CARE MANAGEMENT ORGANIZATIONS - HIGH

Care Management Organization (CMO) - High

Program Description

Care Management Organizations (CMO) are independent, community-based organizations that combine advocacy, individualized service planning and care management into a single, integrated, cross-system process.

CMO services provide a single point of accountability to ensure services and supports are accessed, coordinated, and delivered in a strength-based, individualized, youth and family driven and culturally and linguistically relevant manner. CMO - High provides services to youth with severe intensity treatment needs.

The CMO designs, implements, and manages youth-guided and family-driven, Care Plans for children and adolescents whose needs are complex and require intensive care management techniques that may cross multiple service systems. CMO responsibilities also include the following elements:

- Intended to meet the needs of youth assessed with complex emotional/behavioral challenges.
- Developed through a high-fidelity *Wraparound* planning process, designed to ensure that the family has ownership of the planning process in partnership with the team through the Child Family Team (CFT) Process, and that the family is in agreement with the treatment goals and is committed to carry out the plan.
- Consistent with *Systems of Care* philosophy.
- Incorporated into an individualized, flexible, and sustainable plan of care for the youth and family.
- Designed to help address the needs of youth and their families by facilitating a collaborative relationship with other youth serving systems.
- Coordinated by a CMO care manager who advocates, organizes and arranges necessary supports and/or services in the areas of behavioral health, substance use, and intellectual/developmental disability services, as well as financial, educational, and social services to help restore, enhance and maintain a developmentally appropriate level of functioning for the youth and family.
- Time-limited in nature with the projected duration of care management services to be approximately twelve to fourteen months.

Through implementation of the high-fidelity wraparound model, the CMO facilitates the CFT and coordinates the development of the Care Plan to assure that the youth and family receive customized services that are delivered in the community. The plan is comprehensive in nature and addresses areas of everyday living beyond the treatment of behavioral health symptoms.

Criteria	
Admission Criteria	The relevant clinical information indicate that the youth require a high level of care management services and the youth must meet A through H below: A. The youth is between the ages of five and until their twenty-first birthday. Special consideration will be given to children under five. Eligibility is in place up to and including the day prior to the young adult's twenty-first birthday. B. The youth has been evaluated within the past year and determined to have symptoms and behaviors consistent with, a DSM 5 diagnosis, or they have been diagnosed with a DSM 5 diagnosis. C. Severe intensity symptoms are evident in one or more areas within any of the following domains: 1. Behavioral, emotional symptoms that may include psychosis, impulsivity, hyperactivity, depression, anxiety, oppositional, conduct, or anger control. 2. Risk behaviors that may include suicide risk, self-injurious behavior, danger to others, problematic sexual behavior, substance use, fire setting, or other self-harm. 3. Trauma, which is potentially associated with disturbance in sleeping pattern, eating patterns, elimination practices, attention abilities, impulse control abilities, mood regulation abilities, or re-experiencing past traumatic experiences. The identified trauma could have been explicit, implicit, discrete, or recurrent. D. The behavioral health condition identified above has resulted in the youth's decline from baseline in functional impairment in two or more of the following life domains: 1. Self-Care - Behaviors involving basic hygiene, nutritional needs and physical health needs which are consistent with maintaining the youth's health and wellness. 2. Community Functioning - Behaviors observed in the community demonstrating personal safety and developmentally appropriate decision-making skills. 3. Social Relationships – Behaviors pertaining to maintaining positive and supportive relationships with peers and adults. 4. Family Functioning – Behaviors indicating constructive, considerate relationships with family members. There may be concerns regarding communication and or interactions with care providers, siblings, or other family members. 5. School/Vocational/Work Functioning – Behaviors suggesting successful function in the school or vocational setting. There may

	be concerns regarding poor school attendance, decline in productivity or maladaptive behavior in the school/vocational/work setting. E. Acute Care intensity of treatment is clinically indicated to address the severity of functional impairment that the youth is currently presenting with, or the youth may be receiving inpatient psychiatric treatment or out-of-home treatment at the present time. F. The youth appears to be in need of an array of services and supports requiring coordination and assistance through the CFT process. Specifically, this youth's clinical needs require multidimensional treatment services. Coordination of services may include medication management services, specialized behavioral health services, child study team services, or co-occurring treatment needs involving substance use, physical health, or Intellectual/Developmental Disability. Collaboration and or linkage with family and community supports, or coordination with multiple system agencies such as the Division of Child Protection and Permanency (DCP&P), legal services, or the Juvenile Justice Commission (JJC). G. The youth and caregiver require face-to-face assistance in obtaining or coordinating treatment, rehabilitation, habilitation, financial and/or social services, without which the youth could reasonably be expected to have a decline in functioning that would require more intensive behavioral health services. H. The person(s) with authority to consent to treatment for the youth voluntarily agrees to participate. The assent of a youth who is not authorized under applicable law to consent to treatment is desirable but not required.

