NAIC Parity Workgroup
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The LOCUS* Family of Tools
*Level of Care for Utilization of Services

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Brief intro and disclosures

- No personal financial disclosures or COI
  - I have not benefitted financially from my work with LOCUS
- President, American Association for Community Psychiatry (AACP) 2016 – 2022
  - AACP developed and owns the IP of the LOCUS
  - This non-profit organization stands to benefit financially from large-scale uptake of the LOCUS

Brief intro: A bit about you…

Familiarity with LOCUS Family of tools?

1. Not at all or minimally familiar
2. Somewhat familiar
3. Very familiar

Development of the LOCUS "Family of Tools"

- Mid-late 1990s: LOCUS developed by AACP *(©1999, AACP)*
- 1999-2001: Child and Adolescent version, the CALOCUS jointly developed by AACP and AACAP *(©2001, AACP and AACAP)*
- 2005-9: AACAP develops a modified version of CALOCUS, the CASII *(©2006, AACAP)* and an early childhood version, ECSII *(©2009, AACAP)*
- 2023: AACP and AACAP reunite with CALOCUS/CASII as one instrument
- So, LOCUS family of tools currently includes:
  - LOCUS, CALOCUS/CASII and ECSII

How does the LOCUS* work?
Two Major Components

- Evaluation Parameters
  - 6 dimensions (e.g., risk of harm)
  - Each rated on a 5-point scale

Algorithm

- Level of Care Continuum
  - 7 ordered categories of service intensity

LOCUS = Locus Family of Tools

Evaluation Parameters (Dimensions) of the LOCUS

1. Risk of Harm
2. Functional Status
3. Co-Morbidity
   - Mental health
   - Substance Use
   - Physical Health
4. Recovery Environment
   A. Level of Stress
   B. Level of Support
5. Treatment and Recovery History
6. Engagement

LEVELS OF CARE
Level Six
Medically Managed Residential Services
Level Five
Medically Monitored Residential Services
Level Four
Medically Monitored Non-resdential Services
Level Three
High Intensity Community-based Services
Level Two
Low Intensity Community-based Services
Level One
Recovery Maintenance and Health Management
Level Zero
Basic Services: Universal Prevention and Health Maintenance

Domains of Service Intensity

- Care Environment
  - (e.g., hospital, home/community – level of supervision)
- Clinical Services
  - (e.g., psychiatric, psychological, medical – frequency, intensity)
- Support Services
  - (e.g., housing, vocational, transportation)
- Resolution and Prevention Service
  - (e.g., case management, peer-run respite)

Level of Care Determination

- Generated by the scores on the 6 dimensions
- Algorithm, includes
  - Total (composite) score
  - Differential weighting of certain items
    - “independent placement criteria” e.g., high scores on Risk of Harm are weighted more heavily

Example of LOCUS report

Data entered via
- On-line portal
- API
- EMR integration

Clinical Decision Support Tool

Diagnosis: Recent SI/ SA

Previous Disposition:	6 Medically Managed Residential Services
Recommended Disposition:	5 Medically Monitored Residential Services
Actual Disposition:	5 Medically Monitored Residential Services
Reason For Variance:	
Program / Referred To:	
Evaluating Clinician:	
Attending Physician:	
Evaluation Notes:	

Diagnosis: Recent SI/ SA

Previous Disposition: 6 Medically Managed Residential Services

Recommended Disposition: 5 Medically Monitored Residential Services

Actual Disposition: 5 Medically Monitored Residential Services

Reason For Variance:

LOCUS RESULTS — **LOCUS Score:** 23

Risk of Harm — **Dimension Score:** 3

- No active suicidal/homicidal ideation, but extreme distress and/or a history of suicidal/homicidal behavior exists

Functional Status — **Dimension Score:** 3

- Recently conflicted, withdrawn, alienated or otherwise troubled in most significant relationships, but maintains control of any impulsive, aggressive or abusive behaviors
- Recent gains and/or stabilization in function have been achieved while participating in treatment in a structured and/or protected setting

- At least partial recovery has been maintained for moderate periods of time, but only with strong professional or peer support or in structured settings

Engagement and Recovery Status — **Dimension Score:** 3

- Has some variability, hesitation or uncertainty in acceptance or understanding of illness and disability
- Has limited desire or lacks confidence to change despite intentions to do so (Preparation Stage)

In practice:

- LOCUS can be completed in < 10 minutes
  - Assuming adequate information is available
- LOCUS process can be interactive, collaborative, and iterative
  - Adds time AND value

Ratings sensitive to change over short periods of time

Dimension	Rating on hospital admission	Rating on hospital day 4
I: Risk of Harm	5	3
II: Functional Status	4	3
III: Comorbidity	4	3
IVA. Level of Stress	4	4
IVB. Level of Support	4	4
V: Treatment and Recovery Hx	4	4
VI: Engagement	3	3
Total Score	28	24
Recommended Level of Care	6 Medically managed residential	5 Medically monitored residential

