ▶ “comply”: to act in accordance with another's wishes, or with rules and regulations
- ▶ “adhere”: to cling, cleave (to be steadfast, hold fast), stick fast

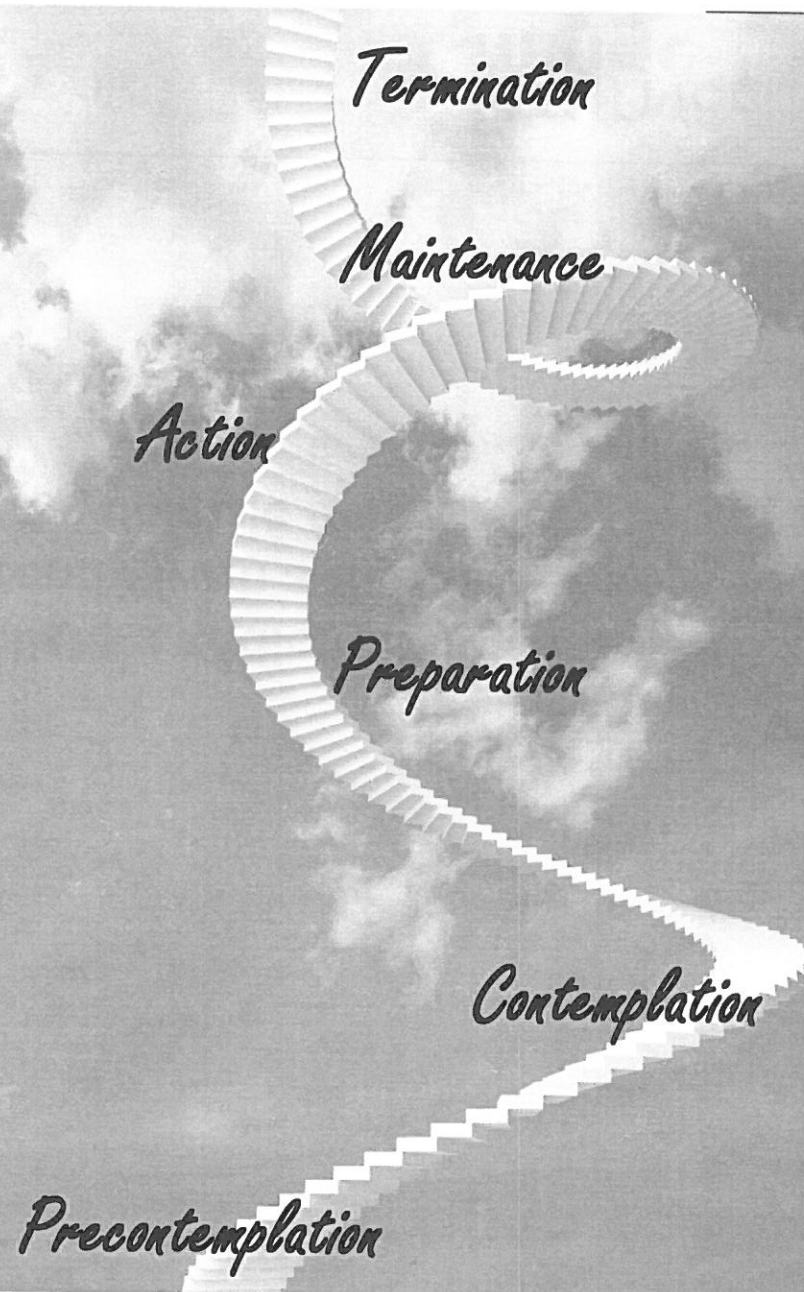


Models of Stages of Change

- ▶ 12-Step model - surrender versus comply; accept versus admit; identify versus compare
- ▶ Transtheoretical Model of Change - Pre-contemplation; Contemplation; Preparation; Action; Maintenance; Relapse and Recycling; Termination
- ▶ Readiness to Change - not ready, unsure, ready, trying, doing what works

The Spiral of Change

Transtheoretical Model of Change
James Prochaska, PhD, John Norcross,
PhD, and Carlo DiClemente, PhD



POLL QUESTION #3



True or False?:

A flare-up or relapse of a client's addiction illness should be treated no differently from a flare-up of a person's mental illness or psychiatric diagnosis.

Revised Constructs for Dim. 5

- A. Historical Pattern of Use or Mental Health Problems
 - 1. Chronicity of Problem Use or MH problems
 - 2. Treatment or Change Response

- B. Pharmacologic Responsivity
 - 3. Positive Reinforcement (pleasure, euphoria)
 - 4. Negative Reinforcement (withdrawal discomfort, fear) (The ASAM Criteria, 2013, pp..403 - 407)



Revised Constructs for Dim. 5 (cont.)

- C. External Stimuli Responsivity
 - 5. Reactivity to Acute Cues (trigger objects and situations)
 - 6. Reactivity to Chronic Stress (positive and negative stressors)

- D. Cognitive and behavioral measures of strengths and weaknesses
 - 7. Locus of control and Self-efficacy

(The ASAM Criteria, 2013, pp..403 - 407)

Revised Constructs for Dim. 5 (cont.)

- D. Cognitive and behavioral measures of strengths and weaknesses (cont.)
- 8. Coping Skills (stimulus control, other cognitive strategies)
 - 9. Impulsivity (risk-taking, thrill-seeking)
 - 10. Passive and passive/aggressive behavior

(The ASAM Criteria, 2013, pp. 403-407)



Recovery and Psychosocial Crises

- ▶ Slips/using substances while in treatment
- ▶ Suicidal – impulsive or wanting to use
- ▶ Loss or death – cravings or impulsive
- ▶ Disagreements, anger, frustration with fellow clients or therapist

(The ASAM Criteria, 2013, pp.407 - 409)

Policy and Procedure



Implements principle of re-assessment and modification of treatment plan:

1. Face to face or telephone appointment ASAP
2. Attitude of acceptance; listen for patient's point of view, rather than lecture, enforce "program rules"; or dismiss their perspective
3. Assess safety and immediate needs in all six ASAM assessment dimensions

(The ASAM Criteria, 2013, pp.407 - 409)

ASAM Six Assessment Dimensions

1. Acute Intoxication and/or Withdrawal Potential
2. Biomedical Conditions and Complications
3. Emotional, Behavioral or Cognitive Conditions and Complications
4. Readiness to Change
5. Relapse/Continued Use, Continued Problem Potential
6. Recovery Environment

The ASAM Criteria (2013) Pages 43-53

Policy and Procedure (cont.)

4. Discuss circumstances surrounding the crisis, develop a sequence of events/precipitants
5. Modify participatory treatment plan to address new or updated problems
6. Reassess treatment contract and what patient wants if any lack of interest in modifying Tx. Plan
7. Determine if modified strategies need same level of care; or more or less intense level

(The ASAM Criteria, 2013, pp.407 - 409)

Policy and Procedure (cont.)

8. If patient recognizes the problem/s; understands need to change, but still chooses no further treatment, then discharge
9. If patient is invested in treatment, then Tx continues
10. Document crisis and modified treatment plan or discharge in the medical record

(The ASAM Criteria, 2013, pp.407 - 409)

Case Presentation Format

Before presenting the case, please state why you chose the case and what you want to get from the discussion

I. Identifying Client Background Data

- ▶ Name
- ▶ Age
- ▶ Ethnicity and Gender
- ▶ Marital Status
- ▶ Employment Status
- ▶ Referral Source
- ▶ Date Entered Treatment
- ▶ Level of Service Client Entered Treatment
- ▶ Current Level of Service (if case presented for Tx. Plan review)
- ▶ DSM Diagnoses
- ▶ Stated or Identified Motivation for Treatment

(The ASAM Criteria, 2013, p.125)

ASAM Six Assessment Dimensions

1. Acute Intoxication and/or Withdrawal Potentia
2. Biomedical Conditions and Complications
3. Emotional, Behavioral or Cognitive Conditions and Complications
4. Readiness to Change
5. Relapse/Continued Use, Continued Problem Potential
6. Recovery Environment

The ASAM Criteria (2013) Pages 43-53

Case Presentation Format (cont.)

First state how severe you think each assessment dimension is and why (focus on brief relevant history information and relevant here and now information):

II. Current Placement Dimension Rating Has It Changed?

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.

(Brief explanation for each rating, note whether it has changed since client entered treatment -why or why not)

(The ASAM Criteria, 2013, p.125)

Case Presentation Format (cont.)



III. What problem(s) with High and Medium severity rating are of greatest concern at this time?

- ▶ Specificity of the problem
- ▶ Specificity of the strategies/interventions
- ▶ Efficiency of the intervention (Least intensive, but safe, level of service)

(The ASAM Criteria, 2013, p.125)

Criminal Justice's View of Presenting Problem and Solution

3 C's
Consequences
Compliance
Control

Coerced Clients and Working with Referral Sources

- ▶ Common purpose and mission
- ▶ Common language of assessment of stage of change
- ▶ Consensus philosophy of addressing readiness to change
- ▶ Consensus on how to combine resources and leverage to effect change, responsibility and accountability
- ▶ Communication and conflict resolution

Working Effectively with Managed Care

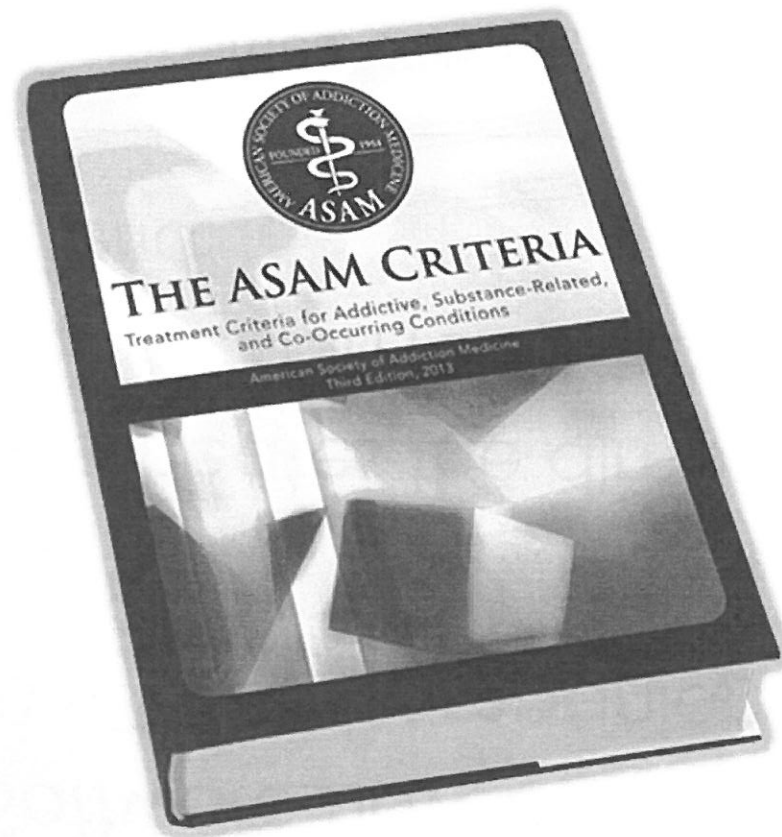
- ▶ Clinical discussion, not game playing - Improve communication between consumers, clinicians, providers payers, managed care, utilization reviewers, care managers
- ▶ Use Case Presentation Format to concisely review biopsychosocial data and focus the discussion
- ▶ Follow through Decision Tree on How to Organize Assessment Data to guide clinical discussion
- ▶ Identify where points of disagreement are: severity rating; priority dimension or focus of treatment; service needs; dose and intensity of services; placement level

(The ASAM Criteria, 2013, pp. 119 - 126)

Working Effectively with Managed Care (cont.)

- ▶ Offer alternative clinical data: severity rating and rationale; priority dimension or focus of treatment; service needed; dose and intensity of services; placement level
- ▶ Appeal if still no consensus

(The ASAM Criteria, 2013, pp. 119 - 126)



 The Change Companies®

Train for
Change



The ASAM Criteria Software
now branded as
Continuum™

- ▶ *The ASAM Criteria* book and *The ASAM Criteria Software* now branded as *Continuum™* are companion text and application
- ▶ The text delineates the dimensions, levels of care, and decision rules that comprise *The ASAM Criteria*

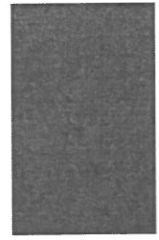
The ASAM Criteria Software now branded as

- ▶ The software provides an approved structured interview to guide adult assessment and calculate the complex decision tree to yield suggested levels of care, which are verified through the text

www.asamcontinuum.org

David Gastfriend, M.D. gastfriend@gmail.com

Brendan McEntee bmcentee@asam.org



Data to Identify Gaps

- ▶ Systems issues cannot change quickly. Each incident of inefficient or inadequate care can be a data point that promotes systems change
- ▶ Finding efficient ways to gather data as it happens in daily care of clients can provide hope, direction for change

(The ASAM Criteria, 2013, p. 126)

Data to Identify Gaps (cont.)



PLACEMENT SUMMARY

Level of Care/Service Indicated	
Level of Care/Service Received	

(The ASAM Criteria, 2013, p. 126)

Data to Identify Gaps (cont.)



PLACEMENT SUMMARY

Reason for Difference - Circle only one number -- 1. Level of care or Service not available; 2. Provider judgment; 3. Client preference; 4. Client is on waiting list for appropriate level/service; 5. Level of care or Service available, but no payment source; 6. Geographic inaccessibility etc.

(The ASAM Criteria, 2013, p. 126)

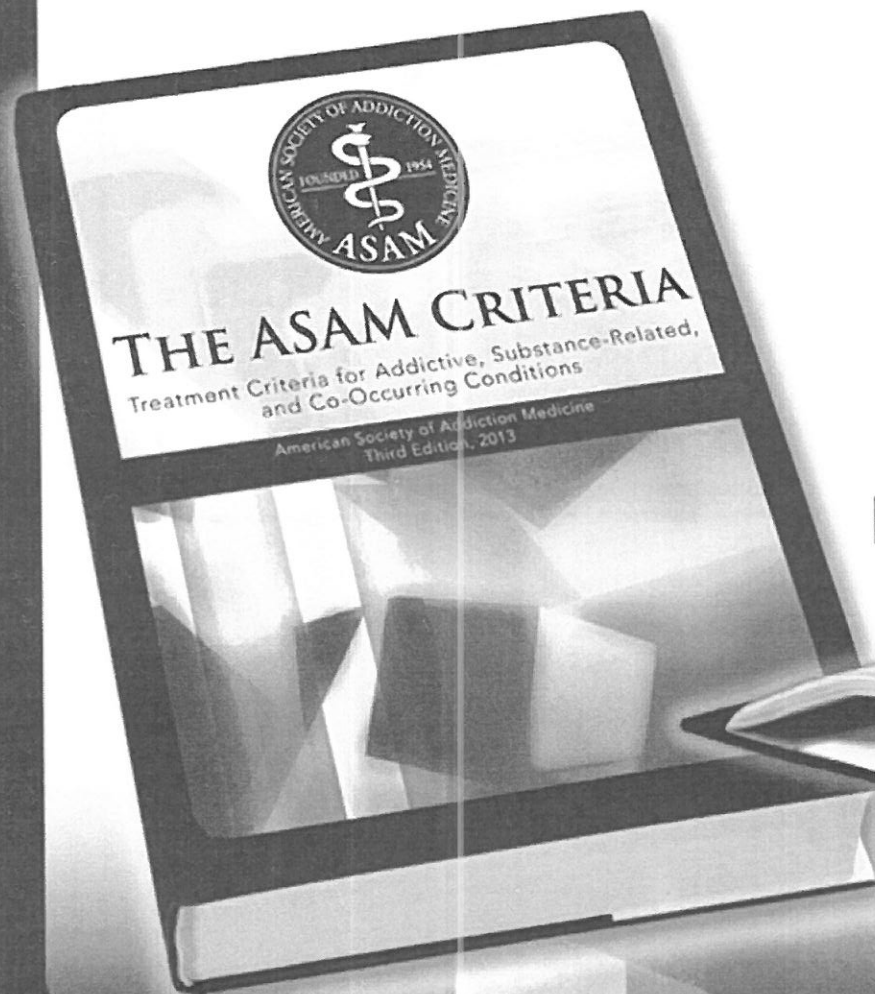
Data to Identify Gaps (cont.)

