DIVISION OF PREVENTION AND BEHAVIORAL HEALTH SERVICES

TREATMENT SERVICES MANUAL

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1 INTRODUCTION

Welcome to the Delaware Department of Services for Children, Youth, and Their Families' (DSCYF) Division of Prevention and Behavioral Health Services (DPBHS). This manual is intended to provide general information, guidelines, policies and procedures for agencies partnering with DPBHS to deliver prevention and behavioral health services to children. We thank you for your commitment to providing the highest quality of care and support available to serve our families and are eager to work in close partnership with you.

All are encouraged to contact DPBHS directly should additional questions arise. Each Provider will be connected with a Program Administrator with whom you can reach out to for assistance and support. DPBHS also encourages, new and existing, providers to visit the Providers' page on the DPBHS website for additional resources, information and DPBHS contact information.

- http://www.kids.delaware.gov/pbhs/pbhs.shtml

Services in this manual and those provided by DPBHS are provided to children and adolescents from birth up to 18 years of age. For individuals 18 and older, behavioral health services are provided by the Division of Substance Abuse and Mental Health (DSAMH). This manual is a supplement to the Department of Services for Children, Youth and Their Families (DSCYF) Operating Guidelines for Service Providers, which sets forth the minimum standards expected for DSCYF providers. DSCYF Operating Guidelines can be found online at:

- http://kids.delaware.gov/pbhs/pbhs_providers_mhsa.shtml

These documents specify performance standards and expectations for DPBHS Providers. These are in addition to but not in lieu of other certifications, licensures, and State or Federal requirements. If appropriate, providers shall reference Office of Child Care Licensing (OCCL), DELACARE, and/or Division of Substance Abuse and Mental Health (DSAMH) regulations and standards.

*For definitions of terms and acronyms used in this manual please refer to Appendix 4.

DPBHS provides a robust statewide continuum of behavioral health prevention, early intervention, and treatment services for children, youth and their families. DPBHS provides licensed psychologists in our Department's secure and non-secure detention facilities, offers support and provides services for early education facilities and families with very young children and works closely with community partners to ensure the needs of children and their families involved with DPBHS are effectively addressed as quickly and efficiently as possible.

Our Mission - To develop and support a family-driven, youth-guided, trauma-informed prevention and behavioral health system of care.

Our Vision - Resilient children and families living in supportive communities.

Guiding Principles:

- Comprehensive service array to meet individual child and family needs;
- Individualized service planning;
- Least restrictive, most normative setting which is clinically appropriate;
- Families should be full participants in all aspects of the planning and delivery of service;
- Intensive care management to ensure coordination and integration of services;
- Early identification and intervention for children is critical;
- Smooth transitions to adult services at age 18;
- Rights of children and their families should be protected; and
- Effective advocacy for children and their families should be promoted.

The Department practices a trauma-informed care approach while working with the children/youth and families we serve. We continually strive to improve our system and incorporate best practices and research-proven programming into the work of our division. Our strategic plan guides our practices and assists us to achieve our goals. Our current plan includes broad-based goals with actionable objectives to help us reach those goals. The plan serves as a framework and will be modified and updated as we progress and our needs change.

Our Strategic Plan was developed by the Division's leadership team in collaboration with contributing staff in each of our program areas.

> "*…By definition, a real plan is never final; it is a living document. As we move forward to accomplish our goals, we will learn new information that may be incorporated into our process and change how we move forward*."
>
> Susan Cycyk, Director

2 PROVIDER NETWORK

DPBHS has recently undergone many changes to strengthen our behavioral health system. DPBHS collaborates with community partners and treatment providers to deliver the best services possible for children and their families. DPBHS has a holistic approach to better manage and coordinate the care of our families.

DPBHS appreciates the importance of family participation and commitment to the care of the children and youth that enter our services. Family choice, family voice, family support and participation are essential components of care. DPBHS creates partnerships that value the input of service providers, community resources and support and most importantly, the families, to develop a plan of care to successfully attend to the issues and challenges faced by the children and families we serve. DPBHS realizes children achieve more successful outcomes when interventions occur early and participants function as a team.

Treatment delivered by DPBHS' Network Providers will be:

- Youth-guided;
- Family-driven;
- Individualized and community based;
- Culturally and linguistically competent; and
- Evidenced based (or supported by best practice standards).

Provider Contracts and Agreements

In order to provide a continuum of behavioral health services, DPBHS contracts with a network of individuals and agencies qualified to render services under the provision of DPBHS. The network includes licensed psychiatrists, psychologists, social workers, masters prepared clinicians and other behavioral health professionals, as well as agencies to ensure numerous clinical and cultural specialties are represented to serve individuals.

In accordance with Delaware Code Title 29 Section 6981, DSCYF purchases professional services in excess of the established current annual expenditure threshold, using a competitive bidding process. In order to join the Provider Network, one must bid to provide a service once a Request for Proposals (RFP) has been announced. To receive automatic notification of bid opportunities, go to the State of Delaware's Bid Solicitation Directory and follow the instructions to register for bid notifications at:

- http://bids.delaware.gov/

Medicaid

Health care services are provided to the majority of Medicaid clients through Delaware's Diamond State Health Plan (DSHP) managed care program. The managed care package includes behavioral health benefit of 30 units of outpatient services. DPBHS provides coverage of services outside of DSHP's managed care

package. Instructions for how MCO providers can access supplementary funding for their outpatient clients is on the DPBHS website:

- http://www.kids.delaware.gov/pbhs/pbhs_providers.shtml

DPBHS providers are required to enroll with the Delaware Medical Assistance Program (DMAP) through the Delaware Medicaid Enterprise System (DMES). Please refer to the following website for information on how to apply to the respective panels for the Medicaid Managed Care organizations, or to obtain information about applying for Medicaid:

- https://medicaid.dhss.delaware.gov/

All licensed mental health providers must be paneled with Medicaid. Licensed staff refers to any licensed practitioner of the healing arts who is licensed in the State of Delaware to diagnose and treat behavioral health and/or substance abuse issues acting within the scope of all applicable state laws and their professional licenses. Within the State of Delaware, those licensed by the Delaware Division of Professional Regulation are as follows:

- Licensed Psychologists;
- Licensed Clinical Social Workers (LCSWs);
- Licensed Professional Counselors (LPCMHs);
- Licensed Marriage and Family Therapists (LMFTs);
- Licensed Chemical Dependency Professionals (LCDP);
- Advanced Practice Registered Nurses; and
- Physician (MD or DO).

Delaware Medicaid and MCO Enrollment Process

1. Obtain an NPI (Individuals and agencies):
   Go to: https://nppes.cms.hhs.gov/NPPES/Welcome.do

Individual Providers:

As an Individual Provider, you may only have a single NPI, which will be associated with your unique, individual information. Once you login to NPPES, you will be able to complete your NPI application.

a) Create a Login through the Identity & Access Management System (I&A).
b) Login to NPPES with your I&A Username and password.

Healthcare Provider Organizations:

Healthcare Organizations are currently required to have a separate Username and password for each NPI associated with the organization.

a) Create an NPPES ONLY Username and password for the NPI you are applying for.

c) Complete the NPI application. *Estimated time to complete the NPI application form is 20 minutes.*

b) Complete the NPI application. *Estimated time to complete the NPI application form is 20 minutes.*

- For DPBHS, select the appropriate taxonomy to provide children's services.
- A business license and liability insurance are required prior to completing above

2. Once NPI is obtained, go to CAQH http://www.caqh.org/
   - To register, select EnrollHub on the right-hand column and go to 'Register Now'
   - If already registered with CAQH, update any changes

3. Go to DHSS website at: https://medicaid.dhss.delaware.gov/
   - Enter the Provider Portal
   - Select Provider Enrollment in left-hand column
   - Select Enrollment Application (you can also select to resume an application or view enrollment status from this screen)
   - Read Provider Enrollment: Welcome page and Continue
   - Complete the mandatory fields on each screen as directed. All mandatory data is required on the page to save and select 'finish later'.
     - For any additional forms that need to be completed, go to:
       - https://medicaidpublications.dhss.delaware.gov/dotnetnuke/search?EntryId=7

4. Fax information to HP Enterprise listed on the top left hand corner of the application
   - Include the following attachments:
     - ✓ Professional licensure
     - ✓NPI Letter
     - ✓Tax ID or Social Security Card
     - ✓Business License
     - ✓Bank Information

5. After enrolled in DMAP (this must be completed first), individuals/agencies are able to enroll with Medicaid MCO's. Provider websites:
   - Health Options: go to High Mark Health Options Delaware website: https://www.highmarkhealthoptions.com/providers
     **Call the number listed to find out more information on how to become a provider
   - United Health Care Delaware: http://www.uhccommunityplan.com/health-professionals.html
     **Call the number listed to find out more information on how to become a provider

3 PROVIDER QUALIFICATION & REQUIREMENTS

In order to be eligible for reimbursement of covered services, a provider must meet specific requirements and become an approved provider of Medicaid services. Per the Memorandum of Understanding between DHSS and DPBHS, DMMA has delegated the functions of developing provider standards and certifying that providers meet those standards. Once DPBHS has determined that a provider is qualified, they are referred to DMMA for enrollment into the Delaware Medical Assistance Program (DMAP). Providers agree to comply with the program standards contained in this manual under that contract. In addition to the DMAP standards included in this manual, DPBHS may also have state contracts with providers to identify additional state requirements that the providers must meet for specific services. DPBHS may also have state contracts with providers to pay for services described in this manual for DPBHS consumers who are not eligible for Medicaid.