Ratings can be collaborative, iterative and change as a result of treatment planning

Dimension	Rating on hospital admission	Rating Day 4 with transition plan 1	Rating Day 4 with transition plan 2
I: Risk of Harm	5	3	3
II: Functional Status	4	3	3
III: Comorbidity	4	3	3
IVA. Level of Stress	4	4	3
IVB. Level of Support	4	4	2
V: Treatment and Recovery Hx	4	4	4
VI: Engagement	3	3	3
Total Score	28	24	21
Recommended Level of Care	6 Medically managed residential	5 Medically monitored residential	4 Medically monitored non-residential

Big Picture: Goals of LOCUS Family of Tools

- To promote a common language among all key stakeholders
  - People served
  - Providers
  - Payers
  - Policy Makers, Population health managers, Public at large?

A common language at two levels

Individual Level

- Finding the best fit between individual needs and behavioral health services
  - Person-centered, recovery oriented
  - Available resources
  - Least restrictive setting (safety)

Systems Level

- Describing and informing the array of services that should be available to best meet the needs of a population

Transparency and Clarity

- The processes leading to critical behavioral healthcare decisions should be as transparent and understandable as possible to each of these key stakeholders

- Enhancing and facilitating collaboration among them
- Empowering

Consistency and Standardization

- The processes by which such decisions are made should be as consistent as possible within and across settings and systems…
  - Enhance equitability and reduce disparities
    - Minimize the effects of subjectivity
    - Capacity to look at potential disparities or biases within and across systems
  - Identify services gaps
  - Benchmarking capacity

Toward A National Standard For Service Intensity Assessment And Planning For Mental Health Care

THE LEVEL OF CARE UTILIZATION SYSTEM (LOCUS) FAMILY OF TOOLS

NATIONAL COUNCIL for Mental Wellbeing

NOVEMBER 2023

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https://www.thenationalcouncil.org/resources/service-intensity-assessment-and-planning/

Tools described in the "towards a national standard…" document

Box 1: Service Intensity and Planning Tools described in this white paper: The LOCUS FT (the first three in the list) and ASAM Criteria.

LOCUS: Level of Care Utilization System; developed by the American Association for Community Psychiatry (AACP) in the 1990's for adults with BH needs.

CALOCUS-CASII: Child and Adolescent Level of Care/Service Intensity Utilization System; co-developed by AACP and the American Academy of Child and Adolescent Psychiatry (AACAP) for those ages 5-18 with BH needs.

ECSII: Early Childhood Service Intensity Instrument; developed by AACAP in 2009 for children ages < 5 with BH needs.

ASAM Criteria: Developed by ASAM in the 1990s for adults with substance use disorders (SUD).

Differences between LOCUS and some commonly used tools for utilization management

	LOCUS Family of Tools	Other commonly used tools
Scope	Trans-diagnostic	Diagnosis or syndrome specific

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Differences between LOCUS and commonly used tools for utilization management

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Scope	Trans-diagnostic	Diagnosis or syndrome specific
Process	Collaborative, interactive, straightforward and accessible	Driven by one source, complex, limiting accessibility and interactivity
Focus	**Promoting long-term recovery**	**Addressing acute symptomatology**

Some differences with commonly used tools for utilization management

	LOCUS Family of Tools	Other commonly used tools
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Process	Collaborative, interactive, straightforward and accessible	Driven by one source, complex, limiting accessibility and interactivity
Focus	Promoting long-term recovery	Addressing acute symptomatology
Result	**To help determine the most appropriate level at any given time within a continuum of service intensity**	**To determine whether criteria are currently met for specific services (yes/no)**

Extra slides

Perhaps to have available in response to questions

Example of dimensions

LOCUS©: Evaluation Parameters

1

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 one's self 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.

Example of dimensions (cont.)

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.

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 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:

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 wellbeing 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.

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:

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.

LOCUS: Levels of Care Continuum

Level	Description	Score*
0	Basic Services for Prevention and Maintenance	7-9
1	Recovery Maintenance and Health Management (e.g., managed by PCP)	10-13
2	Low Intensity Community-Based Services (e.g., routine outpatient psych clinic)	14-16
3	High Intensity Community-Based Services (e.g., Intensive Outpatient Program)	17-19
4	Medically Monitored Non-Residential Services (e.g., Partial Hospital, ACT)	20-22
5	Medically Monitored Residential Services (e.g., Residential treatment facility)	23-27
6	Medically Managed Residential Services (e.g., acute inpatient psychiatric unit)	28+

* Note: Specific "independent placement criteria" override composite scoring