	Youth who receive Out of Home Substance Use Treatment (short term or long term residential) and exhibit co-occurring behavioral health treatment needs are considered presumptively eligible for 30 days from date of enrollment due to serious substance use treatment needs, but must meet the Admission Criteria I: I. Youth is diagnosed with a behavioral health disorder consistent with a DSM 5 diagnosis or symptoms consistent with a DSM 5 diagnosis within thirty days from the date of enrollment. Youth with an Intellectual and/or Developmental Disability (I/DD) in the absence of a co-occurring behavioral health disorder diagnosis, may be exempted from the Admission Criteria B above, but must additionally meet the following criteria J: J. Youth has been determined to be eligible for DD services. Youth who were determined eligible by the Division of Developmental Disabilities (DDD), need not re-apply for a determination of eligibility for Children's System of Care (CSOC) Functional Services. The CSOC will accept the Division of Developmental Disability (DDD) eligibility determination regarding whether the youth has a developmental disability.
Exclusionary Criteria	Any of the following criteria is sufficient for exclusion from this level of care. A. The youth's parent/guardian/caregiver or youth if age eighteen and older does not voluntarily consent to CMO High services. B. The clinical information presented indicates that the youth can be safely maintained and effectively supported in a less intensive level of care management. C. The youth has medical conditions or physical health impairments that would prevent participation in behavioral health services. D. The youth's primary treatment needs pertain specifically to substance use and/or medical intervention or medical monitoring or management is clinically indicated prior to addressing behavioral health treatment needs. E. For youth presenting with a sole diagnosis of I/DD, the youth has not been determined eligible or presumptively eligible for CSOC Functional Developmental Disability Services or DDD Services. F. The youth is not a resident of New Jersey. For minors who are under eighteen years of age, the residency of the parent or legal guardian shall determine the residence of the minor.

Continued Stay Criteria	All the following criteria A through G are necessary for continuing services at the CMO High intensity of service. A. The clinical information presented indicates that the youth continues to exhibit needs consistent with current intensity of service; B. The Care Plan is individualized and appropriate to the youth's changing condition with realistic and specific goals and objectives that are clearly documented. C. Progress is clearly described in objective terms, but goals of treatment have not been fully achieved. The Care Plan has been modified and updated to reflect the current treatment status. D. CMO High services are indicated to maintain the youth, or support reintegration of the youth, in the community and improve level of functioning in the identified life domain(s). E. The Care Plan indicates that the youth and the parent/guardian/caregiver are actively involved in the youth's services, to the extent that is reasonably possible. Limitations to the parent/guardian/ caregiver involvement and strategies to optimize caregiver involvement should be clearly documented in the plan. F. Collaboration between all CFT members, which may include, but not limited to: Intensive In-Community (IIC) providers, Intensive In-Home (IIH) providers, Out of Home (OOH) treatment providers, substance use providers, school staff, medical providers, DCP&P case workers, JJC staff, parent/legal guardian, and youth, is clearly documented in the treatment plan. G. There is documentation of active transition planning with a sustainable community-based after-care plan. Youth in an out-of-home treatment setting must additionally meet the following criteria: H. The youth is in a CSOC OOH treatment setting, and requires intensive service coordination and transition planning, to facilitate successful transition back into the community.

Transition Criteria	Any of the following transition criteria A through G is sufficient for discharge from this level of care management and fulfillment of transition criteria G: A. The youth's documented Care Plan goals and objectives for this Intensity of Service have been substantially met; B. The clinical information presented indicates that the youth requires a different clinical treatment focus or less intensive treatment service. C. The family has demonstrated that the identified strengths of the caregiver and youth can be sustained in the community with services and supports. D. Consent for treatment is withdrawn by the parent/custodian/guardian or young adult if age eighteen and older. E. The youth and parent/guardian/caregiver are competent but non-participatory in treatment or non-complaint with the treatment program's rules and regulations. The noncompliance is significant enough to negatively impact the overall treatment course and compromises the child/youth's ability to have a successful, positive response to treatment. F. Youth has not demonstrated measurable improvement toward Care Plan /treatment goals that has generalized outside of the treatment sessions, after a treatment period of at least twelve to fourteen months. G. Parent/guardian/caregiver or young adult if age eighteen and older is unreachable for an extended period despite documented best efforts to contact or has moved out of state. Youth should be transitioned from CMO services if there is no contact with the youth or family within a two month time period. In addition to the above transition criteria A through G, the following criteria H shall be achieved: H. A transition plan with specific follow-up recommendations (including follow up appointments, intake appointments etc.) and community supports has been arranged and documented in the youth's transition Care Plan.