To participate as a DPBHS provider, the following conditions of participation in the DMAP must be met:

- Applicable State licensing and certification requirements;
- DHSS requirements for Medicaid participation and reimbursement; and
- Comply with State level organizational, administrative, and program standards, and with Federal requirements for the administration of Medicaid services as contained in Federal statutes, regulations and guidelines.

Agencies must meet any applicable federal and state regulations, and the agencies and their staff must maintain and keep current the appropriate professional and business licenses and/or certifications.

Business License(s) - In order to provide services within the State of Delaware, providers must have a Delaware Business License. For non-profit entities, please review Delaware business licensure website for possible exemption. You can apply for a Delaware business license online through the Division of Revenue:

- https://onestop.delaware.gov/osbrlpublic/Home.jsp

Professional License(s) – All providers, agencies and individuals, partnering with DPBHS must be properly licensed and/or certified professionally, in accordance with federal and state laws in which state they are located. For more information visit:

- http://dpr.delaware.gov/

Insurance – proof of commercial liability, motor vehicle and all other insurance coverage as applicable, must be available at all times, and any changes in status must be brought to the attention of DBPHS within 24 hours.

DSAMH License – the Provider shall maintain licensure in good standing with Division of Substance Abuse and Mental (DSAMH), if applicable.

- http://dhss.delaware.gov/dhss/dsamh/

Unlicensed Practitioner – Any unlicensed practitioner providing Medicaid children's behavioral health services must operate within an agency found by DSCYF to meet the requirements above.

Substance Use/Co-Occurring Clinics- Any entity providing Substance Use Disorder (SUD) treatment services must be certified by Delaware Health and Social Service (DHSS) or its designee, DSAMH, in addition to any required scope of practice license required for the facility or agency to practice in the State of Delaware.

Accreditation

DPBHS maintains accreditation by the Commission on Accreditation of Rehabilitation Facilities (CARF) under Business and Services Management Network Standards. CARF accreditation demonstrates DPBHS' commitment to continually enhance the quality of services and programs with a focus on the satisfaction of the persons served.

DPBHS seeks to collaborate with providers who demonstrate a commitment to quality and excellence in service delivery and are accredited by one of the following national accrediting bodies:

- The Joint Commission (TJC);
- Council on Accreditation (COA);
- Commission on Accreditation of Rehabilitation Facilities (CARF); and
- Community Health Accreditation Program (CHAP).

Providers without accreditation status must meet DPBHS clinical standards outlined in this Manual and the Commission on Accreditation of Rehabilitation Facilities (CARF) standards for unaccredited providers under the Business and Services Management Network. The current CARF standards are:

- All providers who are active with DPBHS and have an annual contract of $350,000 or more must have their own independent accreditation;
- Providers who have contracts ranging from $35,000 to $349,999: must obtain independent accreditation within 3 years of the initiation of the contract, whichever is later, and will be treated as unaccredited providers by DPBHS and CARF and subject to compliance with CARF survey requirements as an unaccredited provider; and
- New unaccredited providers who have an annual contract of $350,000 or more will be required to demonstrate a plan to have their own independent accreditation within three years of start-up. They will be treated as unaccredited providers by DPBHS and CARF and subject to compliance with CARF survey requirements as an unaccredited provider until such time as they obtain their individual accreditation.

Accreditation, license(s) and licensure certificate(s) must be prominently displayed at each organizational site. Changes in accreditation status must be brought to the attention of both DPBHS Program Administration Unit and Quality Improvement Unit contacts within 24 hours. DPBHS Quality

Improvement Unit should be provided with any corrective action or performance improvement plans upon submission to or receipt from the accrediting body.

Criminal Background Checks and Child Protection Registry Checks

All contractors and their employees with direct access to DPBHS clients are required to pass a Criminal Background Check which **MUST** be completed by **Delaware State Police** and a Child Abuse Registry check **MUST** be completed by **DSCYF**.

More information on Criminal Background Checks can be found in Delaware Code: Title 31 Chapter 3 Subchapter I section 309 at:

- http://delcode.delaware.gov/title31/c003/sc01/index.shtml

More information on Child Protection Registry checks can be found in Delaware Code – Title 11 Chapter 85 Subchapter V Section 8563 at:

- http://delcode.delaware.gov/title11/c085/sc05/index.shtml

Maintenance of Agency/Provider Records and Documentation

Personnel Practices and Staff Credentialing - The provider will have and implement written policies and procedures for personnel management, which will include but not necessarily be limited to:

- Job descriptions for each position outlining the minimum education, training and experience required to perform each function. These job descriptions must specify education and experience in child-related programs/activities;
- Documentation that primary verification of education, training, past employment history, professional license and/or certification, etc. is completed prior to the hire;
- Evidence of credentials;
- Annual performance plans and reviews;
- Processes for disciplinary actions and termination and documentation that staff are informed of these processes; and
- Processes for tracking participation of staff in training and other professional development opportunities.

<u>Personnel File/Records</u>

Criminal History and Child Protection Registry – Documentation of a completed Delaware State Police background check and Child Protection Registry's approval letter must be present in the employees personnel file on site.

Human Resource Form – All staff with direct, regular access to children and/or providing treatment services or supervising staff providing the services, shall submit a Human Resource Form to DPBHS Program

Administration Unit via fax, mail or email. If employment status changes or if updated information is available, the Human Resource Form must be resubmitted within 10 business days.

Staff Identification Number - Upon receipt of the Human Resources Form, each behavioral health professional will receive a Staff Identification Number. This number will be required for an individual to provide a service and submit a claim to DPBHS. It is required that all staff with direct, routine access to DPBHS clients complete this form immediately upon employment with a DPBHS in-network provider agency. DPBHS will not reimburse claims for services provided by a behavioral health professional that has not been assigned a Staff Identification Number by DPBHS.

Notification of staff change within 48 hours must be made if:

- Termination of employment for cause involving performance in program for use of drugs or alcohol, or whose records and/or conduct may negatively affect fiscal and/or program audits;
- Arrest for any reason;
- Loss of driver's license if staff are required to transport clients;
- Accusation of abuse or neglect of staff's children or those in the care of the program; or
- Loss of professional license or certification.

Credentialing

DPBHS is committed to meeting the highest standards in quality consumer care. Therefore it is expected that all DPBHS employees and network providers will possess appropriate education, skills, and training to fulfill their job responsibilities in a competent manner. Minimum provider qualifications are provided for each service in the DPBHS continuum (Refer to service descriptions in appendix 8).

Supervision

Unlicensed staff members are required to participate in weekly supervision with a licensed behavioral health professional. Supervision will be documented in the Supervision Log which will be available for review by DPBHS upon request. The Supervision Log should contain the name of the employee receiving supervision and list the date, length and time of the supervisory session as well as the number of cases discussed. The licensed behavioral health professional must sign off to document this supervisory session occurred as reported. The licensed behavioral health professional assumes clinical responsibility for employees under their supervision.

The licensed behavioral health professional providing supervision to the unlicensed staff is also required to sign off on assessments, treatment plans and discharge summaries completed by unlicensed staff under their supervision.

For Substance Abuse services: If the licensed professional providing oversight of the agency is not a Licensed Chemical Dependency Professional and is not a Certified Alcohol and Drug Counselor (CADC),

a CADC must be available to supervise all staff that are uncertified in this area. A CADC's signature is accepted on initial assessments and treatment plans for Substance Abuse services.

Risk Management

Risk Management System - The provider will have an overall risk management system as well as procedures for developing individual client risk management plans that include procedures for assuring client safety.
After-Hours Clinical Emergencies - The provider will have 24-hour, 7 day/week on-call coverage for active clients. Services performed by on-call coverage are subject to the same clinical standards as those of the contracted provider.

The provider will give active clients and families clear written directions for how to reach the provider in an after-hours emergency. In substance abuse programs, this also includes that information be provided to caretakers about the signs of overdose as it applies to each child's pattern of substance abuse and instructions for obtaining medical help in case of an emergency. The provider will document that the child has been given this information with a signed form that will be filed in the clinical record.

For all community-based providers, recorded telephone messages shall include the DPBHS Mobile Response and Stabilization Services number 1-800-969-HELP (4357).

If the provider has a client who displays deteriorating symptoms and the provider suspects the child may go into crisis during periods when the client is not receiving direct services, the provider shall:

- Establish a written safety plan with the client and family including contact numbers for people the client and family have identified as supportive to them (someone they are comfortable reaching out to in times of crisis; these identified parties should be aware they are identified on the child's safety plan) along with the 24 hours DPBHS Mobile Response and Stabilization Services number(s);
- Provide the child and family of the provider's crisis procedures;
- Provide reasonable and sufficient hours of operation, including 24-hour availability of information, referral and treatment for emergency conditions;
- With parental consent, provide for the notification of the appropriate DPBHS Mobile Response clinician about the child, current clinical status, and instructions for how to reach the provider if a crisis occurs; and
- If a child is active with DPBHS Mobile Response and Stabilization Services, work with them to reach disposition of child in crisis.

Critical Incidents

All DSCYF providers are required to follow the procedures as listed in the DSCYF Operating Guidelines. These procedures are further articulated in the DPBHS Incident Reporting Policy and Procedure along with the required forms on the DPBHS website:

- http://kids.delaware.gov/pbhs/pbhs_providers_forms.shtml

Written reports are to be faxed to the DPBHS Quality Improvement Unit at E-Fax 1-302-661-7270 or send secure email to DSCYF_DPBHS_QI@state.de.us

Alleged Child Abuse - For any allegation of child abuse:

- **Mandatory Reporting Training –** this training is available to DSCYF providers online through the Office of the Child Advocate's Online Training System. DPBHS strongly encourages providers to make this training mandatory for their staff. This training can be accessed by going to:
  - https://ocade.server.tracorp.com/novus/application/login/
    1. New users should create an account and select the group code **General Public.**
    2. Complete the training entitled: 2016 General Public Mandatory Reporting Training.
    3. After completing the training please exit and refresh your browser. This will help the system to quickly update your completion status.
    4. You can print or save a copy of your completion certificate by clicking **My Account** (on the top toolbar) and selecting **My Certificates** from the dropdown menu.