PLACEMENT SUMMARY

Anticipated Outcome If Service Cannot Be Provided- Circle only one number -- 1. Admitted to acute care setting; 2. Discharged to street; 3. Continued stay in acute care facility; 4. Incarcerated; 5. Client will dropout until next crisis; 6. Not listed (Specify):

(The ASAM Criteria, 2013, p. 126)

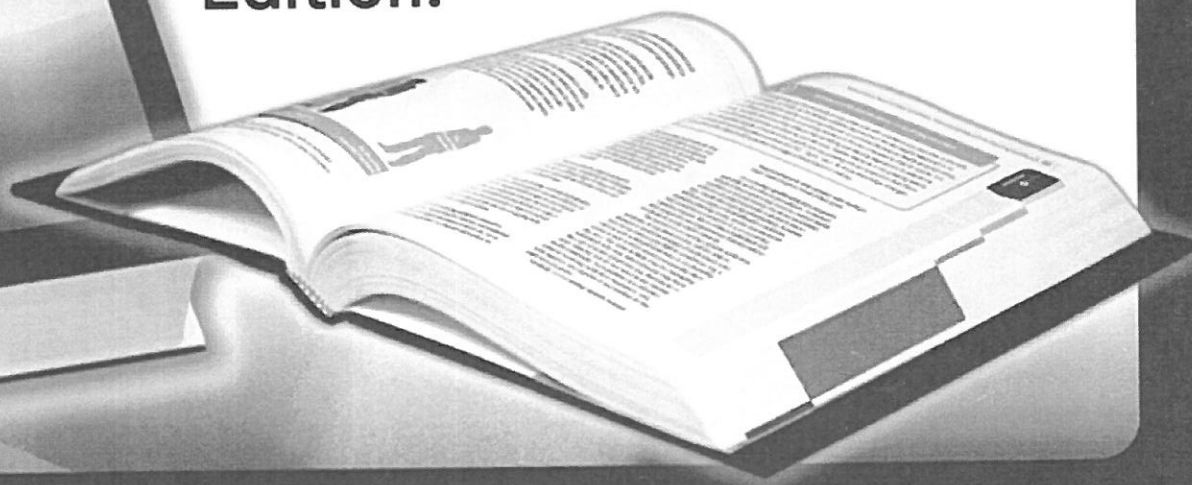
THE ASAM CRITERIA



Now Available

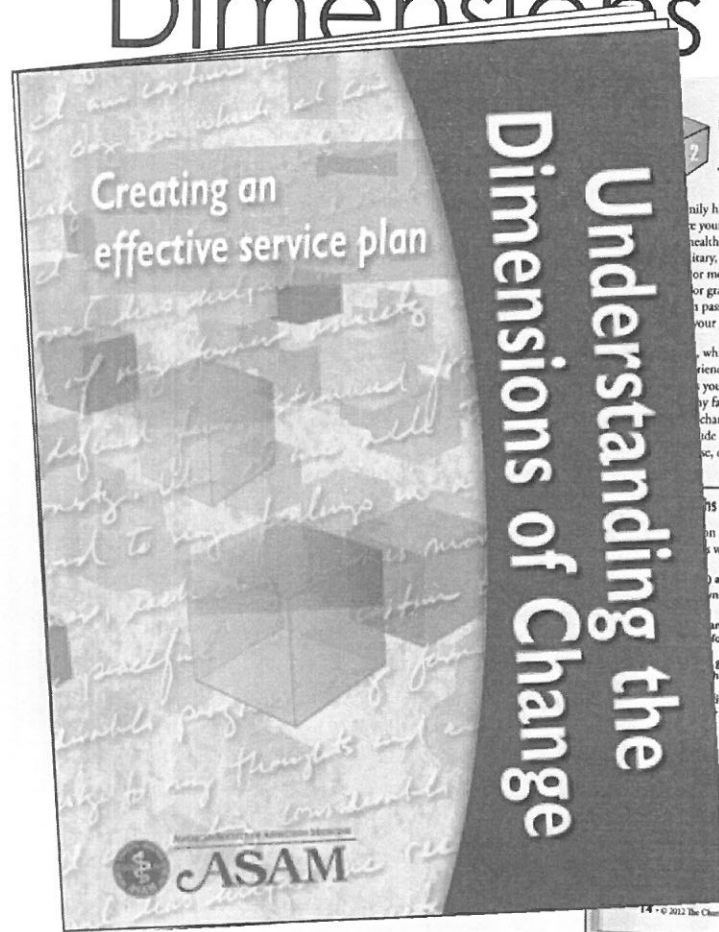
Order Today!

**New
Edition!**



ASAMCRITERIA.ORG

Understanding the Dimensions of Change



Dimension 2: Biomedical Conditions/Complications *Family history and healthy practices*

Family history may also affect your physical health. Health conditions can be hereditary, meaning that a genetic or medical concern from a parent or grandparent might be passed down to you through your genes.

While you may never experience any physical health issues yourself, you will want to discuss any family health issues with your change team. These include a family history of heart disease, cancer or diabetes.

List any physical or medical conditions you are aware of in your family.

Are there any other physical concerns you are worried about? yes no... If yes, please explain.

Strengths for Living a Healthy Lifestyle

In addition to any physical or medical challenges you may face, there are strengths you possess in this area that will help you succeed. List all of the things you do to maintain a healthy lifestyle. Use the blank spaces to add some more to the list. These strengths will help you throughout your change efforts.

Make an effort to eat healthy foods

Get enough sleep at night

Exercise by playing sports regularly

I have a structured workout routine I follow

I don't get sick very often

If I notice a physical or medical problem, I take steps to make it better

I can take care of my physical needs without help from others

I schedule regular medical check-ups for myself

When a health concern arises, I can tolerate or cope with it without too much discomfort

Dimension 2: Biomedical Conditions/Complications *Review with your change team*

Use the space below to describe what you feel is most important about your health and physical condition. Then, share this information with your change team to come up with some strategies and solutions you can use to create an effective service plan. If you and your change team decide this is not a life area that needs to be addressed in your service plan at this time, check the box below and move on to page 16.

I have discussed this life area with a member of my change team and we have agreed that it will not affect my service plan.

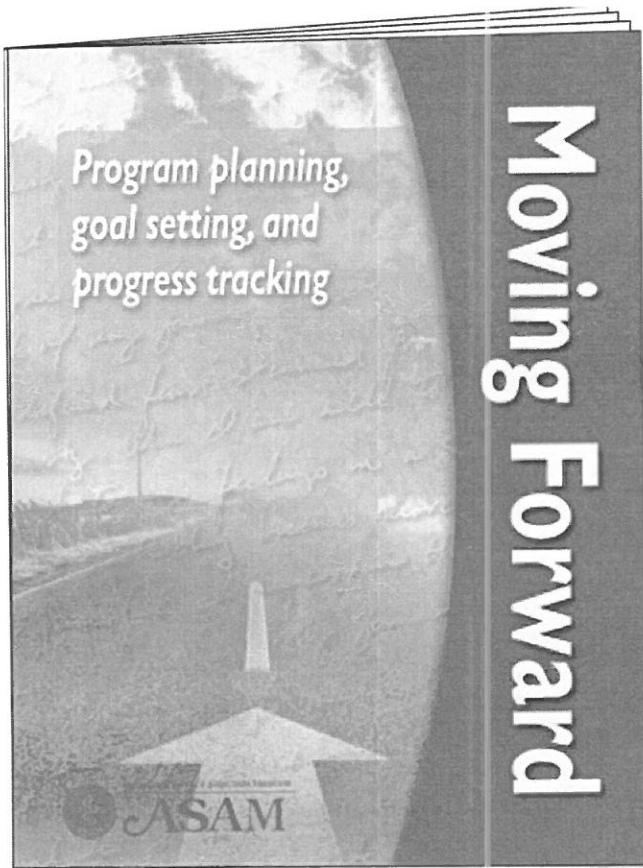
Think about your responses on pages 12-14. What are some of the biggest concerns or challenges you have faced with your physical health? How did you deal with them?

Now think about the times in your life when you were feeling physically healthy. What things were you doing at these times that helped maintain your physical health?

You already may have some strategies and solutions in place for keeping yourself healthy. List these below and make sure to share them with your change team.

These are the strategies my change team and I have developed to address my needs with my health and physical condition:

Name _____ Date _____ Staff Initials _____



Moving Forward Participant Journal



Setting effective program goals

You will be better prepared to make progress if you take your ideas about what you want to work on and turn them into goals for your time in this program. Your program goals are what you will use to measure how close you are getting to what you want.

And for each of your program goals, there is action to be taken. This action

often takes the form of learning, trying or practicing something that brings you closer to the goal.

You will set several action steps for each program goal. As you start to accomplish these steps, you may decide to set even more for yourself. Over time, these little steps will add up to equal big results!

On the following pages, you will set your first three goals to work on within this program. Make sure each goal has clear action steps and is something you can get your ARMS around.

A Your goals should be **ACHIEVABLE** – things that are possible and realistic. They don't have to be easy, it's okay for your goals to be challenging. Just make them doable.

R Your goals should be **REWARDING** – things you want that would make life better for you or others. When possible, state your goals as things you want to increase, improve, create or strengthen.

M Your goals should be **MEASURABLE** – changes that you and others can observe. How will you know that you are making progress toward them?

S Your goals should be **SPECIFIC** – General goals like, "I want to be a better person," aren't clear enough to work on. For a longer-term change project, decide on the steps you want to take.

Your first program goal

On the next three pages you will work with your change team to record your program goals. You and your change team will use what you both have learned so far to create goals that are both important and unique to you. Be sure your program goals are Achievable, Rewarding, Measurable and Specific.

My first program goal:

Date set:

Circle the life areas this program goal is related to.



My reasons for setting this goal are:

This goal will help me move toward getting what I want. Yes No

These are the strengths, skills and resources I will rely on:

Here are a few of the specific action steps I am working on taking to achieve this goal:

- 1) _____
- 2) _____
- 3) _____
- 4) _____
- 5) _____

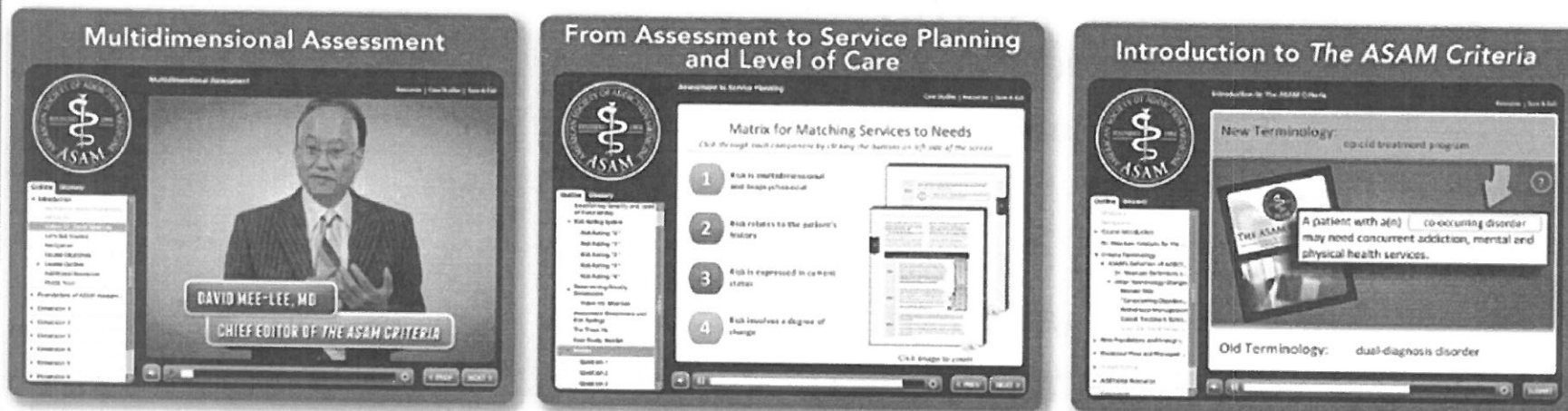
Signature:

Change team initials:

THE ASAM CRITERIA

 The Change Companies®

ASAM Series eTraining Courses



A cost-effective, flexible, interactive and engaging solution for standardizing training.

More info and course samples at:

ASAMCRITERIA.ORG



**David Mee-Lee, M.D.
Senior Vice President
The Change Companies
Carson City, NV
Davis, CA**

davidmeelee@gmail.com
www.changecompanies.net
www.ASAMCriteria.org
www.asamcontinuum.org
www.tipsntopics.com
www.instituteforwellness.com

 **The Change Companies®**

**Train for
Change**

ASAM guide

0 no problem stable; 1 low , 2 moderate; 3 significant ; 4 severe

For outpatient there will never be a 3 or more on dimension 1, 2 and 3

For detox on dimension 1, 2 and 3 needs to be more than 3 but a all 4 will require hospital clearance

A scale of 0 means client does not need any services from us.

	Dimension 1 Acute Intoxication and/or Withdrawal Potential	Dimension 2 Bio-Medical Conditions and Complications:	Dimension 3 Emotional, Behavioral or Cognitive Conditions and Complications	Dimension 4 Readiness to Change:	Dimension 5 Relapse, Continued Use or Continued Problem Potential:	Dimension 6
Outpatient Level I	Scale 0 or 1	Scale 0, 1 or 2	Scale 0; 1 or 2	Scale 0, 1 or 2	Scale 0, 1 or 2	Scale 0. 1 or 2
Saiop level II.1	1 to 2	0,1,2	0.1.2	3 or 4	3 to 4	3 to 4
Sacot/partial hospitaliation level II.5	2	2	2	4 or 4b	4 or 4b	4 or 4b
Detox III.1 clinically managed low intensity residential services III.3 clinically managed popultation	3-4 (er)	3	3	4b	4b	4b

specific high intensity residential services						
III.5 clinically managed high intensity residential services						
Level III.7 → 3.7- Medically-Monitored intensive Inpatient Treatment	4	4	4			

Dimension 1

Withdrawals scales

Clinical Opiate Withdrawal scale

NARCOTIC ASSESSMENT CINA SCALE FOR WITHDRAWAL

Clinical Institute Withdrawal Assessment of Alcohol Scale, Revised (CIWA-Ar)

Include PAWS as well for outpatient clients

Dimension 2

Bio-Medical Conditions and Complications:

Any medical information – past conditions , present conditions, past surgeries , present symptoms , medical diagnosis , medical concerns such as high blood pressure if client on stimulants – Clinical observations such as weight of person, teeth damage , TBI history , seizure history , medications, sleep disturbances; STD, hiv, tb and hep c screenings ; referrals

Dimension 3 Emotional, Behavioral or Cognitive Conditions and Complications

Co- occurring disorders, present and past diagnosis , medications, symptoms client is describing, symptoms client is struggling . Stabilization status , medication compliance , referrals -

Dimension 4 Readiness to Change –

Client past treatment – client referral source - client prognosis – client motivation to enter or stay in treatment – support systems – agencies involved with client – access to care; barrier to care ; support from family and professionals - stage of change that client is at ; consequences client has experienced

Dimension 5 Relapse, Continued Use or Continued Problem Potential:

Client 's relapse history ; client stressors ; client high risk areas; reason why treatment will help with preventing relapse ; why will structure and level of care recommended will help client avoid relapse ;

Dimension 6: Recovery Environment:

Present environment , how can environment be improved ; community resources and peer support services that will help client., support of client . history of client's environment and barrier to care and treatment ; how will service provided will help improve client's environment . referral sources , referrals to community support and other resources for client

LOCUS Training Documents
Supplemental documentation
for staff training for ACUITY
level service appropriateness.

