



## VIRTUAL RESIDENTIAL PROGRAM FOR CHILDREN and ADOLESCENTS

Definition: A Virtual Residential Program (VRP) is an alternative to the two traditional Residential Treatment Center options: Psychiatric Residential Treatment Facilities (PRTF) and Therapeutic Residential Child Care Facilities (TRCCF), which are facilities licensed by State Child Welfare as Residential Child Care Facilities (RCCF) and Colorado Medicaid-certified as Residential Treatment Centers (RTC). PRTF's and TRCCF RTC programs provide 24-hour care in a group milieu environment providing intensive individual, group and family interventions outside of the home setting. VRP, in contrast, provides intensive individual and family interventions inside of the home. VRP and RTC are both intended for the rapid stabilization of acute issues, followed by the resumption of community-based treatment for persistent individual and family therapeutic issues. The active involvement of biological or adoptive families, wherever possible and appropriate, is a fundamental, necessary component for successful residential treatment for children and adolescents.

A. **Initial Authorization Criteria** (Must meet *all* of the following criteria)

1. Presence of covered DSM-IV and ICD-9-CM diagnosis that is the cause of functional impairment significant enough to require 30 to 40-hour per week, in-home residential care supervised by a primary psychotherapist and two behavioral coaches.
2. Less intensive and less restrictive clinical environments have been attempted without success and/or have been ruled out due to safety concerns. Lower levels of care are specifically documented in the child's clinical record as inadequate to meet his/her mental health needs.
3. There is an expectation of improvement through the provision of such services.
4. Placement in a Virtual Residential Program is clinically appropriate for the mental health, medical, and developmental needs of the child.
5. The parent/guardian consents to placement and agrees that the family will participate in treatment, as determined to be clinically necessary.

AND

(Must meet *at least one* of the following criteria)

1. The family would benefit from consistent psycho-education, behavioral coaching, and the implementation of successful, therapeutic interventions within the home.
2. The parents are at risk for the relinquishment of their legal parental rights or their physical custody of the child due to the involvement of the Department of Social Services.
3. The child has a clinically documented history of improvement with in-home psychotherapy.
4. The child would benefit from VRP due to the increased level of family support and collaboration among in-home providers to advance the child's behavioral accountability.

B. **Continued Stay Authorization Criteria** (Must meet *all* of the following criteria)

1. Continued functional impairment (either due to the original impairment at admission or new impairment due to a covered DSM-IV diagnosis) significant enough to require 30 to 40-hour per week, supervised, in-home residential care.
2. There is an expectation of improvement through the provision of such services.

3. Progress in relation to specific symptoms or impairments is evident and can be described in objective terms, but goals of treatment have not yet been achieved. Subsequently, adjustments in the treatment plan with which to address the lack of progress are evident.
4. Unless contraindicated, parent/guardian and family are actively involved in the child's treatment. This involvement must be included in the treatment plan, with specific goals included for the family that relate to the overall goals for the child. There is documentation in the clinical record of family's substantive involvement in the treatment process at least one time per week, or documentation of the contraindications for this involvement.
5. There must be a specific goal in the treatment plan that addresses discharge criteria and a plan for achieving these.
6. VRP services continue to be provided with the original staffing patterns to include active, intensive therapeutic services to the child, parents, and family. Diagnostic formulation and revision/refinement of the child's treatment plan are ongoing. The collaborative communication among the BHO liaison, respective mental health center, and all other relevant agencies involved in the placement of the child is also ongoing.
7. A lack of placement to a lower level of care when the child is no longer meeting medical necessity for VRP cannot be a reason for continued stay, i.e.; VRP is not a "holding environment," nor does it serve as an alternative to daycare.

**C. Criteria For Termination of Authorization** (*At least one of the following criteria is sufficient for termination of authorization from VRP*)

1. The child no longer meets criteria for the VRP level of care.
2. Impairment due to the mental health diagnosis has decreased to a level that no longer requires VRP standards for in-home, supervised care.
3. An appropriate, less restrictive treatment setting is available.
4. The child has achieved his/her treatment goals or has made significant progress toward their achievement, such that continued success is expected in a less restrictive level of care.
5. Discharge criteria, as identified in the treatment plan, have been met.
6. An aftercare plan, agreed upon by the parent/guardian and follow-up treatment provider, has been developed and can be implemented immediately following discharge from VRP.

**D. Exclusion Criteria** (*Any of the following criteria are sufficient for exclusion from VRP*)

1. The child exhibits severe, imminent suicidal or homicidal ideation, or acute mood symptoms/thought disorder, which require inpatient psychiatric hospitalization. History of or recent psychiatric hospitalization does not, in the absence of other exclusionary criteria, preclude admission to VRP.
2. Parent/guardian does *not* voluntarily consent to admission or treatment.
3. The child can be safely maintained and effectively treated at a less intensive level of care.
4. The child/adolescent has medical conditions or impairments that would prevent beneficial utilization of services.
5. The primary problem is social, economic (i.e. housing, family, conflict, etc.).
6. The primary problem is one of physical health without a dual psychiatric diagnosis or concurrent major psychiatric episode, which meets the criteria for VRP.
7. Admission to VRP is being used as an alternative to incarceration.
8. There is evidence that the need for VRP is the result of developmental disabilities (Mental Retardation, Pervasive Developmental Disorders, and other developmental disorders; Traumatic Brain Injuries; genetically-based and neurologically-based Organic Brain Syndromes), substance abuse, or the need for treatment of sexual offenses.