- If the DPBHS provider delivers services in Delaware - The Provider recognizes that its employees and therapists are mandated reporters as specified in Title 16, Delaware Code, Chapter 9, Paragraphs 901-909. The provider shall assure that its entire staff who provide services under this Contract are trained in DFS reporting procedures. When a provider's employee or agent knows of or reasonably suspects child abuse or neglect, including any such incident within the agency, or receives information regarding suspected abuse from the client, then he/she shall make an oral report to the Delaware Child Abuse Report Line by calling 1-800-292-9582. Within 72 hours of the oral report, a completed Child Abuse Reporting Form shall be sent to the appropriate regional office of the Division of Family Services. The Mandatory Reporting Form can be found at:
  - http://kids.delaware.gov/fs/fs_iseethesigns.shtml
- For further information about professional responsibility with regard to abuse and neglect, and to read "The Professional's Guide to Reporting Abuse and Neglect" please consult:
  - http://kids.delaware.gov/pdfs/broch_GuideReportChildAbuseNeglect.pdf
- The Division of Professional Regulation also contains relevant information:
  - http://dpr.delaware.gov/
- If the provider does not deliver services in Delaware - The provider shall adhere to the guidelines for critical incident reporting set forth in the DPBHS policy. Additionally, the provider shall follow the legal requirements for reporting child abuse and neglect in the State in which services are provided. A copy of this report must be forwarded to the DPBHS Quality Improvement Unit via Fax 1-302-661-7270 or send secure email to DSCYF_DPBHS_QI@state.de.us

Environment and Milieu

Trauma-Informed Care is a priority within the Department and this approach is incorporated into all of our practices. Trauma-Informed best practices are strength based, present focused, emphasize choice, and put a priority on building safe relationships and environments which encourage healing. The effects of traumatic events place a heavy burden on both the family and the individual. While many people who experience some form of trauma will go on without lasting negative side effects, there are those that will

have more difficulty and experience stress reactions from those events. It is vital to identify children/youth who are exhibiting any symptoms related to a traumatic or adverse childhood experience.

DPBHS staff and contractors are encouraged to follow the following framework:

- ***realize*** the prevalence of trauma exposure in our clients and staff
- ***recognize*** the signs of exposure for clients and staff
- ***respond*** by incorporating the principles in all aspects of our work (e.g. policies, work environments)
- ***resist re-traumatizing*** clients and staff

*If you have questions about DPBHS Trauma-Informed Care plan, please contact Aileen Fink at aileen.fink@state.de.us.

For more information on the short- and long-term impacts of trauma and its effects on both younger and older children, please visit the following link to a PDF published by the National Child Traumatic Stress Initiative (NCTSI) in conjunction with the Substance Abuse and Mental Health Services Administration (SAMHSA).

- http://store.samhsa.gov/shin/content/SMA15-4923/SMA15-4923.pdf .

For more information on Adverse Childhood Experiences (ACEs), please visit the CDC website at:

- https://www.cdc.gov/violenceprevention/acestudy/

The Delaware Office of Child Care Licensing (OCCL) offers information sessions and multiple trainings on DELACARE Regulations, as well as links to current forms to assist providers in following DELACARE Rules. All OCCL related information, including contact information, can be found at:

- http://kids.delaware.gov/occl/occl.shtml

Smoking - Smoking is not permitted by any minor in any state operated or funded facility or program. Smoking by adults will be permitted only in designated areas which are away from space used in common for therapeutic and living activities and recreation as well as being out of sight of the children. Under no circumstances will the purchase of tobacco products by minors be directly or indirectly supported by program personnel.

Hazardous Materials - If applicable to the treatment setting, the provider will establish and maintain a program to safely control and dispose of hazardous or potentially infectious materials and waste.

Medication - The provider will have policies and procedures for prescribing, transporting, dispensing, administering and/or ordering medications, as applicable. These policies and procedures will address, at minimum, procurement, storage, control and documentation thereof of all medication in accordance with rules and regulations of the State Board of Pharmacy, the State Board of Nursing, DELACARE and other authorizing agencies as applicable. The OCCL offers an Administration of Medication Self-Study Training Guide and Certification Testing in all three counties. To register for the Administration of Medication Certification Test, follow the corresponding link below:

New Castle County:

- http://kids.delaware.gov/occl/pdf/medication-registration-form-newcastle.pdf

Kent County:

- http://kids.delaware.gov/occl/pdf/medication-registration-form-kent.pdf

Sussex County:

- http://kids.delaware.gov/occl/pdf/medication-registration-form-sussex.pdf

Behavior Management/Seclusion/Restraint - (Only for hospital, residential and related day treatment programs which are licensed and/or accredited.) These providers will have policies and procedures in place for the safe and appropriate use of restrictive behavior management techniques such as seclusion and restraint. See section 15 of this manual for additional information.

Handicap Accessibility – providers are required to develop procedures to accommodate child/youth or family with disabilities.

Emergency Preparedness

The provider will have and implement a written plan for natural and man-made emergencies, including but not limited to fire, weather emergencies, criminal and/or terroristic acts. Fire safety plan will comply with the National Fire Protection Association Life Safety Code. Plans will also comply with the DSCYF Operating Guidelines regarding client safety. At minimum, these procedures will list evacuation and shelter-in-place/lockdown procedures as appropriate to the level of care.

- Drills for evacuation procedures will be documented as having occurred, at minimum, once per year on every shift at every location, as applicable to the level of care.
- Drills for lock-down/shelter-in- place will be documented as having occurred, at minimum, once per year on every shift, at every location, as applicable to the level of care.
- Table-top exercises involving all pertinent staff may replace in vivo drills if they are appropriate to the level of care.
- Documentation for drills will include at minimum, date, time, purpose, participants, outcome summary, and lessons learned, if applicable.

Audits and Monitoring

All DPBHS providers are subject to routine review and/or audit by authorized representatives of DSCYF. Reviews may include, but not be limited to: desk audits of available data on utilization and outcome, accreditation and licensure status, complaints, incident reporting and deliverable submissions, etc. DPBHS also conducts on-site monitoring surveys to evaluate client safety, appropriateness of services and compliance with DSCYF and DPBHS standards. By contract, providers agree to allow the authorized representatives access to all requested financial/fiscal and clinical/medical records and documentation, as appropriate. Audit proceedings should not be construed as an indication of any wrongdoing on the part of the provider. Rather, an audit should be looked upon as ongoing and necessary to ensure quality service delivery within State and Federal regulations.

DPBHS supports providers in maintaining compliance with CARF standards and Federal and State regulations, and utilizes audits to identify areas of improvement and determine the accuracy and propriety of provider billing, compliance with Program policy and procedures, quality of care, and utilization of services.

The provider will cooperate with DPBHS in administering reasonable pre- and post-treatment outcome measurement instruments, and report on requests for data on approved DPBHS forms or systems. DPBHS is responsible for monitoring each Evidence Based Practice (EBP) to ensure fidelity. The established measurement criteria will be evaluated on a monthly basis for EBPs.

Documentation in the clinical record must support the code being billed. Services shall not be rendered without a valid authorization for that service type or level, except in exigent circumstances. Should an audit reveal incorrect payments were made, or that the provider's records do not support the payments that were made, the provider shall make appropriate restitution. Audits may be conducted by the Quality Improvement Unit, Billing Unit, Program Administrators, or by the DSCYF Grants and Contract Unit which, oversees contracts.

While DPBHS works with providers to ensure compliance and the highest level of integrity in service delivery, Providers are subject to administrative sanctions. DPBHS may seek to exclude any provider whom it determines for fraudulent activities or crime whenever the federal authority directs such action. Medicaid fraud legislation exists which allows for various penalties due to infractions committed by providers. Should a provider be found to be non-compliant, DPBHS has a duty to report to the appropriate governing body, including Medicaid.

Administrative Sanctions

Administrative sanctions may be imposed against any provider who does not meet the State and Federal guidelines, regulations and laws, DSCYF/DPBHS quality or contract standards, or otherwise demonstrates concerning, significant or repeated deficiencies.

Administrative sanction refers to any administrative action applied by DPBHS, and is designed to improve practices or ensure compliance with the DPBHS policies and procedures, or State/Federal statutes, and regulations.

DPBHS may impose sanctions against a contracted service provider, if DPBHS finds that the provider:

- Is not complying with policy or rules and regulations, or with the terms and conditions prescribed in the provider contract;
- Has submitted a false or fraudulent application for provider enrollment status;
- Is not properly licensed or qualified, or that the provider's professional license, certificate or other authorization has not been renewed or has been revoked, suspended or terminated;
- Failed to comply with DPBHS supervision requirements;

- Has failed to correct any deficiencies in its delivery of service or billing practices after having received written notice of these deficiencies from DPBHS;
- Has presented any false or fraudulent claim for services;
- Has failed to repay or make arrangements for the repayment of any identified overpayment or erroneous payment;
- Has failed to keep or make available for review, audit, or copying any information or records to substantiate payment of claims for service provision;
- Has failed to comply with any Federal, State or DPBHS policy or procedure to ensure the effective delivery of quality services to DPBHS children; and/or
- Has engaged in or enabled unlawful, unethical conduct.