LOCUS

LEVEL OF CARE UTILIZATION SYSTEM FOR PSYCHIATRIC AND ADDICTION SERVICES

Adult Version 20

AMERICAN ASSOCIATION
OF COMMUNITY PSYCHIATRISTS



December 2016

© 1996-2016 American Association of Community Psychiatrists

THIS INSTRUMENT IS PROTECTED BY FEDERAL COPYRIGHT LAW. You may photocopy and use this instrument in this original form. The sole permitted electronic use and/or storage of this instrument is an unmodified, read-only image of the original paper document in “PDF” (Portable Document Format). The PDF can be downloaded from <http://www.communitypsychiatry.org> . You are not permitted to change the instrument in any manner including electronic modifications. You may not store the instrument except as an unmodified PDF file as posted at the above website. You may not change or store the instrument in spreadsheet, database, word processing or other file formats and/or programs. All electronic rights to this instrument are owned by Deerfield Behavioral Health, Inc. More information about electronic/software versions of the instrument can be obtained by contacting Deerfield Behavioral Health, Inc., at <http://www.dbhn.com/locus.html> .



CONTENTS

Introduction 2

Instructions 6

Evaluation Parameters for Assessment of Service Needs 9

Level of Care Definitions and Utilization Criteria 20

Level of Care Determination Decision Tree 32

Level of Care Determination Grid 34

Appendix 1: LOCUS Supplementary Criteria for Residential Placement 35

Appendix 2: Proposed LOCUS Guidelines for Meeting Primary Care Needs 39

Appendix 3: LOCUS Worksheet 43



INTRODUCTION TO ADULT VERSION 20

Since the arrival of managed care programs and principles, the use of quantifiable measures to guide assessment, level of care placement decisions, continued stay criteria, and clinical outcomes has been increasingly important. Until the development of LOCUS twenty years ago, there had been no widely accepted standards to meet those needs. LOCUS, which is now used extensively in 26 states and in several locations internationally, has provided a single instrument that can be used for these functions in diverse settings and systems. Integrating behavioral health and physical health concerns, it provides a common language and set of standards with which to make such judgements and recommendations. Clinicians now have an instrument, which is simple, easy to understand and use, but also meaningful and sufficiently sensitive to distinguish appropriate needs and services. It provides clear, reliable, and consistent measures that are relevant for making decisions related to care and quality improvement.

LOCUS has four main objectives. The first is to provide a system for assessment of service needs for adult clients, based on six evaluation parameters. The second is to describe a continuum of service intensities, which are characterized by the amount and scope of resources available at each “level” of care, in each of four categories of service. The third is to create a methodology for quantifying the assessment of service needs to permit reliable determinations for placement in the service continuum. The fourth is to facilitate clinical management and documentation.

This system is a dynamic one, and it has evolved over the years of its development. Since its inception, LOCUS has included content related to recovery status, stage of change, and choice. Its simple style and structure has invited use not only by a variety of clinicians with various levels of training, but by service users themselves, allowing assessment to become a collaborative process. Engagement in this collaboration is central to person centered treatment planning. We continue to encourage collaboration between the clinician and the person being assessed whenever this is possible, and language adjustments have been made to accommodate that process. With this new revision of LOCUS we have:

- Expanded level of care descriptions
- Provided additional guidance for medical necessity determination and resource management
- Added an appendix with descriptions of subdivisions of residential levels of care
- Added an appendix with proposed guidelines for selecting appropriate primary care programs for LOCUS assessed clients
- Included a LOCUS worksheet to facilitate the quantification and documentation of ratings

As systems develop services and processes to improve the quality of care they provide, these additions will allow LOCUS to be an even more powerful tool to assist these transformations.

One of the most important changes in the current edition of LOCUS is an expanded elaboration of “integration” in light of the progress that has been made in designing and delivering integrated services in the last decade. Just as the previous edition incorporated the ongoing evolution of recovery oriented practice into the language and content of LOCUS, this edition does the same for the evolving development of integrated practice and programming for individuals and families with complex and co-occurring needs. LOCUS (in Dimension III) has always factored in the impact of

co-morbid conditions to help determine the appropriate “level of care”. In this edition we emphasize that co-morbidity, both co-occurring mental health/substance use conditions, and co-occurring health and behavioral health conditions should be an expectation, not an exception, in all programs at all levels of care. Therefore all level of care descriptions include a statement that indicates the need to meet this expectation and that “integrated care” should be included in the design of programs at all levels of care and in all settings. LOCUS encourages the vision that all services should be recovery oriented and “co-occurring capable”. This means they should be able to provide appropriately matched integrated services individuals with co-occurring mental health and substance use conditions, and “capable” in their ability to provide and coordinate appropriate attention to health and wellness issues to people with co-occurring behavioral health and health needs. These changes in level of care program descriptions do not affect the rating system itself. The extensive use of LOCUS and the satisfaction users have had with its recommendations have established its validity. As a result, there are no significant changes to the content of the rating dimensions from Version 2010, so reliability and validity testing results will not be affected.

The instrument continues to demonstrate multiple potential uses:

At the individual client level:

- To assess immediate service needs (e.g., for clients in crisis)
- To monitor the course of recovery and service needs over time
- To provide valid, value driven guidance to payers for “medical necessity criteria” the application of which will better meet the needs of client’s in real world systems
- To inform treatment planning processes

At the system or population level:

- To plan system level resource needs for complex populations over time and help identify deficits in the service array
- To assist in the development of bundled payments or case rates for episodes of care for specific clinical conditions
- To provide a framework for a comprehensive system of clinical management and documentation
- To facilitate communication between systems of care regarding service intensity needs

As with previous versions, the current document is divided into three sections. The first section defines six evaluation parameters or dimensions: 1) Risk of Harm; 2) Functional Status; 3) Medical, Addictive and Psychiatric Co-Morbidity; 4) Recovery Environment; 5) Treatment and Recovery History; and 6) Engagement and Recovery Status. A five-point scale is constructed for each dimension and the criteria for assigning a given rating or score in that dimension are elaborated. In Dimension IV, two subscales are defined, while all other dimensions contain only one scale.

The second section of the document defines six “levels of care” in the service continuum in terms of four variables: 1) Care Environment, 2) Clinical Services, 3) Support Services, and 4) Crisis Resolution and Prevention Services. The term “level” is used for simplicity, but it is not our intention to imply that the service arrays are static or linear. Rather, each level describes a flexible or variable combination of specific service types and might more accurately be said to describe

levels of resource intensity. The particulars of program development are left to providers to determine based on local circumstances and outcome evaluations. Each level encompasses a multidimensional array of service intensities, combining crisis, supportive, clinical, and environmental interventions, which vary independently.

This edition includes language referencing the capability of each level of care to provide matched services for individuals with co-occurring mental health and/or substance use and/or health conditions. Patient placement/medical necessity criteria are then elaborated for each level of care. Separate admission, continuing stay, and discharge criteria are not needed in this system, as changes in level of care will follow from changes in ratings in any of the six parameters over the course of time. Each level of care description provides guidance for payers by establishing usual time frames for review and revision of scores and authorization.

The final section describes a proposed scoring methodology that facilitates the translation of assessment results into placement or level of care determinations. Both a grid chart and a decision flow chart are provided for this purpose.

We hope that this version of LOCUS will continue to stimulate considerable comment, discussion, and testing for reliability and validity in varying circumstances. It is recognized that a document of this type must be dynamic and that adjustments or addendums may be required either to accommodate local needs or to address unanticipated or unrecognized circumstances or deficiencies. The specific needs of special populations, such as children, adolescents, and the elderly may not be adequately addressed in this adult version. It does not claim to replace clinical judgment, and is meant to serve only as an operationalized guide to resource utilization that must be applied in conjunction with sound clinical thinking. It is offered as an instrument that should have considerable utility in its present form, but growth and improvement should be realized with time and further testing. The AACCP welcomes any comments or suggestions. Please send your comments to:

Wesley Sowers, M.D.
Clinical Professor of Psychiatry
University of Pittsburgh Medical Center
Director, Center for Public Service Psychiatry
Western Psychiatric Institute and Clinic
3811 O'Hara St
Pittsburgh, PA 15213
sowerswe@upmc.edu
Phone: (412) 246-5237

Acknowledgments

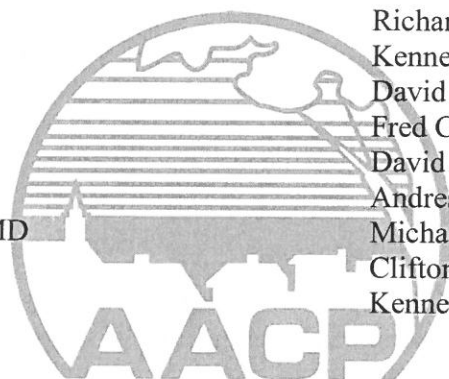
This document was originally developed by the American Association of Community Psychiatrists' Health Care Systems Committee's Task Force on Level of Care Determinations. It was developed in cooperation with and the suggestions of multiple reviewers and users across the country. We would also like to acknowledge the intellectual stimulation provided by the review of multiple documents previously developed to address similar issues. Of particular influence in the conceptualization of LOCUS were the Patient Placement Criteria-1 of the American Society of Addiction Medicine (ASAM-PPC), the Level of Care Assessment Tool of US Healthcare (LOCAT), and the Level of Need-Care Assessment (LONCA) Method.

For LOCUS 20, special thanks goes to Ken Minkoff, MD, Joe Parks, MD, Charley Huffine, MD and Robert Benacci, MA, for their careful review and inputs.

AACP Task Force on Level of Care Determinations

Wesley Sowers, MD, Chairperson

Cheryl S. Al-Mateen, MD
Donald B. Brown, MD
Gordon H. Clark, Jr., MD
Benjamin Crocker, MD
Robert M. Goisman, MD
Steven Goldfinger, MD
Linda Goldwater Gochfeld, MD
Charles Huffine, MD
Margaret Kitchell, MD



Richard C. Lippincott, MD
Kenneth Minkoff, MD
David Moltz, MD
Fred C. Osher, MD
David A. Pollack, MD
Andres Pumariega, MD
Michael A. Silver, MD
Clifton R. Tennison, Jr., MD
Kenneth Thompson, MD

Level of Care Utilization System for Psychiatric and Addiction Services

Instructions for Use

The first step in completing the LOCUS assessment is to complete a rating in each evaluation parameter along a scale of one to five. Each evaluation parameter begins with some guidelines for completing the rating in that section. Each rating in the scale is defined by one or more criteria, which are designated by separate letters. Only one of these criteria need be met for a score to be assigned to the subject. The evaluator should select the highest score or rating in which at least one of the criteria is met. In some cases more than one of the criteria for each rating will be met, and in that case, they can both be recorded. This will assist in treatment planning once the level of care recommendation has been determined.

There will, on occasion, be instances where there will be some ambiguity about whether a subject has met criteria for a score on the scale within one of the parameters. This may be due to inadequate information, conflicting information, or simply difficulty in making a judgment about whether the available information is consistent with any of the criteria for that score. Clinical experience must be applied judiciously in making determinations in this regard, and the rating or criterion that provides the *closest approximation* to the actual circumstance should be selected. However, there will be instances when it will remain difficult to make this determination. In these cases the highest score in which it is more likely than not that at least one criterion has been met should generally be assigned. The result will be that any erroneous ratings will be made on the side of caution.

Since LOCUS is designed as a dynamic instrument, scores should be expected to change over time, sometimes (for people in crisis) in a matter of hours. Scores are generally assigned on a here and now basis, representing the clinical picture at the time of evaluation. In some of the parameters, historical information is taken into account, but it should not be considered unless it is a clear part of the defined criteria. In certain crisis situations, the score may change rapidly as interventions are implemented. In other situations, where a subject may be living under very stable circumstances, scores may not change for extended periods of time. Clinical judgment should prevail in the determination of how frequently scores should be reassessed. As a general rule, they will be reassessed more frequently at higher levels of acuity and at the higher levels of care or resource intensity. At the lowest levels of care, they may show little change from visit to visit, and clinicians need only verify that previous ratings are accurate during quarterly or bi-annual visits.

Once scores have been assigned in all six evaluation parameters, they should be recorded on a worksheet and summed to obtain the composite score. The LOCUS Level of Care Decision Tree should be employed and is the recommended method of obtaining the placement recommendation. A rough estimate of the placement recommendation can be obtained by referring to the LOCUS Placement Grid. There is also a computerized version of LOCUS, which generates a document with the rating summary and criteria profile, along with the service intensity recommendation. Visit www.locusonline.com for further information.

Although the use of LOCUS is fairly intuitive with these simple instructions, there may be situations with which raters might encounter uncertainty in how to apply the criteria as intended. For this reason, we do recommend some additional training for potential users. This may be obtained in two ways. On site, live training can be provided by Deerfield Behavioral Health, Inc. (www.dbhn.com). A second option is the use of the LOCUS Training Manual, which provides expanded instructions, case examples, a post-training assessment, a guided interview and the LOCUS worksheet. The manuals are also available through Deerfield Behavioral Health, Inc.

Each region or service system using LOCUS will want to create a list of existing programs or service sites at each defined level of service intensity as outlined in the second part of the LOCUS tool. Once the level of care recommendation has been obtained, clinicians can consult this catalogue of services to determine treatment options available to the person that is being assessed, and refer or place them accordingly.

In assigning levels of care, there will be some systems that do not have comprehensive services for all populations at every level of the continuum. When this is the case, the level of care recommended by LOCUS may not be available and a choice will need to be made as to whether more intensive services or less intensive services should be provided. In most cases, the higher level of care should be selected, unless there is a clear and compelling rationale to do otherwise. As an example, if a patient initially being served at Level 6 has a reduction in his score which allows a transition to Level 5, but no Level 5 placement is currently available, that patient should continue to be served at Level 6 until they further improve, or until Level 5 placement becomes available. This will again lead us to err on the side of caution and safety rather than risk and instability.

Medical Necessity and Resource Management

LOCUS is an objective tool developed by expert consensus and further validated by the longstanding satisfaction of its users over the past twenty years. As exposure and experience with LOCUS has grown, so has the realization that it provides a superior medical necessity instrument for managing care. In this revision, more detailed guidance is provided on the use of LOCUS by both payers and providers for determining the “medical necessity” for treatment throughout the continuum of care. LOCUS 20 includes, for example, guidance for the appropriate duration of an authorization and the maximum time to reassessment of need for each defined level of service intensity. In some instances, recommendations regarding the workforce most appropriate for various levels of service intensity or types of intervention are also provided.

LOCUS has increasingly demonstrated value as a systematic tool for managed care organizations, as well as for the public and private insurers that may contract with them. Using LOCUS in an organized fashion will guide users to the most effective and economic measures for ensuring good outcomes for both individuals and populations. LOCUS assists payers to manage resources wisely while maintaining a high standard of quality for services delivered by network providers. Many payers have discovered that LOCUS, due to its emphasis on the balance of quality and economy, allows them to reduce overhead costs by eliminating the need for “micro-

management” of care decisions made by providers, thus allowing more resources to be dedicated to the provision of care. Periodic audits to insure the appropriate use of the instrument by providers are sufficient in systems that have matured in their use of LOCUS. Appropriate use of LOCUS can assist both providers and payers in avoiding inappropriate and expensive over utilization of higher levels of care and inappropriate as well as dangerous underutilization of those levels of service intensity.

LOCUS offers several advantages over other available level of care and authorization of stay tools currently available as follows:

- LOCUS provides medical necessity/ placement criteria that are more comprehensive than other existing tools, and which are applicable to the entire continuum of care. Alternatives generally focus on only a single level of care, usually inpatient hospitalization.
- LOCUS provides a method of “value” management is not easily derived from any other existing managed care instruments. It meets the need of both payers and providers for a system to ensure that resources are being applied efficiently and effectively.
- LOCUS criteria take into account the interpersonal and social determinants of functional impairment as well as prior responses to treatment, which alternative tools do not.
- In addition, LOCUS provides a framework for clinical management and documentation extending from the initial assessment, through the treatment planning and progress recording processes, to the transition to less restrictive and intensive levels of care. This clinical framework facilitates monitoring and maintenance of accountability to those entities who bear financial risk and ultimate responsibility for health care outcomes.

In this period of transformation in health care systems, LOCUS has been ahead of the curve in its facilitation of person-centered care. It has likewise been a progressive method for thinking about service needs and the judicious use of resources. We hope that the additions to this version of LOCUS will further advance these aims.