DPBHS may impose various levels of administrative sanctions, including the following:

- Give warning through written notice or consultation;
- Require education in program policies and billing procedures;
- Place claims on manual review before payment is made;
- Suspend or withhold payments;
- Recover money improperly or erroneously paid either by crediting against future billings or by requiring direct payment;
- Refer to the State licensing authority for review;
- Refer for review by appropriate professional organizations;
- Refer to Attorney General's Fraud Control Unit for fraud investigation;
- Suspend certification and participation in the Provider Network;
- Cancellation of Provider's Contract with DSCYF; and/or
- Refuse to allow participation in the Provider Network.

Sanction Levels

Level I – Written Warning, Program Improvement Plan (PIP) – examples include but are not limited to: poor client documentation, consistent billing errors, personnel files, lack of documentation, isolated failure to report;

Level II- Corrective Action Plan (CAP), refer to professional organization – examples include but are not limited to: licensing or ethics violations, fraudulent billing, and frequent IR reporting errors;

Level III- Suspension of services, restrictive plus CAP – examples include but are not limited to: severity and risk of violation, failure to report critical incidents, isolated abuse of child; and

Level IV-Termination of services – examples include but are not limited to: willful and wanton behavior, not addressing previously identified issues, blatant fraudulent activities, flaws in the administrative oversight of the program creating risk for all the children being served.

Performance Improvement
DPBHS is committed to the provision of safe appropriate services that facilitate positive behavioral change and positive outcomes for children, youth and their families. Providers will use a continuous performance improvement process that will achieve these outcomes.

The provider will have and implement a written performance and quality improvement plan which establishes a process for ongoing monitoring and evaluation of the quality and effectiveness of treatment and client safety. The plan and resulting process will assure that there is clinical oversight of services provided by all staff.

Where licensed staff are otherwise operating without clinical supervision, there will be a process by which the quality of their work is reviewed. This may be through peer-review, QI Committee review, etc.

In agencies/programs that have non-licensed staff providing services, the process and frequency of the supervision of these staff by a licensed professional will be included in the plan. This plan and related procedures will start with data/information. Design and implementation of improvements will be tracked and data will be gathered to assess whether the improvements achieved the desired outcomes. Where appropriate, the provider will collaborate with DPBHS in their performance planning and evaluation process

4 ETHICS AND PROFESSIONAL BOUNDARIES

Respect Physical, Mental and Emotional Boundaries
A boundary is how far people can go with comfort in a relationship. It is suggested boundaries be established in the first session, review and discuss ground rules and expectations.

- Physical: Respecting the individual's space and include the act of touching
- Mental: beliefs, thoughts, decisions and choices
- Emotional: refers to self-esteem and feelings

Professional Code of Ethics
Each professional discipline defines its Code of Ethics. Please refer to the most recent version of the Code of Ethics by which you are bound. Below are some of the online resources available for professionals (this is not an exhaustive list):

- http://www.apa.org/ethics/code/
- https://www.socialworkers.org/pubs/code/default.asp
- https://www.counseling.org/resources/aca-code-of-ethics.pdf
- http://www.psychiatry.org/psychiatrists/practice/ethics
- http://dpr.delaware.gov/
- https://www.decertboard.org/ethics

Guiding Principles of Ethical Behavior

Ethical principles can be used to work through an ethical dilemma. All principles are considered equal with no one holding greater weight or importance than another.

Respect for People's Rights and Dignity (Autonomy)

Behavioral Health Professionals respect all clients and their right to privacy, confidentiality and self-determination. Clients are free to choose their own direction and have the ability to make choices free from the constraints of others (APA, 2010). An individual is to be aware of the choice taken and the effect/ consequences it has on others. Limitations to client autonomy apply to those clients who are currently unable to understand the repercussions of their action – for example children and mental health patients (Corey, Corey, & Callanan, 2007; Welfel, 1998).

Beneficence and Non-maleficence

Behavioral Health Professionals seek to safeguard clients and do no harm. Behavioral Health Professionals judgments and actions may affect the lives of other, thus be careful not to misuse their influence and avoid the use of interventions that could or have the potential to harm clients. Behavioral Health Professionals must be aware of the impact of their own physical and mental health on their ability to help others. The Behavioral Health Professional is expected to do the best for the client and if unable to assist, to offer alternatives as appropriate. (APA, 2010; Corey et al., 2007; Welfel, 1998).

Justice

Behavioral Health Professionals will act in a non-discriminatory, fair and just manner to individuals or groups. It is expected that Behavioral Health Professionals will have the ability to acknowledge inequity and apply intervention to suit. (APA, 2010; Welfel. 1998).

Fidelity and Responsibility

Relationships of trust are established between the Behavioral Health Professional and their client. The interests of the client are placed before those of the Behavioral Health Professional even if such loyalty (towards the client) is inconvenient or uncomfortable. A client needs to be able to trust that the words and actions of the Behavioral Health Professional are truthful and reliable. (APA, 2010; Welfel, 1998).

Integrity

Accuracy, honesty and truthfulness are evident in the practice of behavioral health treatment. Behavioral Health Professionals are obligated and responsible to refrain from activities such as fraud, theft, or intentional misrepresentation and avoid unwise or unclear commitments (APA, 2010). *Steps in the Ethical Decision Making Process in Appendix 7.

5 CLIENT ELIGIBILITY

DPBHS provides behavioral health services to children under age 18, who have Medicaid, or who are without insurance coverage, who are residents of the State of Delaware and meet medical necessity for behavioral health services. DPBHS Eligibility policy can be found at:

- http://kids.delaware.gov/pbhs/pbhs.shtml

DPBHS Eligibility for Non-Residents of the State of Delaware – Mobile Response and Stabilization Services and short-term emergency hospitalization may be provided to non-resident children under the age of 18 who are in Delaware and whose behaviors present imminent danger to self or others due to behavioral health disorders. DPBHS reserves the right to seek reimbursement for services provided to non-Delaware residents.

MCO Referral - If you are a MCO Provider seeking DPBHS services for your client:

- For extended outpatient benefits (beyond the 30-unit MCO limit) – please submit a referral to DPBHS' Access Unit. Referral form can be found at:
  - http://kids.delaware.gov/pbhs/pbhs_providers_forms.shtml
- For a more intensive service, submit a Mental Health and Substance Abuse Referral to DPBHS Access Unit. Referral form can be found at:
  - http://kids.delaware.gov/pbhs/organizational-structure.shtml

6 FAMILY CHOICE

DPBHS appreciates the time and effort a family takes to make sure their child/youth receives proper behavioral health care. Family engagement in the child's care maximizes the benefits received from treatment. When the family is engaged, the child/youth is more likely to succeed and experience more positive outcomes from the treatment than a child/youth without an engaged family (Kuhlthau & et al., 2010).

A family might ask, "Why is it so important that I make the decisions and not just let the professionals?" The answer is simple. The family serves as the expert in having first-hand knowledge concerning their child. The family can offer their expertise and perspectives regarding the child/youth's behavior across multiple settings, such as school, home, and in the community. The family can also provide valuable input and feedback that provides specific information such as when the child/youth's behaviors occur, certain environmental triggers, and the emotional, behavioral manifestations, and so much more. It is pivotal to remember that the information provided by the family is essential to designing an effective treatment plan for the child/youth and family. A professional cannot duplicate the information and expertise provided by

the family. As the child/youth enters and continues in treatment, the family is empowered to remain engaged throughout the process to ensure their expertise informs the child/youth's treatment.

DPBHS is fully committed to the value of family involvement thus; families must be included in all decisions regarding the planning and provision of behavioral health services for their children. DPBHS makes every effort to ensure DPBHS services meet the physical, cultural and linguistic needs of the children and families served. If a provider is unable to offer services in the children or family's first language, DPBHS will arrange for translation services to be available for the children and family through its State contracts. Clients may obtain Medicaid services from any qualified provider enrolled in the Delaware Medicaid program to provide specific services in accordance with section 1902(a)(23) of the Social Security Act.

7 EARLY INTERVENTION AND PREVENTION

DBPHS K-5 Early Intervention Program is a voluntary program managed in partnership with the Department of Education and participating local school districts. The program employs Family Crisis Therapists statewide to work with children and families identified as "at-risk" by the school principals. Family Crisis Therapists assigned to designated elementary schools provide a range of interventions designed to remove barriers to academic and social success. Program staff provide interventions within a system of care framework and enhance collaboration among state agencies and communities to meet the needs of children and their families. The K-5 Early Intervention Program is currently serving fifty-four elementary schools in fourteen school districts and five charter schools statewide. Services provided by the K-5 Early Intervention Program are:

- Individual Counseling
- Family Counseling
- Child/Parent Support Groups
- Collaboration with the School and Outside Agencies
- Social Skills Workshops for Children
- Conflict Resolution
- Discipline Alternatives
- Location of Resources (as needed)

For more information on the K-5 Early Intervention Program, please call (302) 892-4576 or email dscyf_intake_general@state.de.us.

DPBHS provides an array of Prevention services in which all children and families are able to participate. Prevention services are directed towards promoting health and wellness and to prevent child abuse and neglect, dependency, juvenile delinquency, truancy, tobacco/drug/alcohol use, domestic violence and other risky behaviors. Children and families are not required to be active with DPBHS treatment services to benefit from Prevention Services. Connecting children and families with Prevention services, programs and resources is an expectation of DPBHS providers. In addition to the programs below, there are after school

and summer programs available your children and their families. For more information on any of the Prevention Programs listed below, please call 302-633-2586.

PREVENTION PROGRAMS

Promoting Safe and Stable Families – (PSSF)
The Promoting Safe and Stable Families Program (PSSF) is a community-based family support and preservation program which provides consultation services to families who are "at risk or in crisis" due to one or a combination of stressors that may lead to child maltreatment. The consultation process engages and guides parents and their family through a self-assessment tool, supporting the identification of potential and presenting risk factors. The family engages in the completion of a family drive planning process to address their core concerns and needs, identifying formal and informal support systems to successfully accomplish the family established goals increasing the family protective factor in providing safe and stable family environment. DPBHS contracts with *First State Community Action Agency (New Castle, Kent & Sussex County)*, Connection in Sussex County, Jewish Family Services of Delaware in New Castle County, and two Neighborhood House sites (Wilmington & Middletown), in order to provide this program within a community-based setting statewide. *Funded by Title IVb, Subpart 2.

Delaware Fatherhood & Family Coalition – (DFFC)
Delaware Fatherhood & Family Coalition is an extension of the Promoting Safe and Stable Families Program and the Responsible Fatherhood Initiative created specifically to give a voice to fathers and the importance of their involvement for the well-being of their children. The DFFC believes in the power of fatherhood and families where children's safety is not at risk. The DFFC is an advocacy coalition with diverse and unified membership. The DFFC infrastructure was created to develop platforms to address social barriers and challenges that prevent fathers from being involved in raising their child(ren). The membership is made up of parents, community leaders, grass-root, service, state, interfaith and community-based organizations. The coalition connects multiple sectors of the community in a comprehensive approach, continuously develops partners, trains and educated to achieve real outcomes. *Funded by Title IVb, Subpart 2. ***For more information contact admin@dffcdads.org or (855) 733-3232***

Child Development Watch – (CDW)
Early intervention program for children ages birth to three. The program's mission is to enhance the development of infants and toddlers with disabilities or developmental delays and to enhance the capacity of their families to meet the needs of their young children. ***For more information contact: (Kent & Sussex Counties 302-424-7300; New Castle County (302) 283-7140)***

The Intensive Family Consultation Service – (IFC)
Intensive Family Consultation is an intervention service designed to support families who are experiencing more complex issues in their lives. These multiple complex needs are associated with **parent /child conflict, substance abuse, family instability associated with homelessness, single parent stressor and isolation, blended family stressors, unresolved mental health needs, absence of supports and**

resources, etc. IFC Services uses a team approach to assist the family in creating opportunities to acquire competencies that will permit them to mobilize supports necessary to cope, adapt, and grow in response to life's many challenges and empower families by giving them the tools needed to:

- Care for and protect their children
- Improve their family functioning
- Build connections to various support networks within their community
- Self-Advocate

IFC Services are provided statewide by the DPBHS staff.

Separating and Divorcing Parent Education Program (SDPE)

On July 18, 1996, Delaware passed a law mandating divorcing parents with children up to age 17 to attend a parenting education course. Additionally, this course will specifically provide information regarding domestic violence, its prevention and effect upon children. For reference, see Senate Bill 288, Title 13, Section 1507 of the Delaware Code, subsection (h) as signed by the Governor Thomas R. Carper. All programs must be certified by the Department of Services for Children, Youth and Their Families, Division of Prevention and Behavioral Health Services (DPBHS). The law also states that persons with a history of domestic violence must complete a program specifically addressing those issues. The goal of this program is to help educate parents of the effects upon their children of divorce/separation and to help both parties minimize the harmful effects on their children, whenever possible.

Substance Abuse Block Grant (SABG)

*Supports funding for universal and targeted substance abuse prevention services. ****Please contact Yvonne Bunch (302) 633-2513 for more information on the SABG.***

- **University of Delaware: Botvin Life Skills**

  The Botvin Life Skills Training Program is free for Delaware students 8-14 years old. This comprehensive and exciting program facilitated by the University of Delaware provides children and adolescents with the confidence and skills necessary to successfully handle challenging situations. Program sessions are delivered statewide at self-identified schools and community centers. Interested schools and community centers can contact, Lindsay Hughes, Extension Educator, directly at (302)856-2585 x 523.

- **Community Assessment and Coalition Capacity Building**

  The Delaware Prevention Coalition (DPC) is a statewide collaborative group designed to build and strengthen the capacity of community partners to create, safe, healthy drug-free communities. They implement a comprehensive statewide prevention effort to promote wellness and reduce alcohol, tobacco, and other drug abuse in the State of Delaware. Currently, the Greater Dover Boys and Girls Club serve as the Kent County site for DPC activities. Bellevue Community Center serves as the New Castle County site and 1st State Community Action Agency serves as the Sussex site Local communities and potential partners can contact the DPC Statewide coordinator, at West End Neighborhood House directly for more information at (302) 658-4171.

- **Lunch and Learn Program**

The Delaware Prevention Coalition's (DPC) Lunch and Learn Program is held during the scheduled lunch periods within the school's cafeteria. Tables are set up exhibiting and disseminating factual information pertaining to alcohol and other abusive substances. Lunch and Learn is a beneficial program for the schools, as it does not take away from the normal classroom time or having to conduct extracurricular activities that can be costly; it is intended to spread positive prevention messages to the students. The Lunch and Learn Program is very informative and interactive. The program ensures that information and brochures concerning the effects of alcohol in the body, the mind and the family are distributed. Discussions pertaining to binge drinking, laws, and risky behaviors are just a few of the topics that are mentioned. The Lunch and Learn Program impacts the student body, with the essence of the program to give the student the opportunity to engage in discussions without being embarrassed and a time to change their minds and also convince them that what they have experienced and/or learned from their friends may not be safe or factual. Please contact West End Neighborhood House directly for more information at (302) 658-4171.

- **Youth Prevention Frontliners Committee**

They are increasing involvement and engagement in Youth Prevention Frontliners Committee through leadership activities for the coalition. The Prevention Frontliners are students encouraged to support adult staff in each school district to lead and promote student advocacy groups. This helps the youth to create something that is theirs and it provides recognition for committee members. It also creates an increase in reception of prevention messaging if they are providing the message to peers through media and at gatherings such as the Annual Teen Summit. Please contact West End Neighborhood House directly for more information at (302) 658-4171.

Families and Centers Empowered Together – (FACET)

(FACET) is a family engagement, family support and empowerment program located in six diverse Early Learning Centers. The program is designed to strengthen families through educational and life-enhancing /stress relieving activities, and other support services within the community. These non-threatening, family enhancing activities and support services are chosen by the parents themselves through a parent council designed to promote their involvement and give them control over the program. Through FACET, families of preschool age children are strengthened through activities designed to build community relationships, improve parenting skills, increase self-esteem and a sense of control, and reduce stress. FACET follows the belief that to do the best we can for children; we must support and strengthen their families and communities. The formula is simple: parents who possess a sense of fulfillment not only feel good about themselves and their family life, but also become better parents. There are four FACET Providers in New Castle County which include The Kingswood Community Center, The Latin American Community Center, Mary E. Herring Child Care Center, and The Little Futures Learning Academy. Each of these sites are located in the City of Wilmington. In Kent County, the FACET Provider Sites include The Tender Hearts Learning Center, and The Children's First Learning Center.

Project LAUNCH

Delaware Project LAUNCH (Linking Actions for Unmet Needs in Children's Health) aims to promote the wellness of young children from birth to 8 years by addressing the physical, social, emotional, cognitive,

and behavioral aspect of their development. The coordination of child-serving systems and the integration of behavioral and physical health services drive this work to ensure children are thriving in safe, supportive environments and entering school ready to learn. Additionally, the work advances Delaware's shared vision for the wellness of young children as outlined in *Sustaining Early Success: Delaware's Strategic Plan for a Comprehensive Early Childhood System.* Delaware Project LAUNCH focuses on neighborhoods that are feeder patterns for Warner Elementary and Shortlidge Academy. These communities long identified with multiple environmental risk factors and gaps in services and supports for youth children, birth to 8 years, and their families. These communities are areas of high poverty have experienced high crime and violence and have few, if any high quality early care and education programs.

There are five core prevention and promotion strategies identified by SAMHSA for Project LAUNCH:

- Screening and assessment in a range of child-serving settings
- Integration of behavioral health into primary care
- Mental Health consultation in early care and education
- Enhanced home visiting with a focus on social and emotional well-being
- Family strengthening and parent skills training

Early Childhood Mental Health Consultation – (ECMHC)

ECMHC is a free service and partnership with providers of early care and education programs that is effective in addressing and supporting young children's social and emotional development in early care and education settings (2-5 years old). All consultants are licensed mental health professionals with experience working in early learning settings.

Youth Suicide Prevention Initiatives

Under the Garret Lee Smith (GLS) grant professionals are trained on the Suicide Prevention and Resource Center's (SPRC) curriculum, *Assessing and Managing Suicide RISK (AMSR)*, presenting at workshops to school personnel and the public on suicide, trained family crisis therapists in elementary schools on suicide prevention, working on a campaign to reduce stigma and provide social marketing on texting. ***For general information, referral and routine intake please call 1-800-722-7710***

Behavioral Health Consultants (BHC's)

The Behavioral Health Services initiative was designed to allow licensed mental health professionals (BHC's) to provide brief mental health services to students in middle schools throughout Delaware. The BHC Program is a 12-Month Program. Services provided by the BHC's include the following:

- Assist with Crisis Referrals
- Complete Risk Assessments
- Complete Brief Mental Health Screenings
- Facilitate Referrals for Mental & Behavioral Health Services
- Provide Brief Individual Counseling Sessions (3-5 sessions)
- Facilitating Group Therapy Sessions
- Providing Family Therapy Sessions

- Conducting Home Visits and Engaging Families
- Collaborating with School Personnel in meeting the Youth's needs.

For more information please contact Dr. Helena Carter (302) 633-2579.