LOCUS Instrument Version 20

Evaluation Parameters for Assessment of Service Needs

Definitions

I. Risk of Harm

This dimension of the assessment considers a person's potential to cause significant harm to self or others. While this may most frequently be due to suicidal or homicidal thoughts or intentions, in many cases unintentional harm may result from misinterpretations of reality, from inability to adequately care for oneself, or from altered states of consciousness due to use of intoxicating substances in an uncontrolled manner. For the purposes of evaluation in this parameter, deficits in ability to care for oneself are considered only in the context of their potential to cause harm. Likewise, only behaviors associated with substance use are used to rate risk of harm, not the substance use itself. In addition to direct evidence of potentially dangerous behavior from interview and observation, other factors may be considered in determining the likelihood of such behavior such as; past history of dangerous behaviors, inability to contract for safety (while contracting for safety does not guarantee it, the inability to do so increases concern), and availability of means. When considering historical information, recent patterns of behavior should take precedence over patterns reported from the remote past. Risk of harm may be rated according to the following criteria:

1 - Minimal Risk of Harm

- a- No indication of suicidal or homicidal thoughts or impulses, and no history of suicidal or homicidal ideation, and no indication of significant distress.
- b- Clear ability to care for self now and in the past.

2 - Low Risk of Harm

- a- No current suicidal or homicidal ideation, plan, intentions or severe distress, but may have had transient or passive thoughts recently or in the past.
- b- Occasional substance use without significant episodes of potentially harmful behaviors.
- c- Periods in the past of self-neglect without current evidence of such behavior.

3 - Moderate Risk of Harm

- a- Significant current suicidal or homicidal ideation without intent or conscious plan and without past history.
- b- No active suicidal/homicidal ideation, but extreme distress and/or a history of suicidal/homicidal behavior exists.
- c- History of chronic impulsive suicidal/homicidal behavior or threats, but current expressions do not represent significant change from usual behavior.
- d- Binge or excessive use of substances resulted in potentially harmful behaviors in the past, but there have been no recent episodes.
- e- Some evidence of self-neglect and/or decrease in ability to care for oneself in current environment.

4 - Serious Risk of Harm

- a- Current suicidal or homicidal ideation with expressed intentions and/or past history of carrying out such behavior but without means for carrying out the behavior, or with some expressed inability or aversion to doing so.
- b- History of chronic impulsive suicidal/homicidal behavior or threats with current expressions or behavior representing a significant elevation from usual behavior.
- c- Recent pattern of excessive substance use resulting in loss of self-control and clearly harmful behaviors with no demonstrated ability to abstain from use.
- d- Clear compromise of ability to care adequately for oneself or to be adequately aware of environment.

5 - Extreme Risk of Harm

- a- Current suicidal or homicidal behavior or such intentions with a plan and available means to carry out this behavior...
 - without expressed ambivalence or significant barriers to doing so, or
 - with a history of serious past attempts which are not of a chronic, impulsive or consistent nature, or
 - in presence of command hallucinations or delusions which threaten to override usual impulse control.
- b- Repeated episodes of violence toward self or others, or other behaviors resulting in harm while under the influence of intoxicating substances with pattern of nearly continuous and uncontrolled use.
- c- Extreme compromise of ability to care for oneself or to adequately monitor environment with evidence of deterioration in physical condition or injury related to these deficits.

II. Functional Status

This dimension of the assessment measures the degree to which a person is able to fulfill social responsibilities, to interact with others, maintain their physical functioning (such as sleep, appetite, energy, etc.), as well as a person's capacity for self-care. This ability should be compared against an ideal level of functioning given an individual's limitations, or may be compared to a baseline functional level as determined for an adequate period of time prior to onset of this episode of illness. Persons with ongoing, longstanding deficits who do not experience any acute changes in their status are the only exception to this rule and are given a rating of three. If such deficits are severe enough that they place the client at risk of harm, they will be considered when rating Dimension I in accord with the criteria elaborated there. For the purpose of this document, sources of impairment should be limited to those directly related to psychiatric and/or addiction problems that the individual may be experiencing. While other types of disabilities may play a role in determining what types of support services may be required, they should generally not be considered in determining the placement of a given individual in the behavioral treatment continuum.

1 - Minimal Impairment

- a- No more than transient impairment in functioning following exposure to an identifiable stressor.

2 - Mild Impairment

- a- Experiencing some problems in interpersonal interactions, with increased irritability, hostility or conflict, but is able to maintain some meaningful and satisfying relationships.
- b- Recent experience of some minor disruptions in aspects of self-care or usual activities.
- c- Developing minor but consistent difficulties in social role functioning and meeting obligations such as difficulty fulfilling parental responsibilities or performing at expected level in work or school, but maintaining ability to continue in those roles.
- d- Demonstrating significant improvement in function following a period of difficulty.

3 - Moderate Impairment

- a- Recently conflicted, withdrawn, alienated or otherwise troubled in most significant relationships, but maintains control of any impulsive, aggressive or abusive behaviors.
- b- Appearance and hygiene falls below usual standards on a frequent basis.
- c- Significant disturbances in physical functioning such as sleep, eating habits, activity level, or sexual appetite, but without a serious threat to health.
- d- Significant deterioration in ability to fulfill responsibilities and obligations to job, school, self, or significant others and these may be avoided or neglected on some occasions.
- e- Ongoing and/or variably severe deficits in interpersonal relationships, ability to engage in socially constructive activities, and ability to maintain responsibilities.
- f- Recent gains and/or stabilization in function have been achieved while participating in treatment in a structured and/or protected setting.

4 - Serious Impairment

- a- Serious decrease in the quality of interpersonal interactions with consistently conflictual or otherwise disrupted relations with others, which may include impulsive, aggressive or abusive behaviors.
- b- Significant withdrawal and avoidance of almost all social interaction.
- c- Consistent failure to maintain personal hygiene, appearance, and self-care near usual standards.
- d- Serious disturbances in physical functioning such as weight change, disrupted sleep, or fatigue that threaten physical well being.
- e- Inability to perform close to usual standards in school, work, parenting, or other obligations and these responsibilities may be completely neglected on a frequent basis or for an extended period of time.

5 - Severe Impairment

- a- Extreme deterioration in social interactions which may include chaotic communication, threatening behaviors with little or no provocation, or minimal control of impulsive, aggressive or otherwise abusive behavior.
- b- Development of complete withdrawal from all social interactions.
- c- Complete neglect of personal hygiene and appearance and inability to attend to most basic needs such as food intake and personal safety with associated impairment in physical status.
- d- Extreme disruptions in physical functioning causing serious harm to health and well being.
- e- Complete inability to maintain any aspect of personal responsibility as a citizen, or in occupational, educational, or parental roles.

III. Medical, Addictive, and Psychiatric Co-Morbidity

This dimension measures potential complications in the course of illness due to level of acuity or disability related to co-occurring medical illness, substance use disorder, or psychiatric disorder in addition to the condition first identified or most readily apparent (here referred to as the presenting disorder). The presence of co-occurring conditions, when sufficiently unstable or severe, may prolong the course of illness in some cases, or may necessitate more intensive or more closely monitored services in other cases. Unless otherwise indicated, the simple presence of *potentially* interacting disorders should not be considered in this rating. They will only be considered when significant activation of the presenting disorder is evident. For patients who present with substance use disorders, physiologic withdrawal states should be considered to be medical co-morbidity for scoring purposes.

1 - No Co-Morbidity

- a- No evidence of medical illness, substance use disorders, or psychiatric disturbances apart from the presenting disorder.
- b- Any co-occurring illnesses that may have been previously present are now inactive and pose no threat to the stability of the current condition.

2 - Minor Co-Morbidity

- a- Existence of medical problems which are not themselves immediately threatening or debilitating and which have no impact on the course of the presenting disorder.
- b- Occasional episodes of substance misuse, but any recent episodes are self-limited, show no pattern of escalation, and there is no indication that they adversely affect the course of a co-occurring psychiatric disorder.
- c- May occasionally experience psychiatric symptoms which are related to stress, medical illness, or substance use, but these are transient and have no detectable impact on a co-occurring substance use disorder.

3 - Significant Co-Morbidity

- a- Medical conditions exist, or have potential to develop (such as diabetes or a mild physiologic withdrawal syndrome), which may require significant medical monitoring.
- b- Medical conditions exist which may have been created or adversely affected by the existence of the presenting disorder.
- c- Medical conditions exist which may adversely affect the course of the presenting disorder.
- d- Ongoing or episodic substance use occurring despite negative consequences with significant or potentially significant negative impact on the course of any co-occurring psychiatric disorder.
- e- Recent substance use which has had clearly detrimental effects on the presenting disorder but which has been temporarily arrested through use of a highly structured or protected setting or through other external means.
- f- Significant psychiatric symptoms and signs are present which are themselves somewhat debilitating, and which interact with and have an adverse affect on the course and severity of any co-occurring substance use disorder.

4 - Major Co-Morbidity

- a- Medical conditions exist, or have a very high likelihood of developing (such as a moderate, but uncomplicated, alcohol, sedative, or opiate withdrawal syndrome, mild pneumonia, or uncontrolled hypertension), which may require intensive, although not constant, medical monitoring.
- b- Medical conditions exist which are clearly made worse by the existence of the presenting disorder.
- c- Medical conditions exist which clearly worsen the course and outcome of the presenting disorder.
- d- Uncontrolled substance use occurs at a level that poses a serious threat to health if unchanged, and/or which poses a serious barrier to recovery from any co-occurring psychiatric disorder.
- e- Psychiatric symptoms exist which are clearly disabling and which interact with and seriously impair ability to recover from any co-occurring substance use disorder.

5 - Severe Co-Morbidity

- a- Significant medical conditions exist which may be poorly controlled and/or potentially life threatening in the absence of close medical management (e.g., severe or complicated alcohol withdrawal, uncontrolled diabetes mellitus, complicated pregnancy, severe liver disease, debilitating cardiovascular disease).
- b- Presence and lack of control of presenting disorder places client in imminent danger from complications of existing medical problems.

- c- Uncontrolled medical condition severely worsens the presenting disorder, dramatically prolonging the course of illness and seriously impeding the ability to recover from it.
- d- Severe substance dependence with inability to control use under any circumstance and which may include intense withdrawal symptoms or continuing use despite clear worsening of any co-occurring psychiatric disorder and other aspects of well being.
- e- Acute or severe psychiatric symptoms are present which seriously impair client's ability to function and prevent recovery from any co-occurring substance use disorder, or seriously worsen it.

IV. Recovery Environment

This dimension considers factors in the environment, social, and interpersonal determinants of health and well being, that may contribute to the onset or maintenance of addiction or mental illness, and/or may support efforts to achieve or maintain mental health and/or abstinence. Stressful circumstances may originate from multiple sources and include interpersonal conflict or torment, life transitions, losses, worries relating to health and safety, and ability to maintain role responsibilities. Supportive elements in the environment are resources which enable persons to maintain health and role functioning in the face of stressful circumstances, such as availability of adequate material resources and relationships with family members. The availability of friends, employers or teachers, clergy and professionals, and other community members that provide caring attention and emotional comfort, are also sources of support. Persons being treated in locked or otherwise protected residential settings should be rated based on the conditions they would encounter outside that setting prior to a transition to a new or pre-existing living situation. This will ensure that adequate support and personal resources are in place to protect against more stressful environments prior to the transition.

A) Level of Stress

Criteria marked at their conclusion with an asterisk (*) apply to persons with past or present difficulties with substance use.

1 - Low Stress Environment

- a- Essentially no significant or enduring difficulties in interpersonal interactions and significant life circumstances are stable.
- b- No recent transitions of consequence.
- c- No major losses of interpersonal relationships or material status have been experienced recently.
- d- Material needs are met without significant cause for concern that they may diminish in the near future, and no significant threats to health or safety are apparent.
- e- Living environment poses no significant threats or risk.
- f- No pressure to perform beyond capacity in social role.

2 - Mildly Stressful Environment

- a- Presence of some ongoing or intermittent interpersonal conflict, alienation, or other difficulties.
- b- A transition that requires adjustment such as change in household members or a new job or school.
- c- Circumstances causing some distress such as a close friend leaving town, conflict in or near current residence, or concern about maintaining material well being.
- d- A recent onset of a transient but temporarily disabling illness or injury.
- e- Potential for exposure to alcohol and/or drug use exists. *
- f- Performance pressure (perceived or actual) in school or employment situations creating discomfort.

3 - Moderately Stressful Environment

- a- Significant discord or difficulties in family or other important relationships or alienation from social interaction.
- b- Significant transition causing disruption in life circumstances such as job loss, legal difficulties or change of residence.
- c- Recent important loss or deterioration of interpersonal or material circumstances.
- d- Concern related to sustained decline in health status.
- e- Danger in or near habitat.
- f- Easy exposure and access to alcohol and drug use. *
- g- Perception that pressure to perform surpasses ability to meet obligations in a timely or adequate manner.

4 - Highly Stressful Environment

- a- Serious disruption of family or social milieu which may be due to illness, death, divorce or separation of parent and child, severe conflict, torment and/or physical or sexual mistreatment.
- b- Severe disruption in life circumstances such as going to jail, losing housing, or living in an unfamiliar, unfriendly culture.
- c- Inability to meet needs for physical and/or material well being.
- d- Recent onset of severely disabling or life threatening illness.
- e- Difficulty avoiding exposure to active users and other pressures to partake in alcohol or drug use. *
- f- Episodes of victimization or direct threats of violence near current home.
- g- Overwhelming demands to meet immediate obligations are perceived.

5 - Extremely Stressful Environment

- a- An acutely traumatic level of stress or enduring and highly disturbing circumstances disrupting ability to cope with even minimal demands in social spheres such as:
 - ongoing injurious and abusive behaviors from family member(s) or significant other.
 - witnessing or being victim of extremely violent incidents brought about by human malice or natural disaster.
 - persecution by a dominant social group.
 - sudden or unexpected death of a loved one.
- b- Unavoidable exposure to drug use and active encouragement to participate in use. *
- c- Incarceration or lack of adequate shelter.
- d- Severe pain and/or imminent threat of loss of life due to illness or injury.
- e- Sustained inability to meet basic needs for physical and material well being.
- f- Chaotic and constantly threatening environment.

B) Level of Support

1 - Highly Supportive Environment

- a- Plentiful sources of support with ample time and interest to provide for both material and emotional needs in most circumstances.
- b- Effective involvement of Assertive Community Treatment Team (ACT) or other similarly highly supportive resources.
(Selection of this criterion pre-empts higher ratings)

2 - Supportive Environment

- a- Supportive resources are not abundant, but are capable of and willing to provide significant aid in times of need.
- b- Some elements of the support system are willing and able to participate in treatment if requested to do so and have capacity to effect needed changes.
- c- Professional supports are available and effectively engaged (i.e. ICM).
(Selection of this criterion pre-empts higher ratings)

3 - Limited Support in Environment

- a- A few supportive resources exist in current environment and may be capable of providing some help if needed.
- b- Usual sources of support may be somewhat ambivalent, alienated, difficult to access, or have a limited amount of resources they are willing or able to offer when needed.
- c- Persons who have potential to provide support have incomplete ability to participate in treatment and make necessary changes.
- d- Resources may be only partially utilized even when available.
- e- Limited constructive involvement with any professional sources of support that are available.

4 - Minimal Support in Environment

- a- Very few actual or potential sources of support are available.
- b- Usual supportive resources display little motivation or willingness to offer assistance, or they are themselves troubled or hostile toward client.
- c- Existing supports are unable to provide sufficient resources to meet material or emotional needs.
- d- Client may be on bad terms with and unwilling to use supports available in a constructive manner.

5 - No Support in Environment

- a- No sources for assistance are available in environment either emotionally or materially.

V. Treatment and Recovery History

This dimension of the assessment recognizes that a person's past experience provides some indication of how that person is likely to respond to similar circumstances in the future. While it is not possible to codify or predict how an individual person may respond to any given situation, this scale uses past trends in responsiveness to treatment exposure and past experience in managing recovery as its primary indicators. Although the recovery process is a complex concept, for the purposes of rating in this parameter, recovery is defined as a period of stability with good control or management of symptoms. It is important to recognize that some clients will respond well to some treatment situations and poorly to others. This may, in some cases, be unrelated to level of intensity of care, but rather to the characteristics and quality of the treatment provided. Nonetheless, past experience is one predictor of future response to treatment and must be taken into account in determining service needs and the recovery plan. Most recent experiences in treatment and recovery should take precedence over more remote experiences in determining the proper rating.