The Resource Center (Pamphlets and Brochures)

Universal intervention services are provided through the Division of Prevention and Behavioral Health Resource Center which disseminates thousands of informational pamphlets on topics including, but not limited to: child development, separation and divorce/successful co-parenting strategies, parenting skills/tips, fatherhood, stress, drug and alcohol prevention, skill building, substance abuse, bullying, mental health, coping, budgeting, child abuse, violence prevention, and a host of other topics. These materials are distributed to individuals and organizations across the state free of charge. A resource order form is provided to the individual or organization that desires to receive some materials, typically through email or fax. The online order form can also be obtained at:

- http://kids.delaware.gov/pdfsFillSave/pbh_ResourceCenterOrderForm_2013_fs.pdf

The Resource Center has reached out to more than 65 agencies in Delaware to assist them in building their resource areas by delivering informational pamphlets. These agencies represent schools, daycares, Head Start and early childhood centers, community centers, hospitals, universities and colleges, faith-based organizations and state organizations. The Resource Center is currently putting forth a stronger effort towards the awareness of alcohol, tobacco, prescription drug, and other drug prevention. ***For more information please call (302) 892-6440.***

8 ACCESS

The Access Unit is responsible for screening referrals and determining eligibility of a child/youth and family who are referred to DPBHS for a level of care coordination and behavioral health services. This unit makes determinations at both a routine intake level and an acute care level.

Access Unit - Routine Intake

Outpatient Referral Process: For a child/youth without insurance who is in need of outpatient services or for a child/youth who has exceeded their 30-unit outpatient benefit though their Medicaid MCO.

1. Parents/caretakers may call any of the DPBHS mental health or substance use outpatient providers listed in the DPBHS information brochure and on the DPBHS Website. These providers will assess clinical and financial eligibility and assist the child/youth and their families to obtain appropriate care by completing and submitting a referral to DPBHS Access Unit. The referral form can be found at:
   - http://kids.delaware.gov/pbhs/pbhs_providers_forms.shtml
2. Once DPBHS receives a completed referral with the required documentation (and any other relevant information), it will be reviewed for eligibility. Completed referrals will be processed within 1 week. Incomplete referrals will be returned to the referral agent. Corrections must be

received within 30 days otherwise; a new referral with current clinical information and signatures dates within the last 30 days will be required.

3. If approved, an authorization will be sent to the provider specifying the length of time the authorization is valid. If the youth continues to need outpatient treatment and remains without coverage, a reauthorization request must be submitted no more than two weeks prior to the authorization's end date. *For a child/youth without insurance it is DPBHS expectation that the provider assist the family in applying for Medicaid coverage.

Higher Level of Care Referral Process: For non-emergency situations in which a child/youth is in need of a Higher Level of Care (HLOC). A HLOC referral may be submitted when a child/youth is in need of more intensive care coordination and/or behavioral health services, greater than what is available through their MCO.

1. Referrals may come from a variety of sources such as a child/youth's current behavioral health provider, a school counselor, a physician, or the family. If you need additional information on making a referral call 1-800-722-7710. **If the child/youth is in a behavioral health crisis and could cause self-harm or harm someone else, call the Mobile Response Hotline 1-800-969-HELP (4357).** Regardless of the origin of the referral, DPBHS uses the information and completes the intake process. Referral form can be found at:
   - http://kids.delaware.gov/pbhs/organizational-structure.shtml
2. Once DPBHS Access Unit receives a completed referral with the required documentation (and any other relevant information), it will be reviewed for eligibility.
   a. Completed referral packets will be processed within 2 business days.
   b. Referrals missing sections or having incomplete responses making them insufficient to determine eligibility will be returned to the referral agent. If the referral is missing required supplemental documentation, the referral agent will be contacted and informed of what is needed to process the referral. If that information is not received within 10 business days, the referral will be closed. After 30 days, a new HLOC referral will need to be completed and submitted for processing.
   c. If there is an immediate need for services, Access Unit - Acute Care will authorize services through Mobile Response and Stabilization Services.
3. If a child/youth and family are determined to be eligible for a greater level of service intensity and/or care coordination, the case may be assigned to a Child and Family Care Coordination Team and the child/youth and family will be provided with a Care Coordinator. The Care Coordinator will assist the child/youth and family in the selection of service(s) and provider(s) based on the family's needs and preferences. The Care Coordinator will provide the child/youth and family with any additional information, regarding service expectations, so they can make an informed decision.

Access Unit - Acute Care

Mobile Response and Stabilization Services (MRSS) are available 24 hours per day, 7 days a week, 365 days per year including weekends and holidays. Mobile Response and Stabilization Services are delivered to youth experiencing escalating emotional symptoms, behaviors or traumatic circumstances, which have compromised or impacted the youth's ability to function at their baseline within their family, living situation, school and/or community environments. These crises arise from situations, events, and/or circumstances that are unable to be resolved with the usual resources and coping abilities. Without Mobile Response and Stabilization Services, the youth may be at risk of out of home treatment, legal charges, loss of their living arrangement or psychiatric hospitalization. **If the child/youth is in a behavioral crisis and could cause self-harm or harm someone else, call the Mobile Response Hotline 1-800-969-HELP (4357).**

Mobile Response and Stabilization Services Referral Process: Mobile Response and Stabilization Services are initiated by a telephone call to the Mobile Response Hotline at 1-800-969-HELP (4357). All calls are answered by qualified staff with training in completing a safety screen (triage). When the safety screen indicates the need for immediate response to prevent further behavioral and/or emotional escalation, this initiates the Mobile Response and Stabilization Services by dispatching a Mobile Response Worker to respond within 1 hour of the initial dispatch request. The Mobile Response Worker will provide on-site intervention for immediate de-escalation of the presenting problem, complete the Crisis Assessment Tool (CAT) and an Individualized Crisis Plan (ICP), and provide linkage to appropriate resources in order to stabilize the presenting problem.

1. If it is determined the youth needs an acute bed based service, the Access Unit – Acute Care will complete utilization reviews to determine length of stay based on clinical necessity.
2. If it is determined the youth is able to stay in the community, a Mobile Response Worker may stay involved with the child/youth and family for stabilization and to assist with the connection to outpatient services. A Mobile Response Worker may also facilitate a request for Higher Level of Care (HLOC) services.
    a. If the Mobile Response Worker is assisting with connection to outpatient, they will remain involved until after the first session.
    b. If it is determined a HLOC is needed, a referral must be submitted to the Access Unit – Acute Care worker and will follow the same process as the routine referral. In all of these situations the Access Unit – Acute Care remains involved as long is necessary.

9 LEVEL OF SERVICE DETERMINATION

The Access Unit and Child and Family Care Coordination Teams use established DPBHS clinical criteria, clinical instruments, standardized assessments along with child/youth and family input and referral information provided to assist in determining the child/youth's eligibility for services, level of service need,

and care coordination support across the DPBHS service continuum. Clinical necessity criteria are available in Appendix 8. A summary of the clinical instruments and standardized assessments are provided below:

Clinical Instruments

Child and Adolescent Service Intensity Instrument (CASII)

The CASII is a standardized instrument that assists in a determination of the appropriate level of services needed by a child or adolescent and his or her family (AACAP, 2015). The CASII assesses the service intensity needs of children and adolescents presenting with psychiatric, substance use, psychosocial and/or developmental concerns. It incorporates holistic information on the child, within the context of his/her family and social ecology, assessing across six key dimensions: Risk of Harm, Functional Status, Co-Occurrence, Recovery Environment-Stress/ Recovery Environment-Support, Resiliency and/or Response to Services, and Involvement in Services.

The CASII is developmentally informed and compatible with the System of Care approach -- embracing individualized service planning, offering child and family teams, and providing a broad service array. CASII recognizes use of home and community based services and natural supports as part of the "medical necessity" and treatment implementation equation.

CASII is applicable to children living in the community with their parents or extended family, and to children in foster care, and institutional settings. The CASII is culturally informed, and supports active participation by child and family during assessment and thereafter. The CASII can be used at all stages of intervention and is designed for use in all child-serving systems (behavioral health, physical health, education, child welfare, juvenile justice, etc.) to facilitate integrated attention to the child's needs. It promotes effective communication between providers and systems and informs clinicians' engagement with the child, family, and community.

- http://www.aacap.org/aacap/Member_Resources/Practice_Information/CASII.aspx

American Society of Addiction Medicine (ASAM)

ASAM Criteria is a national set of criteria for providing outcome-oriented and results-based care in the treatment of addiction. ASAM criteria has become the most widely used and comprehensive set of guidelines for placement, continued stay and transfer/discharge of patients with addiction and co-occurring conditions. ASAM's criteria are required in over 30 states.

ASAM's treatment criteria creates comprehensive and individualized treatment plans. Treatment plans are developed through a multidimensional patient assessment over five broad levels of treatment that are based on the degree of direct medical management provided, the structure, safety and security provided and the intensity of treatment services provided.

- http://www.asam.org/quality-practice/guidelines-and-consensus-documents/the-asam-criteria

Standardized Assessments

DSM-5 Parent/Guardian-Rated Level 1 Cross-Cutting Symptom Measure
The tool assesses mental health domains that are important across psychiatric diagnoses. It is intended to help clinicians identify additional areas of inquiry that may have significant impact on the child's treatment and prognosis. The measure may also be used to track changes in the child's symptom presentation over time (APA, 2013). This will replace the EPSDT form.

The information gathered using the tool will be used in conjunction with the other information provided in a higher level of care referral to determine eligibility.

- http://www.psychiatry.org/psychiatrists/practice/dsm/dsm-5/online-assessment-measures

Child and Adolescent Needs and Strengths (CANS)
The Child and Adolescent Needs and Strengths (CANS) is a multi-purpose tool developed for children's services to support decision making, including level of care and service planning, to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services. The CANS was developed from a communication perspective so as to facilitate the linkage between the assessment process and the design of individualized service plans including the application of evidence-based practices. The CANS is meaningful to an individual child and family. The way the CANS works is that each item suggests different pathways for service planning.

For information on using the CANS as a multi-purpose tool, please use the following link:

- https://praedfoundation.org

Assessment for Residential Treatment (ART) Committee
The ART Committee was created to review Residential Rehabilitative Services, Psychiatric Residential Treatment Facility (PRTF), Day Treatment and Family Based Service referrals by using a standardized instrument (the CASII) and a standardized format (the ART Referral Checklist). The ART Committee reviews RTC, Day Treatment and Family Based referrals to match the needs of child and families with the most appropriate level of service intensity and natural supports.

ART Committee goals include:

- Assuring inter-rater reliable use of the CASII instrument;
- Using a standardized method of case presentation;
- Developing collaborative case consultation to address areas of risk and need with the most appropriate level of service intensity and natural supports;
- Consistent level of care decision-making across clinical service teams; and
- A uniform, collaborative approach to support Child and Family Care Coordination in explaining level of service intensity decisions to families and other stakeholders.

ART Committee process:

- The ART Committee meets once per week;

- The ART Committee members are not required to attend every meeting and should determine their attendance based upon their work priorities;
- Team Leaders may rotate into the ART schedule to improve their reliable use of the CASII;
- ART limits reviews to new RTC referrals and review of boarders.

10 CARE COORDINATION

DPBHS provides care coordination to support the child and family's success in attaining individualized goals, navigating systems, and promoting the family's achievement of their greatest level of self-sufficiency. Care Coordinators are trained professionals in wraparound practices, which guide and support families in the coordination, engagement and obtaining of services and supports across the system, as well as providing linkages to community-based natural services. The ten guiding principles of Wraparound include the following:

Family Voice and Choice – Team Based - Natural Supports – Collaboration – Community Based – Cultural/Linguistic Competence – Individualized – Strengths Based – Persistence – Outcome Based

DPBHS maintains wraparound coaches and trainers on staff to ensure sustainability and adherence to the practice model. Care Coordinators partner with families, providers, and other community, natural supports, and stakeholders who have an invested interest in the family to promote continuity of care. Care coordination is an essential component of the DPBHS service continuum for children/youth and families with high level service needs and/or who are at-risk for deeper end services and supports. Care coordination activities reflect and support a family-driven, youth-guided, trauma-informed prevention and behavioral health system of care. Wraparound care coordination provides a bridge of support across multiple systems for the overall benefit of the child and family.

Why Wraparound?

- Wraparound is provided to ensure children and families have equal ACCESS to needed services and supports. Wraparound is a critical part of the solution.
- Wraparound is provided to ensure the family's VOICE is acknowledged, valued, and respected. The family's voice is fully integrated in the decision making process.
- Wraparound is provided to ensure the family has OWNERSHIP of the planning process and partners with the team carry out the family's desired goals and vision.

Wraparound is a process of individualized care planning and coordination designed to address the complex needs of children/youth and their families. Ideally, wraparound serves children/youth and families with multiple overlapping challenges, those with unmet needs, and families who have been unsuccessful in navigating systems for services or supports. Wraparound includes four distinctive phases; Engagement,

Initial Plan Development, Plan Implementation and Transition/Discharge. *Please see Appendix 6 for more information on the four distinctive phases of wraparound.

The wraparound process includes a team of professional (formal) and natural community (informal) supports. The wraparound team convenes to address essential components of a family's life, culture, relationships and other relevant concerns. The purpose of the team is to address key service and support needs of the family then formulate possible solutions via a plan of care with the child/youth, and family's input. The wraparound team works to identify the family's strengths, develop and implement a plan of care and work endlessly toward the family's achievement of their vision and goals. Ideally, the wraparound team is comprised of an equal number of formal/informal supports (50/50). The number of informal supports increases over time as the family becomes more empowered and self-reliant. *Examples of informal supports include; friends, neighbors, teachers, coaches, extended family members, etc. Examples of formal supports include; therapists, psychiatrists, physicians, care coordinators, case workers, etc.

The Wraparound Team process commits to the following:

- One Family – One Plan – One Team
- Holding each other accountable
- Brainstorming creative ways to meet complex needs
- A common approach and goal
- Celebrating accomplishments together
- Tracking progress

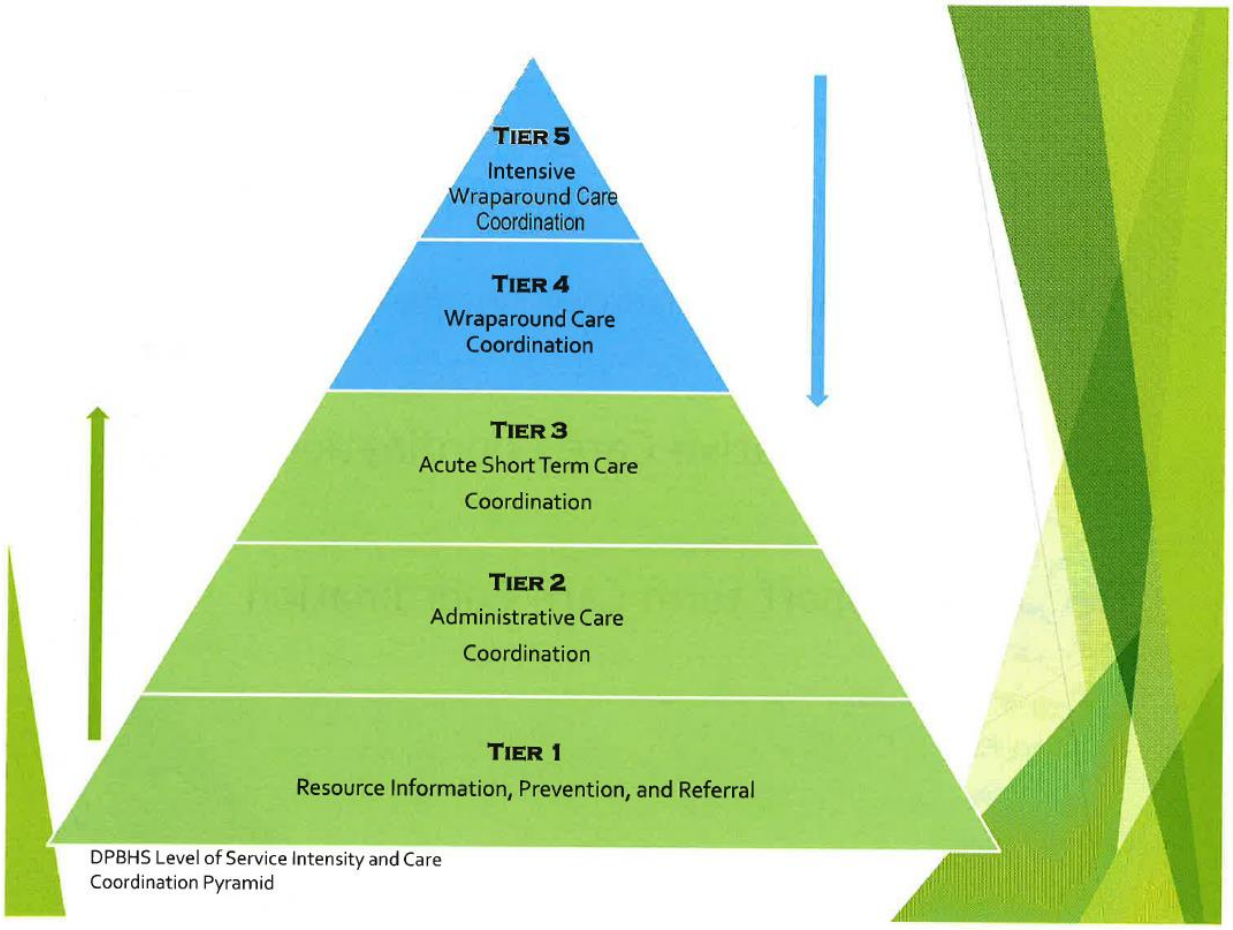
DPBHS wraparound care coordination is represented by Tier 4 (Wraparound Care Coordination) and Tier 5 (Intensive Wraparound Care Coordination). Each tier of wraparound care coordination is designed to support the child and family's higher level of service and Care Coordination need.

- DPBHS Tier 4 (Wraparound Care Coordination) generally serves children/youth and families in active need of community-based services and supports to promote and maintain stability in the home, school or community.

- DPBHS Tier 5 (Intensive Wraparound Care Coordination) generally serves children/youth and families in need of intensive community-based services to establish and maintain stability in the home, school or community with a focus on the reduction of crisis and high risk for residential care services.

In addition, DPBHS contracts with a provider to deliver Intensive Wraparound services. DPBHS provides administrative oversight of this Intensive Wraparound service at the Tier 2 level.