1 - Fully Responsive to Treatment and Recovery Management

- a- There has been no prior experience with treatment or recovery.
- b- Prior experience indicates that efforts in all treatments that have been attempted have been helpful in controlling the presenting problem.
- c- There has been successful management of extended recovery with few and limited periods of relapse even in unstructured environments or without frequent treatment.

2 - Significant Response to Treatment and Recovery Management

- a- Previous or current experience in treatment has been successful in controlling most symptoms but intensive or repeated exposures may have been required.
- b- Recovery has been managed for moderate periods of time with limited support or structure.

3 - Moderate or Equivocal Response to Treatment and Recovery Management

- a- Previous or current treatment has not achieved complete remission of symptoms or optimal control of symptoms.
- b- Previous treatment exposures have been marked by minimal effort or motivation and no significant success or recovery period was achieved.
- c- Unclear response to treatment and ability to maintain a significant recovery.
- d- At least partial recovery has been maintained for moderate periods of time, but only with strong professional or peer support or in structured settings.

4 - Poor Response to Treatment and Recovery Management

- a- Previous or current treatment has not achieved complete remission of symptoms or optimal control of symptoms even with intensive and/or repeated exposure.
- b- Attempts to maintain whatever gains that can be attained in intensive treatment have limited success, even for limited time periods or in structured settings.

5 - Negligible Response to Treatment and Recovery Management

- a- Past or current response to treatment has been quite minimal, even with intensive medically managed exposure in highly structured settings for extended periods of time.
- b- Symptoms are persistent and functional ability shows no significant improvement despite this treatment exposure.

VI. Engagement and Recovery Status

This dimension of the assessment considers a person's understanding of illness and treatment and ability or willingness to engage in the treatment and recovery process. This is sometimes referred to as "patient activation". Factors such as acceptance of disabilities, stage in the change process, ability to trust others and accept assistance, interaction with treatment opportunities, and ability to take responsibility for recovery should be considered in selecting the rating for this dimension. These factors will likewise impact a person's ability to be successful at a given level of care.

1 - Optimal Engagement and Recovery

- a- Has complete understanding and acceptance of illness and its effect on function.
- b- Actively maintains changes made in the past (Maintenance Stage).
- c- Is enthusiastic about recovery, is trusting, and shows strong ability to utilize available resources and treatment.
- d- Understands recovery process and takes on a personal role and responsibility in a recovery plan.

2 - Positive Engagement and Recovery

- a- Has significant understanding and acceptance of illness and its effect on function.
- b- Willing to change and is actively working toward it (Action Stage).
- c- Positive attitude toward recovery and treatment, capable of developing trusting relationships, and uses available resources independently when necessary.
- d- Shows recognition of personal role in recovery and accepts significant responsibility for it.

3 - Limited Engagement and Recovery

- a- Has some variability, hesitation or uncertainty in acceptance or understanding of illness and disability.
- b- Has limited desire or lacks confidence to change despite intentions to do so (Preparation Stage).
- c- Relates to treatment with some difficulty and establishes few, if any, trusting relationships.
- d- Does not use available resources independently or only in cases of extreme need.
- e- Has limited ability to accept responsibility for recovery.

4 - Minimal Engagement and Recovery

- a- Rarely, if ever, is able to accept reality of illness or any disability that accompanies it, but may acknowledge some difficulties in living.
- b- Has no desire or is afraid to adjust behavior, but may recognize the need to do so (Contemplation Stage).
- c- Relates poorly to treatment and treatment providers and ability to trust is extremely narrow.
- d- Avoids contact with and use of treatment resources if left to own devices.
- e- Does not accept any responsibility for recovery or feels powerless to do so.

5 - Unengaged and Stuck

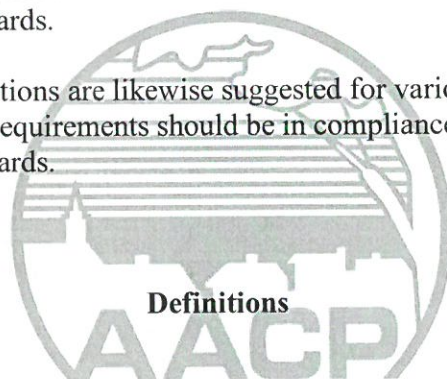
- a- Has no awareness or understanding of illness and disability (Pre-contemplation Stage).
- b- Inability to understand recovery concept or contributions of personal behavior to disease process.
- c- Unable to actively engage in recovery or treatment and has no current capacity to relate to another or develop trust.
- d- Extremely avoidant, frightened, or guarded.

LEVELS OF CARE

As stated in the introduction of this instrument, *the term “level of care” is used for simplicity, but it is not the intention of this section to imply that the service arrays are static or linear. Rather, each level describes a flexible or variable combination of specific service types and might more accurately be said to describe **levels of resource intensity**. The particulars of program development are left to providers to determine based on local circumstances and outcome evaluations. Each level encompasses a multidimensional array of service elements, combining crisis, supportive, clinical, and environmental interventions, which vary independently depending on identified needs.*

This edition includes specifications for the capacity of each level of care to provide matched services for individuals with co-occurring mental health and/or substance use and/or health conditions. Service design should assume that users have complex needs. With that in mind, each section’s definition includes a reminder that services should reflect this expectation. In addition, suggested durations for authorizations and reviews of clinical status are provided to facilitate oversight processes and reduce unnecessary administrative expenditures. Intensity of services should be consistent with Center for Medicare and Medicaid Services (CMS) certification and accreditation organization standards.

Optimal workforce qualifications are likewise suggested for various elements of service at each level of care. Specific staffing requirements should be in compliance with state, federal, and accreditation organization standards.



BASIC SERVICES - Prevention and Health Maintenance

Definition:

Basic services are designed to prevent the onset of illness or to limit the magnitude of morbidity associated with already established disease processes. These services may be developed for individual or community application, and are generally carried out in a variety of community settings. These services will be available to all members of the community with special focus on children and families. These services are often referred to as crisis resolution and/or emergency services. The expectation that individuals utilizing these services may have complex needs requires that these services should be designed to be welcoming to all individuals and provide preventive, holistic care. They should be capable of providing quality care to those who present with “co-occurring” disorders.

This level of care should be available to everyone in the community without obtaining a prior authorization from insurers. Professionals providing services should be appropriately licensed

and in good standing. Many support services may be provided by appropriately trained and/or certified paraprofessionals, including peer specialists.

1. **Care Environment** - An easily accessible office and communications equipment. Adequate space for any services provided on-site must be available. Central offices are likely to be most conveniently located in or near a community health center. Most services will be provided in the community, however, in schools, places of employment, community centers, libraries, churches, etc., and transportation capabilities must be available.
2. **Clinical Services** - Twenty-four hour physician and nursing capabilities will be provided for emergency evaluation, brief intervention, and outreach services.
3. **Support Services** - As needed for crisis stabilization, having the capability to mobilize community resources and facilitate linkage to more intense levels of care if needed.
4. **Crisis Stabilization and Prevention Services** - In addition to crisis services already described, prevention programs would be available and promoted for all covered members. These programs would include: 1) Community outreach to special populations such as the homeless, elderly, children, pregnant woman, disrupted or violent families, child protection services, services for victims of domestic violence and criminal offenders; 2) Mental health first aid for victims of trauma or disaster and first responders; 3) Frequent opportunities to screen for high risk members in the community; 4) Health maintenance education (e.g., coping skills, stress management, recreation); 5) Violence prevention education and community organization; 6) Consultation to primary care providers and community groups; 7) Facilitation of mutual support networks and empowerment programs; 8) Environmental evaluation programs identifying mental health toxins; 9) Support of day care and child enrichment programs; and 10) Hot and warm lines for crisis support.

Placement Criteria:

These Basic Services should be available to all members of the community regardless of their status in the dimensional rating scale.

I. LEVEL ONE - Recovery Maintenance and Health Management

Definition:

This level of care provides treatment to clients who are living either independently or with minimal support in the community, and who have achieved significant recovery from past episodes of illness. It is a “step down” level of care, designed to prevent or mitigate future episodes of deterioration. Treatment and service needs do not require supervision or frequent contact. With the expectation that individuals utilizing these services may have complex needs, these services should be designed to be welcoming to individuals who have multiple conditions, and to be able to provide “co-occurring capable” services.

This low intensity level of care should not require prior authorization from insurers, and should be available as long as it is needed in much the same way as periodic visits to primary care providers are provided. Professionals providing services should be appropriately licensed or

certified. Many support services may be provided by appropriately trained and/or certified paraprofessionals, including peer specialists.

Level One programs must provide the following:

1. **Care Environment** - Adequate space should be available to carry out activities required for treatment. Space should be easily accessible, well ventilated and lighted. Access to the facility can be monitored and controlled, but egress cannot be restricted. Services may be provided in community locations or in some cases, in the place of residence.
2. **Clinical Services** - Treatment programming (i.e. individual, family and/or group therapy) will be available up to one hour per month, and usually not less than one hour every three months. Psychiatric or physician review and/or contact should take place about once every three to six months. Medication use can be monitored and managed in this setting. Capabilities to provide individual or group supportive therapy should be available in at this level. Coordination with primary care providers should be arranged as appropriate.
3. **Supportive Services** - Assistance with arranging financial support, supportive housing, systems management, and transportation may be necessary. Facilitation in linkage with mutual support networks, individual advocacy groups, and with educational or vocational programming will also be available according to client needs. Provision of these services should not require more than 1-2 hours per month on average, though there may be occasional life crises that require additional support for short periods of time.
4. **Crisis Stabilization and Prevention Services** - Clients must have access to 24-hour emergency evaluation and brief intervention services including a respite environment. Educational and employment opportunities, and empowerment programs will be available, and access to these services will be facilitated. In addition, all Basic Services (see page 20) will be accessible.

Placement Criteria:

1. **Risk of Harm** - clients with a rating of two or less may step down to this level of care.
2. **Functional Status** - clients should demonstrate ability to maintain a rating of two or less to be eligible for this level of care.
3. **Co-Morbidity** - a rating of two or less is generally required for this level of care.
4. **Recovery Environment** - a combined rating of no more than four on Scale "A" and "B" should be required for treatment at this level.
5. **Treatment and Recovery History** - a rating of two or less should be required for treatment at this level.
6. **Engagement and Recovery Status** - a rating of two or less should be obtained in this dimension for placement at this level of care.
7. **Composite Rating** - placement at this level of care implies that the client has successfully completed treatment at a more intensive level of care and primarily needs assistance in maintaining gains realized in the past. A composite rating of more than 10 but less than 14 should generally be obtained for eligibility for this service.

II. LEVEL TWO - Low Intensity Community Based Services

Definition:

This level of care provides treatment to clients who need ongoing treatment, but who are living either independently or with minimal support in the community. Treatment and service needs do not require intense supervision or very frequent contact. Programs of this type have traditionally been clinic-based programs. With the expectation that individuals utilizing these services will often have complex needs, these services should be welcoming to individuals who have multiple conditions, and to be able to provide “co-occurring capable” services.

Some payers may require that these services be authorized, but close oversight should not be needed as it would likely incur more expense than savings. Reviews should not be required more often than every four months. Professionals providing services should be appropriately licensed and certified. Many support services may be provided by appropriately trained and/or certified paraprofessionals, including peer specialists.

Level Two programs must provide the following:

- 1. Care Environment** - Adequate space should be available to carry out activities required for treatment. Space should be easily accessible, well ventilated and lighted. Access to the facility can be monitored and controlled, but the way out cannot be restricted. In some cases services may be provided in community locations or in the place of residence.
- 2. Clinical Services** - Treatment programming should be available up to two hours per week, but usually not less than one hour every four weeks. Frequency of contacts may vary in response to fluctuating needs. Psychiatric or physician review and/or contact should be available according to need as indicated by initial and ongoing assessment. Medication use can be monitored and managed in this setting and should be available within a reasonable amount of time. Physical health needs can be met through coordination with primary care, preferably co-located. Capabilities to provide individual, group, and family therapies should be available in these settings.
- 3. Supportive Services** - Case management services will generally not be required at this level of care, but assistance with arranging financial support, supportive housing, systems management, and transportation may be necessary. Liaison with mutual support networks and individual advocacy groups, and coordination with educational or vocational programming will also be available according to client needs. Provision of support services should not average more than 2-3 hours per month.
- 4. Crisis Stabilization and Prevention Services** - Clients must have access to 24-hour emergency evaluation and brief intervention services including a respite environment. Educational and employment opportunities, and empowerment programs will be available, and access to these services will be facilitated. In addition, all other Basic Services (see page 20) will be accessible.

Placement Criteria:

1. **Risk of Harm** - a rating of two or less would be most appropriate for this level of care. In some cases, a rating of three could be accommodated if the composite rating falls within guidelines.
2. **Functional Status** - ratings of three or less could be managed at this level.
3. **Co-Morbidity** - a rating of two or less is required for placement at this level.
4. **Recovery Environment** - a rating of three or less on each scale and a combined score of no more than five on the “A” and “B” scales is required for treatment at this level.
5. **Treatment and Recovery History** - a rating of two or less is generally most appropriate for this level of care. In some cases, a rating of three could be attempted at this level if stepping down from a more intensive level of care and a rating of two or less is obtained on scale “B” of Dimension IV.
6. **Engagement and Recovery Status** - a rating of two or less is generally most appropriate for this level of care. In some cases, a rating of three may be placed at this level if unwilling to participate in treatment at a more intensive level.
7. **Composite Rating** - placement at this level of care will generally be determined by the interaction of a variety of factors, but will be excluded by a score of four or more on any dimension. A composite score of at least 14 but no more than 16 is required for treatment at this level.

III. LEVEL THREE - High Intensity Community Based Services

Definition:

This level of care provides treatment to clients who need intensive support and treatment, but who are living either independently or with minimal support in the community. Service needs do not require daily supervision, but treatment needs require contact several times per week. Programs of this type have traditionally been clinic-based programs. With the expectation that individuals utilizing these services will commonly have complex needs, these services should be welcoming to individuals who have multiple conditions, and should be able to provide “co-occurring capable” services.

Minimal oversight should be required for this level of service and reviews should not be required more often than every two weeks for persons with acute conditions and every two months for those with more slowly evolving conditions. Professionals providing services should be appropriately licensed and certified. Many support services may be provided by appropriately licensed and/or certified paraprofessionals, including peer specialists.

Level Three programs must provide the following:

1. **Care Environment** - Adequate space should be available to carry out activities required for treatment. Space should be easily accessible, well ventilated and lighted. Access to the facility can be monitored and controlled, but egress can not be restricted. These services may be provided in community locations in some cases, including the place of residence.

2. **Clinical Services** - Treatment programming (including group, individual and family therapy) should be available about three days per week and about two or three hours per day. Psychiatric/medical staffing should be adequate to provide review and/or contact as needed according to initial and ongoing assessment. On call psychiatric/medical services will generally not be available on a 24-hour basis. Skilled nursing care is usually not required at this level of care, and medication use can be monitored but not administered. Close coordination with primary care should be in place and co-located if possible. Capabilities to provide individual, group, family and rehabilitative therapies should be available in these settings.
3. **Supportive Services** - Case management or outreach services should be available and integrated with treatment teams. Assistance with providing or arranging financial support, supportive housing, systems management and transportation should be available. Liaison with mutual support networks and individual advocacy groups, facilitation of recreational and social activities, and coordination with educational or vocational programming will also be available according to client needs. Although the need for support services is variable at this level, an average of two hours per week is commonly required.
4. **Crisis Stabilization and Prevention Services** - Clients must have access to 24-hour emergency evaluation and brief intervention services including a respite environment. Mobile service capability, day care and child enrichment programs, education and employment opportunities, and empowerment programs will be available, and access to these services will be facilitated. All other Basic Services (see page 20) will also be available.

Placement Criteria:

1. **Risk of Harm** - a rating of three or less can be managed at this level.
2. **Functional Status** - a rating of three or less is required for this level of care.
3. **Co-Morbidity** - a rating of three or less can be managed at this level of care.
4. **Recovery Environment** - a rating of three or less on each scale and a combined score of no more than five on the "A" and "B" scales is required for treatment at this level.
5. **Treatment and Recovery History** - a rating of two is most appropriate for management at this level of care, but in many cases a rating of three can be accommodated.
6. **Engagement and Recovery Status** - a rating of three or less is required for this level of care.
7. **Composite Rating** - placement at this level of care will generally be determined by the interaction of a variety of factors, but will be excluded by a score of four or more on any dimension. A composite score of at least 17 and no more than 19 is required for treatment at this level.

IV. LEVEL FOUR - Medically Monitored Non-Residential Services

This level of care refers to services provided to clients capable of living in the community either in supportive or independent settings, but whose treatment needs require intensive management by a multi disciplinary treatment team. Services, which would be included in this level of care, have traditionally been described as partial hospital programs and as assertive community treatment programs. Individuals utilizing these services will usually have complex needs, so these services should be welcoming to individuals who have multiple conditions, and to be able to provide “co-occurring capable” services.

Payer oversight may be required for this level of service, but reviews should not be required more often than every two weeks for acute care settings such as partial hospital, and no more than every three months for extended care services such as ACT. Professionals providing services should be appropriately licensed and certified and should include a full array of disciplines including rehabilitation, addiction, and medical specialists. Many support services may be provided by appropriately trained and/or certified paraprofessionals, including peer specialists.

Level Four services must be capable of providing the following:

- 1. Care Environment** - Services may be provided within the confines of a clinic setting providing adequate space for provision of services available at this level, or they may in some cases be provided by wrapping services around the client in the community (i.e. ACT team).
- 2. Clinical Services** - Clinical services should be available to clients throughout most of the day on a daily basis. Psychiatric services would be accessible on a daily basis and contact would occur as required by initial and ongoing assessment, usually not less than one hour per month, or more than four hours per month. Psychiatric services would also be available by remote communication on a 24-hour basis. Nursing services should be available about 40 hours per week. Physical assessment and primary care should be provided on-site if possible, preferably integrated into the treatment team. Intensive treatment should be provided at least five days per week and include individual, group, and family therapy depending on client needs. Rehabilitative services will be an integral aspect of the treatment program. Medication can be carefully monitored, but in most cases will be self-administered. Non-psychiatric clinical services generally average 5-16 hours weekly.
- 3. Supportive Services** - Case management services will be integrated with on site treatment teams or mobile treatment teams and will provide assistance with providing or arranging financial support, supportive housing, systems management, transportation and ADL maintenance. Liaison with mutual support networks and individual groups, facilitation of recreational and social activities, and coordination with educational or vocational programming will also be available according to client needs. The need for supportive services will vary, but will usually require an average 5 to 10 hours per week including indirect service time.

- 4. Crisis Stabilization and Prevention Services** - Clients must have access to 24-hour emergency evaluation and brief intervention services including a respite environment. Mobile service capability, day care and child enrichment programs, education and employment opportunities, and empowerment programs will be available, as will other Basic Services.

Placement Criteria:

- 1. Risk of Harm** - a rating of three or less is required for placement at this level independent of other variables, and a rating higher than three should not be managed at this level.
- 2. Functional Status** - a rating of three is most appropriate for this level of care independent of other variables. In some cases, a rating of four could be managed at this level if placed in conjunction with a rating of one on scale "A" and "B" in Dimension IV. (Availability of Assertive Community Treatment (ACT) would be equivalent to a rating of one on scale "B". An "A" scale rating of two could generally be managed in conjunction with ACT).
- 3. Co-Morbidity** - a rating of three or less is most appropriate for this level of care. In some cases, a rating of four could be managed at this level if placed in conjunction with a rating of one on scale "A" and "B" in Dimension IV. (Availability of Assertive Community Treatment would be equivalent to a rating of one on scale "B". An "A" scale rating of two could generally be managed in that circumstance).
- 4. Recovery Environment** - an "A" scale rating of three or less is most appropriate for this level of care. In some cases, a rating of four could be managed at this level if placed in conjunction with a rating of one on scale "B". (Availability of Assertive Community Treatment would merit a rating of one on scale "B"). A "B" scale rating of three or less could otherwise generally be managed at this level.
- 5. Treatment and Recovery History** - a rating of three or less is most appropriate for this level of care. In some cases, a rating of four could be managed at this level if placed in conjunction with a rating of one on scale "A" and "B" in Dimension IV. (Availability of Assertive Community Treatment would be equivalent to a rating of one on scale "B". An "A" scale rating of two could generally be managed in conjunction with ACT).
- 6. Engagement and Recovery Status** - a rating of three or less is most appropriate for this level of care. In some cases, a rating of four could be managed at this level if placed in conjunction with a rating of one on scale "A" and "B" in Dimension IV. (Availability of Assertive Community Treatment would be equivalent to a rating of one on scale "B". An "A" scale rating of two could generally be managed in conjunction with ACT).
- 7. Composite Rating** - in many cases, utilization of this level of care will be determined by the interaction of a variety of factors. A composite rating of 20 requires treatment at this level with or without ACT resources available. (The presence of ACT reduces scores on Dimension IV enabling these criteria to be met even when scores of four are obtained in other dimensions.)

V. LEVEL FIVE - Medically Monitored Residential Services

Definition:

This level of care refers to residential treatment provided in a community setting. This level of care has traditionally been provided in non-hospital, free standing residential facilities based in the community. In some cases, longer-term care for persons with chronic, non-recoverable disability, which has traditionally been provided in nursing homes or similar facilities, may be included at this level. With the expectation that individuals utilizing these services will usually have complex needs, these services should be welcoming to individuals who have multiple conditions, and should be able to provide “co-occurring capable” services.

Payer authorization is often required for this level of service, but reviews should not be more often than every week for sub-acute intensive care settings such as respite or step down facilities, and no more than every three months for extended care services such as nursing facilities. Professionals providing services should be appropriately licensed and certified and should include a full array of disciplines including rehabilitation, addiction, and medical specialists. Many support services may be provided by appropriately trained and/or certified paraprofessionals, including peer specialists.

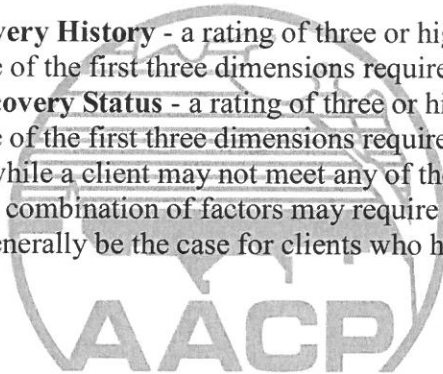
Level Five services must be capable of providing the following:

- 1. Care Environment** - Facilities will provide adequate living space for all residents and be capable of providing reasonable protection of personal safety and property. Physical barriers preventing egress or access to the community may be used at this level of care but facilities of this type will generally not allow the use of seclusion or restraint. Food services must be available or adequate provisions for residents to purchase and prepare their food must be made.
- 2. Clinical Capabilities** - Access to clinical care must be available at all times. Psychiatric care should be available either on site or by remote communication 24 hours daily and psychiatric consultation should be available on site at least weekly, but client contact may be required as often as daily. Facilities serving the most acute populations will require 0.5 to 1.0 hours of psychiatric time per client per week. Emergency and ongoing medical care services should be easily and rapidly accessible, preferably available on site and/or integrated with the treatment team. On site nursing care should be available about 40 hours per week if medications are being administered on a frequent basis. On site treatment should be available seven days a week including individual, group and family therapy. Non-psychiatric clinical services generally average 8-20 hours per client weekly. In addition, rehabilitation and educational services must be available either on or off site. Medication is monitored, but does not necessarily need to be administered to residents in this setting.
- 3. Supportive Services** - Residents will be provided with supervision of activities of daily living, and custodial care may be provided to designated populations at this level. On site supervision should be available 24 hours daily. Staff will facilitate recreational and social activities and coordinate interface with educational and rehabilitative programming provided off site.

4. **Crisis Resolution and Prevention** - Residential treatment programs must provide services facilitating return to community functioning in a less restrictive setting. These services will include coordination with community case managers, family and community resource mobilization, liaison with community based mutual support networks, and development of transition plan to supportive environment.

Placement Criteria:

1. **Risk of Harm** - a rating of four requires care at this level independently of other parameters.
2. **Functional Status** - a rating of four requires care at this level independently of other dimensional ratings, with the exception of some clients who are rated at one on Dimension IV on both scale "A" and "B" (see Level Three criteria).
3. **Co-Morbidity** - a rating of four requires care at this level independently of other parameters, with the exception of some clients who are rated at one on Dimension IV on both scale "A" and "B" (see Level Three criteria).
4. **Recovery Environment** - a rating of four or higher on the "A" and "B" scale and in conjunction with a rating of at least three on one of the first three dimensions requires care at this level.
5. **Treatment and Recovery History** - a rating of three or higher in conjunction with a rating of at least three on one of the first three dimensions requires treatment at this level.
6. **Engagement and Recovery Status** - a rating of three or higher in conjunction with a rating of at least three on one of the first three dimensions requires treatment at this level.
7. **Composite Rating** - while a client may not meet any of the above independent ratings, in some circumstances, a combination of factors may require treatment in a more structured setting. This would generally be the case for clients who have a composite rating of 24 or higher.



VI. LEVEL SIX - Medically Managed Residential Services

Definition:

This is the most intense level of care in the continuum. Level Six services have traditionally been provided in hospital settings, but in many cases, they may be provided in freestanding non-hospital settings. With the expectation that individuals utilizing these services will almost always have complex needs, these services should be welcoming to individuals who have multiple conditions, and should be able to provide “co-occurring capable” services.

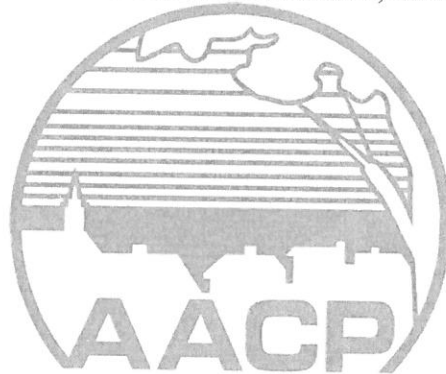
Payer authorization is usually required for this level of service. Reviews of revised LOCUS assessments should not be more often than every three days for acute intensive care settings such as inpatient psychiatric hospitals, and no more than every month for long term secure care services such as state hospitals or community based locked facilities. Professionals providing services should be appropriately licensed and certified and should include a full array of disciplines including rehabilitation, addiction, and medical specialists. Some support services may be provided by paraprofessionals, including peer specialists, who have been trained and/or certified.

Whatever the case may be, Level Six settings must be able to provide the following:

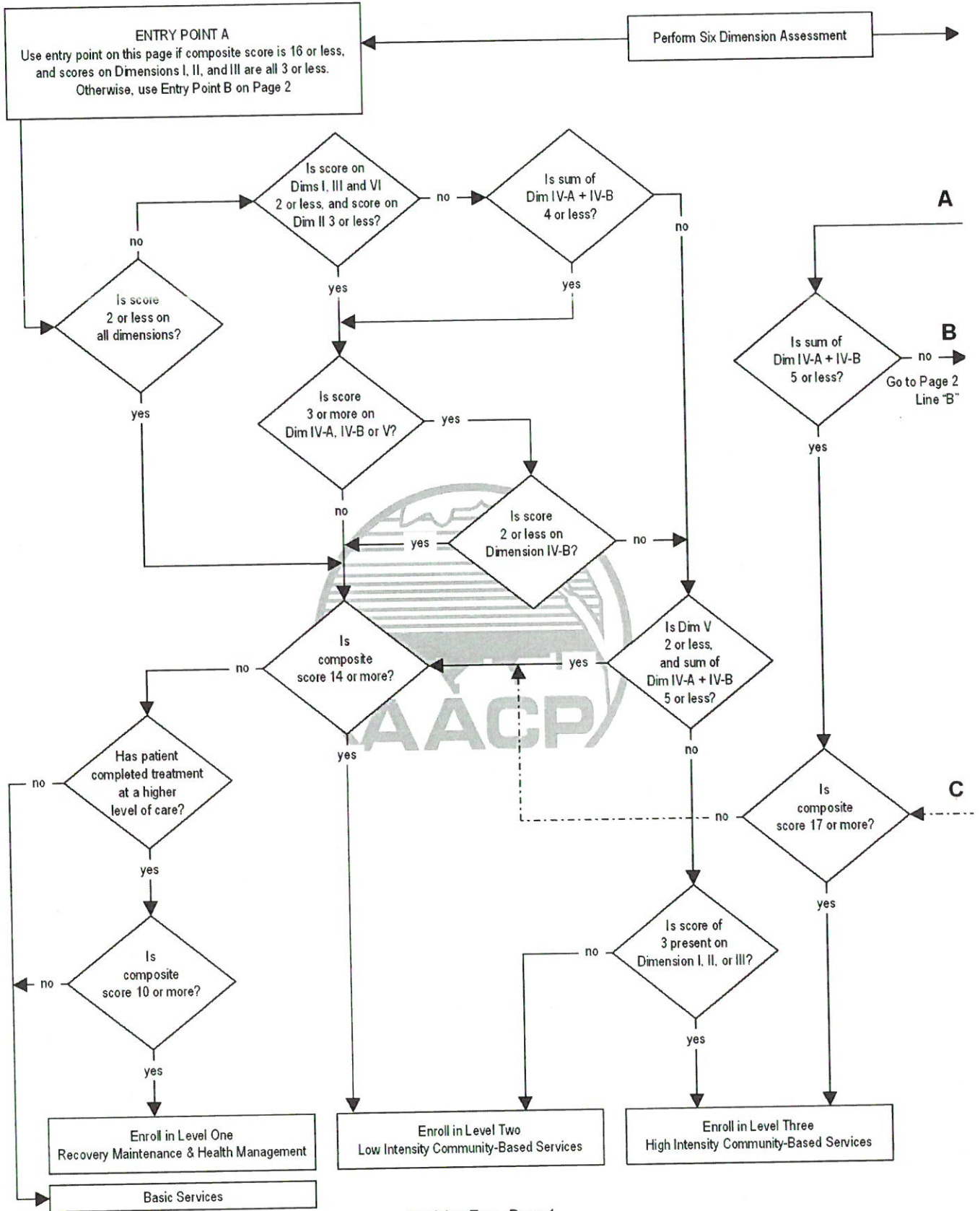
- 1. Care Environment** - The facility must be capable of providing secure care, usually meaning that clients should usually be contained within a locked environment (this may not be necessary for services such as detoxification, however) with adequate space to accommodate effective de-escalation techniques and isolation if needed. It should be capable of providing involuntary care when called upon to do so. Facilities must provide adequate space, light, ventilation, and privacy. Food services and other personal care needs must be adequately provided.
- 2. Clinical Services** - Clinical services must be available 24 hours a day, seven days a week. Psychiatric, nursing, and medical services must be available on site, or in close enough proximity to provide a rapid response, at all times. Psychiatric/medical contact will generally be made on a daily basis. Treatment will be provided on a daily basis and would include individual, group and family therapy as well as pharmacologic treatment, depending on the client’s needs. Intensity of services should be consistent with CMS certification and Joint Commission accreditation requirements.
- 3. Supportive Services** - All necessities of living and well being must be provided for clients treated in these settings. When capable, clients will be encouraged to participate in and be supported in efforts to carry out activities of daily living such as hygiene, grooming and maintenance of their immediate environment.
- 4. Crisis Resolution and Prevention Services** - These residential settings must provide services designed to reduce the stress related to resuming normal activities in the community. Such services might include coordination with community case managers, family and community resource mobilization, environmental evaluation and coordination with residential services, and coordination with and transfer to less intense levels of care.

Placement Criteria:

1. **Risk of Harm** - a rating of five qualifies an admission independently of other parameters.
2. **Functional Status** - a rating of five qualifies placement independently of other variables.
3. **Co-Morbidity** - a rating of five qualifies placement independently of other parameters.
4. **Recovery Environment** - a rating of four or more would be most appropriate for this level, but no rating in this parameter qualifies placement independently at this level, nor would it disqualify placement if otherwise warranted.
5. **Treatment and Recovery History** - a rating of four or more would be most appropriate for this level but, no rating in this dimension qualifies placement independently at this level, nor would it disqualify an otherwise warranted placement.
6. **Engagement and Recovery Status** - a rating of four or more would be most appropriate for this level but no rating in this parameter qualifies or disqualifies placement independently at this level.
7. **Composite Rating** - in some cases, patients not meeting independent criteria in any one category, may still need treatment at this level if ratings in several categories are high, thereby increasing the risk of treatment in a less intensive setting. A composite rating of 28 (an average rating of four or more in each dimension) would indicate the need for treatment at this level.

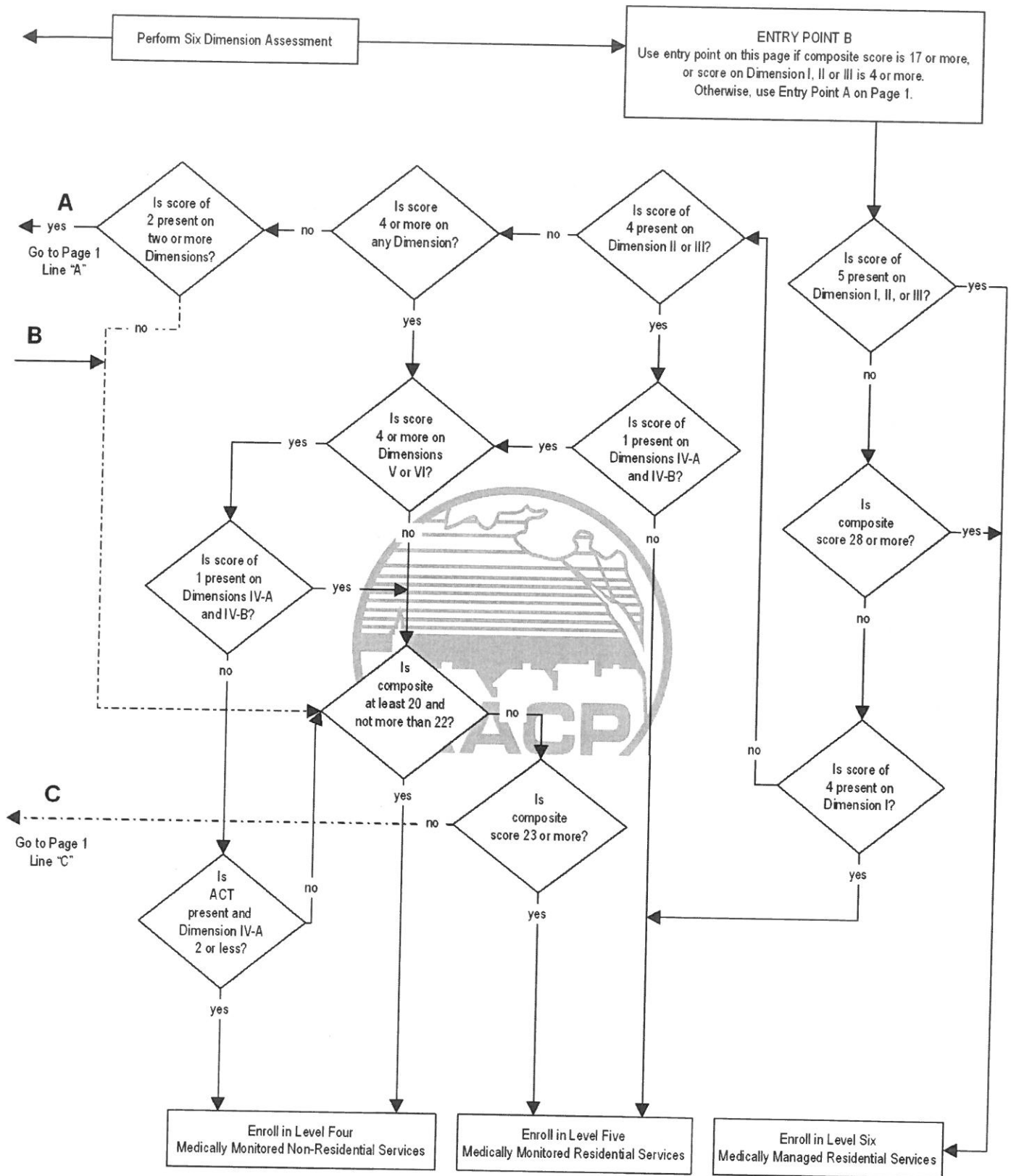


AACP LEVEL OF CARE DETERMINATION DECISION TREE



Decision Tree, Page 1

AACP LEVEL OF CARE DETERMINATION DECISION TREE



Decision Tree, Page 2

AACP LEVEL OF CARE DETERMINATION GRID

Level of Care Dimensions		Recovery Maintenance Health Management	Low Intensity Community Based Services	High Intensity Community Based Services	Medically Monitored Non-Residential Services	Medically Monitored Residential Services	Medically Managed Residential Services
		Level 1	Level 2	Level 3	Level 4	Level 5	Level 6
I.	Risk of Harm	2 or less	2 or less	3 or less	3 or less	④ 3	⑤ 4
II.	Functional Status	2 or less	2 or less	3 or less	3 or less	④* 3	⑤ 4
III.	Co-Morbidity	2 or less	2 or less	3 or less	3 or less	④* 3	⑤ 4
IV A.	Recovery Environment "Level of Stress"	Sum of IV A + IV B is 4 or less	Sum of IV A + IV B is 5 or less	Sum of IV A + IV B is 5 or less	3 or 4	4 or more	4 or more
IV B.	Recovery Environment "Level of Support"				3 or less	4 or more	4 or more
V.	Treatment & Recovery History	2 or less	2 or less	3 or less	3 or 4	3 or more	4 or more
VI.	Engagement & Recovery Status	2 or less	2 or less	3 or less	3 or 4	3 or more	4 or more
Composite Rating		10 to 13	14 to 16	17 to 19	20 to 22	23 to 27	28 or more

○ indicates independent criteria - requires admission to this level regardless of composite score

* Unless sum of IV A and IV B equals 2

APPENDIX I

LOCUS Supplementary Criteria for Residential Placement

In the LOCUS system, Levels Five and Six represent the most intensive and restrictive treatment programs. As with all LOCUS levels of care, there is a spectrum of service elements and venues that can be offered to those who require this degree of service intensity. LOCUS is designed to respect the wisdom of local providers to make appropriate decisions regarding need and service matching given their awareness of the array of services that are available in their area. Still, some users have requested some guidance for making these decisions and these criteria intend to provide just that. With these supplementary criteria, two distinct types of programs are described for Level Six and three for Level Five. For each of these subtypes, specific LOCUS criteria in a client's profile indicate their appropriateness for the designated service. Suggested lengths of stay and workforce requirements are indicated as well. These recommendations continue the LOCUS tradition of placing the final well-reasoned decisions to providers and their partners who are using services.

Level 5A: Intensive-Short Term Residential Services

Description: This type of residential treatment facility has capacity to treat persons who are stepping down from acute inpatient care or people who are in crisis but who do not require the security of a locked facility. These services are capable of providing intense treatment programming (as described for all Level 5 services) and they are sometimes referred to as sub-acute or respite care. Length of stay usually would not exceed 7-10 days.

Criteria:

- 1) Meets criteria for LOCUS Level 5 (Medically Monitored Residential Services)
AND
- 2) Meets at least one of the following specific criteria:
 - I.4a Current suicidal or homicidal ideation with expressed intentions and/or past history of carrying out such behavior but without means for carrying out the behavior, or with some expressed inability or aversion to doing so.
 - I.4b History of chronic impulsive suicidal/homicidal behavior or threats with current expressions or behavior representing a significant elevation from usual behavior.
 - III.3a Intoxication with potential to develop a physiologic withdrawal syndrome, which may require significant medical monitoring.
 - III.3d Episodic substance use impacting the severity of the risk of harm or functional impairment.
 - IV-A.4a-g Recent or sudden exposure to traumatic event or circumstances impacting functional status.
 - IV-B.4a-d Recent deterioration in supportive structures impacting functional capacity.
 - V.3b Past episodes of treatment have provided little or no benefit.
 - V.4a Repeated past inpatient admissions with limited benefit.
 - VI.3b Has limited desire or commitment to change.

- VI.3c Relates to treatment with some difficulty and establishes few, if any, trusting relationships.
- VI.3e Has limited ability to accept responsibility for recovery.

Level 5B: Moderate Intensity Intermediate Stay Residential Treatment Programs

Description: This type of residential treatment facility has capacity to treat persons who are in need of rehabilitation and skill building following stabilization of a crisis situation or to prevent precipitous deterioration in functioning. It would provide an intensive treatment environment as described for all Level 5 programs. These programs are sometimes referred to as short-term residential rehabilitation facilities and length of stay usually does not exceed 60 days.

Criteria:

1) Meets criteria for LOCUS Level 5 (Medically Monitored Residential Services)

AND

2) Meets at least one of the following specific criteria:

- I.3a-c Client may experience some ideation or have some history related to harm of self or others, but the current risk of engaging in such behaviors is relatively low.
- II.3f Recent gains and/or stabilization in function have been achieved while participating in treatment in a structured and/or protected setting (Medically Managed Res. Rx).
- II.4a Significant disturbance in interpersonal skills and interactions.
- II.4e Serious impairment in expected role functioning at work, school, or home.
- III.3d&f Co-occurring substance use and mental health disorders are both active and interact to seriously impede ability to enter recovery.
- III.3e Substance use temporarily arrested in a highly structured or protected setting, but recovery is not initiated.
- III.4a-c Acute or unstable medical conditions exist which may require intensive medical monitoring and which may be adversely affected by coexisting substance use or mental health issues.
- IV-A.3a-g Ongoing difficulties with life circumstances exceeding ability to cope and enter recovery process.
- IV-B.3.e Difficulty developing relationship with or using available sources of support.
- V.3a-c Previous treatment, particularly in less intensive levels of care, have not been successful.
- VI.3a-e Agrees to participate in intensive residential treatment, whether coerced or voluntarily, despite limited understanding of illness, desire to change, ability to accept responsibility, or to engage with caregivers or programs.

Level 5C: Moderate Intensity Long Term Residential Treatment Programs

Description: This type of residential treatment facility has capacity to treat persons who are suffering from long term and persistent disabilities that require extended rehabilitation and skill building in order to develop capacity for community living. This category would include long term nursing and rehabilitation facilities. These facilities will provide intensive treatment as described for all Level 5 programs and the length of stay will vary from two months to a year.

Criteria:

1) Meets criteria for LOCUS Level 5 (Medically Monitored Residential Services)

AND

2) Meets at least one of the following specific criteria:

- I.4d Clear and chronic compromise of ability to care adequately for oneself or to be adequately aware of environment.
- II.3e Chronic and severe deficits in interpersonal skills, ability to engage in socially constructive activities and ability to maintain even minimal responsibilities.
- III.4a Chronic medical conditions exist which may require intensive medical monitoring.
- III.4b Chronic medical conditions exist which are seriously exacerbated by concurrent psychiatric or addiction problems which cannot be controlled outside a structured setting.
- III.4d Substance use is uncontrolled outside a structured setting and seriously destabilizes psychiatric disorder.
- V.4a-b Minimal past response to treatment and inability to maintain any gains achieved outside an intensive and highly structured setting.
- V.5a-b Symptoms are persistent despite extensive and intensive treatment exposure.
- VI.5a-d Chronic inability to understand disability, recovery, responsibility or to relate to other individuals.

Level 6A: High Intensity, Acute Medically Managed Residential Programs

Description: Acute residential programs are most analogous to services commonly provided by community or specialty hospital based psychiatric care, providing a highly secure and intensively monitored environment. Frequent psychiatric contact and close management is provided in addition to a full range of additional treatment options. In most cases, clients requiring this level of care can be stabilized within a short period of time (length of stay less than 7 days) and can be stepped down to Level 5A, Intensive Short Term Residential Services.

Criteria:

1) Meets criteria for LOCUS Level 6 (Medically Managed Residential Services)

AND

2) Meets at least one of the following specific criteria:

- I.4b History of chronic impulsive suicidal/homicidal behavior or threats with current expressions or behavior representing a significant elevation from usual behavior.

- I.5a Current suicidal or homicidal behavior or such intentions with a plan and available means to carry out this behavior...
 - without expressed ambivalence or significant barriers to doing so, or
 - with a history of serious past attempts which are not of a chronic, impulsive or consistent nature, or
 - in presence of command hallucinations or delusions which threaten to override usual impulse control.
- I.5b Repeated episodes of violence toward self or others, or other behaviors resulting in harm while under the influence of intoxicating substances with pattern of nearly continuous and uncontrolled use.
- I.5c Extreme compromise of ability to care for oneself or to adequately monitor environment with evidence of deterioration in physical condition or injury related to these deficits.
- II.5a Extreme deterioration in social interactions which may include chaotic communication, threatening behaviors with little or no provocation, or minimal control of impulsive, aggressive or otherwise abusive behavior.
- II.5c Complete neglect of personal hygiene and appearance and inability to attend to most basic needs such as food intake and personal safety with associated impairment in physical status.
- II.5d Extreme disruptions in physical functioning causing serious harm to health and well being.
- III.5a Significant medical conditions exist which may be poorly controlled and/or potentially life threatening in the absence of close medical management (e.g., severe or complicated alcohol withdrawal, uncontrolled diabetes mellitus, complicated pregnancy, severe liver disease, debilitating cardiovascular disease).

Level 6B: Medically Managed Extended Care Residential Programs

Description: This level of service is intended for clients who cannot be adequately stabilized within a short period of time and display variably volatile or dysfunctional behaviors producing ratings which indicate that they require extended care on Level 6. Extended Care Residential Programs are most analogous to services commonly provided at State Hospitals or Highly Secure Community Based Locked Facilities (sometimes known as Long Term Secure Residential {LTSR} Facilities). There are situations in which persons who are severely ill may require such a setting for many months before they can be stepped down to Level 5 Services.

Criteria:

- 1) Meets criteria for LOCUS Level 6 (Medically Managed Residential Services)
- AND
- 2) Does not meet any of the specific criteria needed for Level 6A, High Intensity, Acute Medically Managed Residential Programs

APPENDIX II

Proposed LOCUS Guidelines for Meeting Primary Care Needs

One of the most important changes in behavioral health in recent years is the expanded understanding of “integration” and the substantial progress that has been made in designing and delivering integrated services in the last decade. This appendix to LOCUS 20 proposes specific criteria for the degree of integration or collaboration in behavioral health programs and how they address the complex needs of the individuals they serve. The main focus is on those individuals with co-occurring behavioral health and physical health conditions. Dimension III of LOCUS has always incorporated an assessment of the level of risk and severity related to co-morbidity as a factor in determining the recommended “level of care”. These guidelines use the specific ratings in Dimension III that relate to medical conditions to suggest the type of program that is most likely to meet the identified needs of an individual.

With these criteria we hope to begin a more formal and specific dialogue about what a standard of care regarding integration might look like. We offer this framework as a work in progress. This pilot version is provided to generate feedback from users regarding the utility of these guidelines. Specifically, are the guidelines useful to clinicians making placement decisions? Do the Dimensional ratings allow meaningful distinctions to be made regarding these decisions? Are the levels of integration useful constructs? Your comments and suggestions are appreciated.

Definitions of levels of integration:*

- A. Minimal collaboration:** Behavioral health and primary care providers work in separate facilities, have separate systems and communicate intermittently as needed for referral purposes.
- B. Basic collaboration at a distance:** Behavioral health and primary care providers have separate systems at separate sites and engage in periodic communication about shared patients.
- C. Close Collaboration – collaboration on-site with minimal integration:** Behavioral health and primary care providers have separate systems but share the same facility. Proximity allows more communication, but each provider remains in the separate clinical culture.
- D. Partial Integration – close collaboration on-site in a partly integrated system:** Behavioral health and primary care providers share the same facility and have some systems in common, such as scheduling appointments or medical records. Physical proximity allows for regular face-to-face communication. There is a greater sense of being part of a clinical team in which providers have separate/specialized as well as shared roles in working together to treat their patients.
- E. Full Integration – close collaboration approaching a fully integrated system:** Behavioral health and primary care providers are part of the same team. The patient experiences the behavioral health and primary care as jointly and interdependently provided.

* Derived from Pollack et al. Handbook of Community Psychiatry, Chapter 14, Integrated Care and Psychiatrists; Ed McQuiston H. et al Springer Publishing, New York 2012

Level 1: Recovery Maintenance and Health Management

Coordination with primary care providers should be arranged as appropriate. People at this level will have scores of 3 or lower on Dimensions I, II and III, and can have their needs met as follows:

A. Minimal Collaboration: Dim III rating 2 or lower

Whole health needs can be met by the primary care physician OR the primary care psychiatrist for people assigned these scores. When the person is seeing both PCP and a psychiatrist, communication lines should be in place.

B. Basic Collaboration: Dim III rating 3a, 3b or 3c

Whole health needs should be met through coordination between primary care and behavioral health providers for people obtaining these scores. Dually trained physicians (Primary Care and Psychiatry) are preferred if available.

Level 2: Low Intensity Community Based Services

Physical health needs can be met through coordination with primary care, preferably co-located. People at this level will have scores of 3 or lower on Dimensions I, II and III, and can have their needs met as follows:

A. Minimal Collaboration: Dim III rating 2 or lower

Whole health needs can be met by the primary care physician OR the primary care psychiatrist for people assigned these scores. When the person is seeing both PCP and a psychiatrist, communication lines should be in place.

B. Basic Collaboration: Dim III rating 3a, 3b or 3c

Whole health needs should be met through coordination between primary care and behavioral health providers for people obtaining these scores. Dually trained physicians (Primary Care and Psychiatry) are preferred if available.

C. Close Collaboration: Dim III rating 3a, 3b or 3c

Primary health needs should be well coordinated between behavioral and physical health care providers. In many cases where psychiatric resources are scarce, collaborative care arrangements will be appropriate and effective. Telepsychiatry may be an option for persons living in isolated areas.

Level 3: High Intensity Community Based Services

Close coordination with primary care should be in place and co-located if possible. People at this level will have scores of 3 or lower on Dimensions I, II and III, and can have their needs met as follows:

A. Minimal Collaboration: Dim III rating 2 or lower

Whole health needs can be met by a primary care physician for people assigned these scores, in coordination with the treating psychiatrist. A method of communication should be established and effective.

B. Basic Collaboration: Dim III rating 3a, 3b or 3c; Dim I and II ratings are both 2 or lower
Whole health needs should be met through coordination between primary care and behavioral health providers for people obtaining these scores. Dually trained physicians (Primary Care and Psychiatry) are preferred if available.

C. Close Collaboration: Dim III rating 3a, 3b or 3c; Dim I and II ratings are both 3 or lower
Primary health needs should be well coordinated between behavioral and physical health care providers. When possible, co-located primary care will be advantageous. Dually trained physicians will also offer many advantages.

D. Partial Integration: Dim III rating 3a, 3b or 3c; Dim I and II ratings are both 3 or lower; Sum of Dim IV-A, IV-B, V and VI ratings 10 or higher

This level of collaboration will rarely be required at this level of care. More significant medical issues (4 or higher) will need a higher level of care. However, programs that offer this level of integration will be advantageous for people who have some medical issues and several other complicating factors that might impair their ability to care for themselves well.

Level 4: Medically Monitored Non-Residential Services

Physical health care needs will vary considerably at this level and co-located services will be desirable. People will at this level will have scores of 3 or lower on Dimensions I, II and III, and can have their needs met as follows:

B. Basic Collaboration: Dim III rating 2 or lower

Whole health needs should be met through coordination between primary care and behavioral health providers for people obtaining these scores. Minor health issues do not require co-located primary care, although it would be advantageous when programs are able to provide it.

C. Close Collaboration: Dim III rating 3a, 3b or 3c; Sum of Dim I and II ratings is 5 or lower; Sum of Dim IV-A, IV-B, V and VI ratings is 14 or higher

Primary health needs should be well coordinated between behavioral and physical health care providers. When possible, co-located primary care will be advantageous. Dually trained physicians will also offer many advantages.

D. Partial Integration: Dim III rating 3a, 3b or 3c; Sum of Dim I and II ratings is 6 or higher; Sum of Dim IV-A, IV-B, V and VI ratings is 15 or higher

This level of collaboration is desirable for people who score in this range. More significant medical issues (4 or higher) will need a higher level of care. Programs that offer this level of integration will be advantageous for people who have some medical issues and several other complicating factors that might impair their ability to care for themselves well or which put them at risk of developing significant physical illness.

Level 5: Medically Monitored Residential Services

Physical health care needs will vary considerably at this level and co-located services will be desirable. Scores of 4 or less will be present on Dimensions I, II and III, and primary care needs can be met as follows.

B. Basic Collaboration: Dim III rating 2 or lower

Whole health needs should be met through coordination between primary care and behavioral health providers for people obtaining these scores. Minor health issues do not require co-located primary care, although it would be advantageous when programs are able to provide it. Programs offering this low level of collaboration must be able to make accommodations for off site doctor's visits.

C. Close Collaboration: Dim III rating 3a, 3b or 3c; Sum of Dim I and II ratings is 5 or lower

Primary health needs should be well coordinated between behavioral and physical health care providers and services should be co-located primary care or provided on site. Dually trained physicians will also offer many advantages.

D. Partial Integration: Dim III rating of 3 or 4; Sum of Dim I and II ratings is 6 or higher

This level of collaboration is desirable for people who score in this range. More significant medical issues (5 or higher) will require a higher level of care. Programs that offer this level of integration will be advantageous for people who have some unstable medical issues and several other complicating factors that require close collaboration to ensure safety.

E. Full Integration: Dim III rating of 4; Sum of Dim I and II ratings is 7 or higher; Sum of Dim IV-A, IV-B, V and VI ratings is 15 or higher

Programs offering this level of integration can care for persons who are unstable both mentally and physically requiring frequent contact and monitoring as well as close coordination of care.

Level 6: Medically Managed Residential Services

Physical health needs may be intense at this level, and many of these clients will have restricted access to the community. Scores up to 5 may be present on Dimensions I, II and III.

E. Full Integration:

Programs providing care for persons with this level of need should be able to offer fully integrated services to all clients receiving care. This will be particularly important for people who are unstable both mentally and physically.

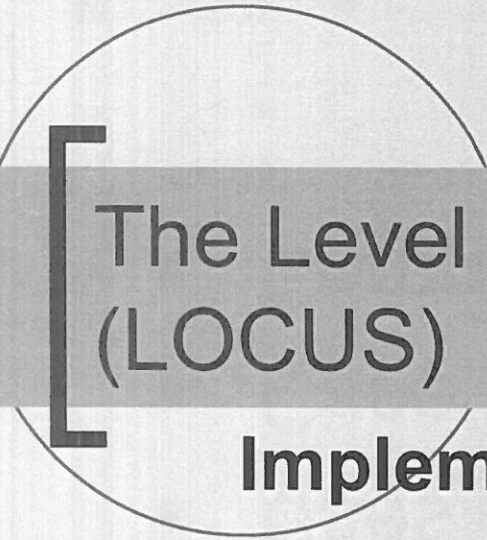
LOCUS WORKSHEET VERSION 20

Client Name _____ Date _____

Please check the applicable ratings within each dimension and record the score in the lower right hand corner.
Total your score and determine the recommended level of care using the Decision Tree.

<p>I. Risk of Harm Criteria</p> <p><input type="checkbox"/> 1. Minimal Risk of Harm _____</p> <p><input type="checkbox"/> 2. Low Risk of Harm _____</p> <p><input type="checkbox"/> 3. Moderate Risk of Harm _____</p> <p><input type="checkbox"/> 4. Serious Risk of Harm _____</p> <p><input type="checkbox"/> 5. Extreme Risk of Harm _____</p> <p style="text-align: right;">Score _____</p>	<p>IV-B. Recovery Environment - Level of Support Criteria</p> <p><input type="checkbox"/> 1. Highly Supportive Environment _____</p> <p><input type="checkbox"/> 2. Supportive Environment _____</p> <p><input type="checkbox"/> 3. Limited Support in Environment _____</p> <p><input type="checkbox"/> 4. Minimal Support in Environment _____</p> <p><input type="checkbox"/> 5. No Support in Environment _____</p> <p style="text-align: right;">Score _____</p>
<p>II. Functional Status Criteria</p> <p><input type="checkbox"/> 1. Minimal Impairment _____</p> <p><input type="checkbox"/> 2. Mild Impairment _____</p> <p><input type="checkbox"/> 3. Moderate Impairment _____</p> <p><input type="checkbox"/> 4. Serious Impairment _____</p> <p><input type="checkbox"/> 5. Severe Impairment _____</p> <p style="text-align: right;">Score _____</p>	<p>V. Treatment and Recovery History Criteria</p> <p><input type="checkbox"/> 1. Fully Responsive _____</p> <p><input type="checkbox"/> 2. Significant Response _____</p> <p><input type="checkbox"/> 3. Moderate or Equivocal Response _____</p> <p><input type="checkbox"/> 4. Poor Response _____</p> <p><input type="checkbox"/> 5. Negligible Response _____</p> <p style="text-align: right;">Score _____</p>
<p>III. Co-Morbidity Criteria</p> <p><input type="checkbox"/> 1. No Co-Morbidity _____</p> <p><input type="checkbox"/> 2. Minor Co-Morbidity _____</p> <p><input type="checkbox"/> 3. Significant Co-Morbidity _____</p> <p><input type="checkbox"/> 4. Major Co-Morbidity _____</p> <p><input type="checkbox"/> 5. Severe Co-Morbidity _____</p> <p style="text-align: right;">Score _____</p>	<p>VI. Engagement and Recovery Status Criteria</p> <p><input type="checkbox"/> 1. Optimal Engagement and Recovery _____</p> <p><input type="checkbox"/> 2. Positive Engagement and Recovery _____</p> <p><input type="checkbox"/> 3. Limited Engagement and Recovery _____</p> <p><input type="checkbox"/> 4. Minimal Engagement and Recovery _____</p> <p><input type="checkbox"/> 5. Unengaged and Stuck _____</p> <p style="text-align: right;">Score _____</p>
<p>IV-A. Recovery Environment - Level of Stress Criteria</p> <p><input type="checkbox"/> 1. Low Stress Environment _____</p> <p><input type="checkbox"/> 2. Mildly Stressful Environment _____</p> <p><input type="checkbox"/> 3. Moderately Stressful Environment _____</p> <p><input type="checkbox"/> 4. Highly Stressful Environment _____</p> <p><input type="checkbox"/> 5. Extremely Stressful Environment _____</p> <p style="text-align: right;">Score _____</p>	<p>Composite Score []</p> <p>Level of Care Recommendation []</p>

Rater Name _____



The Level of Care Utilization System
(LOCUS)

Implementation and Practical Application

District of Columbia
Department of Mental Health



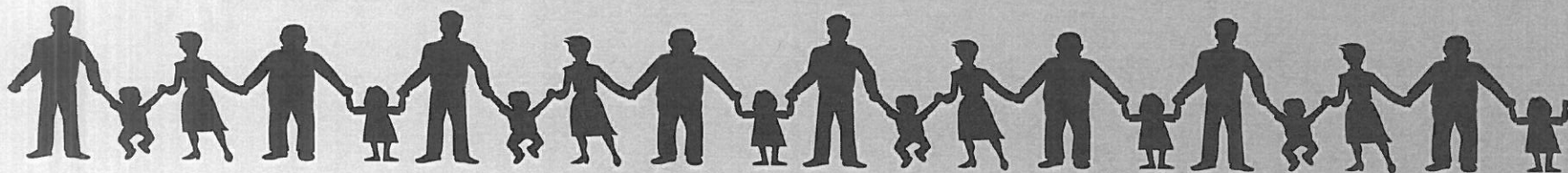
[Training agenda]

- LOCUS overview
- Scoring the LOCUS
- Uses of the LOCUS
- Case vignettes
- Completing LOCUS on the Web



The LOCUS

What is it and why use it?



[What is the LOCUS?]

- **L** – Level
- **O** – of
- **C** – Care
- **U** – Utilization
- **S** – System

An assessment and placement instrument developed by American Association of Community Psychiatrists (AACCP)

- Created to :
 - guide assessment: asking and evaluating relevant data
 - level of care, (LOC) placement decisions
 - continued stay criteria: envisioned as continuing need for service over time
 - clinical outcomes: impact of treatment

[Why use the LOCUS?]

- Quantifiable, facilitating communication, interactiveness, consistency and tracking change
- Combines assessment (clinical needs) with levels of care (resource management)
- Reliable – used across the country; multiple locations, programs, etc.

Why use the LOCUS?

- Not diagnostically driven
 - Looks at current needs – recognizes that some individuals need similar treatment models even with different diagnoses
 - Prioritizes needs: current needs
 - Snapshot only: things change – in some cases quite rapidly
- Adaptable - allows for a changing continuum

[Fundamental principles]

- Simple to use
- Able to be completed after or during assessment – removes redundancy
- Measures both psychiatric and addiction problems and their impact on client together
- Levels of care are flexible – describes resources and intensity not programs – adaptable to any continuum of care
- Dynamic model – measures client needs over time – eliminates need for separate admission, discharge and continuing stay criteria when using this instrument

LOCUS

Assessment Dimensions

- Determine the intensity of service needs
- Provide a spectrum along which a client may lie on each of the dimensions
- Quantifiable to convey information easily
 - **Composite Score based on 5-point scale**
- Shows interaction of individual dimensions
- Creates moving picture of client over time

[Six assessment dimensions]

1. Risk of Harm;
2. Functional Status;
3. Medical, Addictive and Psychiatric Co-Morbidity;
4. Recovery Environment;
5. Treatment and Recovery History; and
6. Engagement.

[LOCUS levels of care]

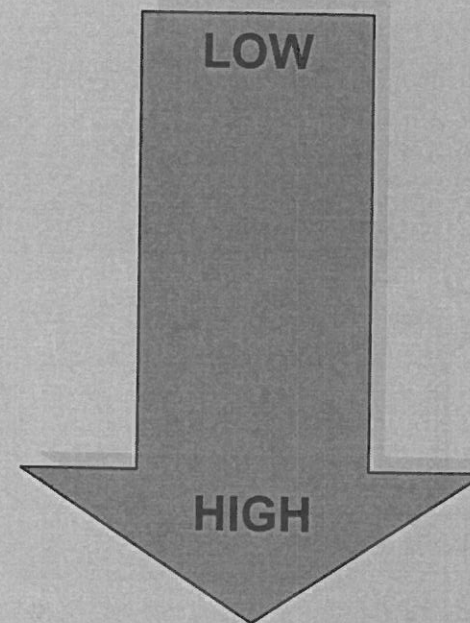
- Define resources in flexible/adaptable terms
- Applicable to wide variety of service environments and systems
- Each level made up of 4 “main ingredients:”
 - Care Environment,
 - Clinical Services
 - Support Services, and
 - Crisis Resolution and Prevention Services

Six service levels of care

- Basic Services (not a service level of care)

LEVELS:

- I. Recovery maintenance and health management
- II. Low Intensity Community-Based
- III. High Intensity Community-Based
- IV. Medically monitored non-residential
- V. Medically monitored residential
- VI. Medically managed residential



Scoring the LOCUS

Procedures and considerations for
determining appropriate levels of care

Dimensional rating system

- Assesses level of severity of client's needs
- Each dimension has a 5-point rating scale
- Each point has one or more criteria
- Only 1 criteria needs to be met for the rating to be assigned
- If there is criteria in two points pick the highest
- Do not add criteria to get a higher score

[Dimensional rating system]

- Ratings range from minimal (0) to extreme (5)
- If nothing fits exactly, pick the closest fit – err on the side of caution
- Use interview, clinical judgment, records, family, school, and collaborative data **Resource: LOCUS interview protocol*

[Dimensional rating system]

- Score is based on an evaluation of 6 dimensions
- ***Must use a primary presenting issue to complete the evaluation: e.g. dually diagnosed – choose one***
- Other conditions seen as co-morbidity
- Think of the condition most readily apparent, the primary reason why someone came into care or is still in care

[Scoring the LOCUS]

- Scoring:
 - The composite score:
 - 6 dimensions, 7 scores
 - Highest possible score for each dimension= 5

**Scoring Resources: 1) Decision Grid; 2) Decision Tree and 3)
LOCUS Web-based Application*

- Must evaluate the client as he or she is now
 - In a residential facility strip away supports. (functionality, stress, supports)