DPBHS offers a five tiered care coordination model:



DPBHS Level of Service Intensity and Care Coordination Pyramid

Tier Level	Focus of Tier	Care Coordination Intensity	Frequency of Contact	Eligibility Criteria
Tier 1: *Resource Information, Prevention, and Referral*	The child/youth and their family are looking for information on community based low level services. They are connected to community resources through referrals given and are able to effectively access these resources on their own or with minimal guidance and support.	This is a single service intervention (incoming phone call) where resources are provided verbally on the phone call and/or provided via mail, email, and/or fax. If it is determined during the phone call more services are warranted to support the request, the caller will be offered a referral packet to complete and submit to the Access Unit. If necessary, a caller may be transferred to Mobile Response and Stabilization Services and triaged to Tier 3.	Only through incoming call with no follow up.	Single service need for intervention; looking for low level/non intensive community based resources.
Tier 2: *Administrative Care Coordination*	A child/youth and their family are in need of administrative support to access services that meet PBH eligibility and do not require tier 4 or 5 care coordination.	Administrative management and coordination of community services. The child/youth and family are able to effectively access resources on their own or with minimal guidance and support. A child/youth or family who does not respond to this level of care coordination, or are experiencing an increase in need, may be eligible for Tier 4 or 5 Care Coordination.	Contact with providers based on utilization review criteria.	PBH service eligibility and does not meet criteria for tier 3, 4 or 5 care coordination.
Tier 3: *Acute Care Short-Term Care Coordination*	Child/Youth and their family are in need of brief intervention and crisis stabilization. Following stabilization an assessment will be completed to determine the most appropriate LOC and/or Care Coordination for continuation of services.	There is communication and coordination with current and aftercare providers and with family as needed. A child/youth who needs more than this LOC will have a CASII completed to determine eligibility for another Tier and level of care coordination.	Utilization reviews as well as contact with providers and/or families is 1 or more times per week.	Admission into Mobile Response and Stabilization Services, Crisis Residential Service, or Inpatient Hospital.

Tier Level	Focus of Tier	Care Coordination Intensity	Frequency of Contact	Eligibility Criteria
Tier 4: *Wraparound Care Coordination*	A child/youth and their family are in active need of community-based services and supports to promote and maintain stability in the home, school or community.	Care coordination services are delivered to assist the child-youth and family in achieving stability and support. A child-youth and family may have multiple needs for services and support or may not have achieved success in Tiers 1 – 3. Care coordination services involve a child-youth and family meeting process which supports System of Care (S0C) and wraparound values and principles. *Child & Family Meetings (CFM) are held every 90 days or PRN.	Care coordination contact frequency will include Informal contact (i.e. call, text, email) biweekly with family (child and caregiver). Face to face family (child and caregiver) contact must occur at least once a month and PRN for a review of progress and family satisfaction. Informal contact monthly and PRN with service providers and division agencies to ascertain progress toward identified goals on the POC. If crises arise, the family will be contacted within one business day and a CFM held within three business days. CFM every 90 days and PRN.	DPBHS Eligibility Criteria, CANS, Standardized Instruments (CASII Dimensions/ASAM Criteria), Cultural and Linguistic Factors and other considerations.
Tier 5: *Intensive Wraparound Care Coordination*	A child/youth and their family are in need of intensive community-based services to establish and maintain stability in the home, school or community with a focus on the reduction of crisis and risk for residential care services.	Care coordination services are delivered with intensive wraparound support with an emphasis on integrating the child-youth into the community and building the family's natural and social support networks. Care coordination services involve a child-youth and family driven team process, based on System of Care (S0C) and wraparound values and principles. *Child & Family Team Meetings (CFTM) are held every 30 days or PRN.	Care coordination contact frequency will include Informal contact (i.e. call, text, email) once a week with family (child and caregiver). Face to face family (child and caregiver) contact must occur at least once a month and PRN for a review of progress and family satisfaction. Informal contact monthly and PRN with service providers and division agencies to ascertain progress toward identified goals on the POC. If crises arise, the family will be contacted within one business day and a CFTM held within three business days. CFTM every 30 days and PRN.	DPBHS Eligibility Criteria, CANS, Standardized Instruments (CASII Dimensions/ASAM Criteria), Cultural and Linguistic Factors and other considerations.

The level of Care Coordination is determined by the Tier assignment. When a referral for a Higher Level of Care (HLOC) is received by the Access Unit and the child/youth has been determined to be eligible for a greater level of service intensity and/or Care Coordination support through Tier levels 4 or 5, they will be assigned to a Child and Family Care Coordination (CFCC) Team. CFCC Teams are comprised of a Licensed Child and Family Care Coordination Team Leader (CFCCTL), Psychiatric Social Worker III (PSW III), Child and Family Care Coordinator (CFCC) and Family Services Assistant (FSA).

DPBHS Tier 4 and 5 referrals are initially directed to and reviewed by the Regional Supervisor who then assigns the case to a CFCCTL. Within two business days of receiving a new case, the CFCCTL is responsible for the review of available case related documents, initial case conceptualization and the authorization of interim services for up to 30 days. The CFCCTL will then assign the child/youth and families case to a CFCC/PSW III who is responsible for determining if there is missing and/or additional needed information, ensures existing consents are current and signed and identifies other agencies and/or divisions involved with the child/youth and family. The CFCC serves as the primary person responsible for coordinating care for the child/youth and family.

Within two business days of receipt of assignment of a new case, the CFCC/PSW III will contact the family to schedule an initial Child and Family Engagement Meeting. This meeting is to be scheduled to occur within seven business days. The location of the initial Child and Family Engagement Meeting should be at the discretion of the child/youth and family and may occur at a multitude of sites, e.g. family home, state office buildings or other appropriate community settings, etc.

- If necessary, multiple reasonable attempts over several days to initiate contact with the child - youth and family are made and if still unsuccessful, an outreach letter proposing closure is sent within two weeks of case assignment.

The initial Child and Family Engagement Meeting will introduce and educate the child/youth and family about the wraparound process, discuss HIPAA regulations, advise about available services, and review consents. At this stage, the Child and Family Team Meeting (CFTM) is scheduled to occur within thirty days of the receipt of the referral. CFTMs include the child/youth, parents or primary caregivers, any adult(s) living in the home, divisional agencies and the CFCC. Natural Supports are also encouraged to attend the CFTM. With the support of a CFCC, families work as drivers of their own care and interact directly with the providers serving them. CFCCs act as facilitators and strategic interventionists for the family and guide them through the process of CFTM. ***Please note, only children/youth and families assigned to Tier 4 and Tier 5 will receive CFTMs.**

CFCC responsibilities may include:

- Client and Family Support:
- Information and referral to community services;
- Case-specific consultation to parents, educators, and medical and social service providers in home and agency settings;

- Training in public benefits and local systems of care.
- Assist the child/youth and family to coordinate medical, social and educational systems;
- Identify the changing needs of their child/youth and family;
- Understand the full range of available public benefits;
- Identify community resources to assist;
- Gain access to specific programs and services;
- Become more effective advocates;
- Connect with other families who face similar challenges; and
- Plan for greater self-sufficiency and community integration.

11 UTILIZATION REVIEW

The Utilization Review (UR) function is completed for children/youth throughout the division. The UR schedule is determined by the Level of Care and is completed for children/youth admitted to Residential Treatment, Inpatient Psychiatric Hospitals, Day Treatment and Partial Hospitalization Programs. UR is an ongoing process of reviewing clinical documentation, consulting with medical and treatment staff, assessing treatment plans, justifying length of treatment and completing case documentation. The purpose of UR is to determine clinical necessity and ensure proper utilization of treatment services. UR is responsible for preauthorization and/or reauthorization of a specific treatment service and contributes to aftercare and discharge planning. Care Coordinators (Access/CFCC) are responsible for collaborating with the UR staff to determine discharge/transition planning. Regardless of Tier assignment, the information that is required by DPBHS UR staff consists of the following from the time of last review:

- Status of presenting problems (no progress, slight progress, moderate progress, significate progress, problem not addressed in treatment, regression, etc)
- Status of problems that have emerged during the course of treatment
- Continued challenges faced by the child/youth and family
- Areas requiring continued intervention
- Significant changes to the physical health of the child/youth
- Total number of individual sessions, family sessions and group sessions
- Total number of incident reports
- Total number of medication checks
- Any changes in medications
- Any PRNs
- Total number of seclusions/restraints
- Diagnostic impressions

12 CONTRACTED TREATMENT SERVICES

Below is a brief overview of DPBHS' service continuum. DPBHS has developed a continuum of services to accommodate the children and families that are served. Providers offer services statewide with extended hours to make services available for those with varying needs. Appendix 8 provides additional information including a complete service description and clinical necessity.

Outpatient Services, Mental Health

Outpatient therapy is an individualized treatment which provides services in the least restrictive environment possible (office, home or community settings) to address a wide variety of concerns, from behavior problems; and relational conflicts to mood issues like depression or anxiety. Presenting problems and symptoms are the focus of treatment, with discharge when the child is stable and treatment goals have been reasonably achieved. Outpatient therapy is intended to restore and enhance the child's capacity to find solutions, identify and utilize available resources. Family members and/or other caregivers are encouraged to participate in these services. Outpatient therapy providers will continually assess client needs and make referrals to community resources as appropriate as the client's needs change. Length of stay will varying based on the individual's needs. Length of stay will vary based on the individual's needs.

Outpatient Services, Substance Abuse

Outpatient therapy is an individualized treatment which provides services in the least restrictive environment possible (office, home or community settings) to addresses a wide variety of concerns, from substance use, behavior problems, and relational conflicts to mood issues like depression or anxiety. Presenting problems and symptoms are the focus of treatment, with discharge when the child is stable and treatment goals have been reasonably achieved. Outpatient therapy is intended to restore and enhance the child's capacity to find solutions, identify and utilize available resources. Family members and/or other caregivers are encouraged to participate in these services. Outpatient therapy providers will continually assess client needs and make referrals to community resources as appropriate as the client's needs change. Length of stay will varying based on the individual's needs. Length of stay will vary based on the individual's needs.

Therapeutic Support for Families (TSF)

Therapeutic Support for Families provides psycho-educational, therapeutic and supportive services for parents/ caregivers and youth who are eligible for services from the Division of Prevention and Behavioral Health Services. TSF services are typically delivered in conjunction with other treatment services but may, in some instances, be the only service provided by DPBHS. TSF goals will be included in the youth and family's treatment plan and will include the projected frequency and length of service along with the specific interventions and activities (with purpose) to be incorporated in the attainment of these goals.

TSF services may be provided individually or in family and/or group settings. TSF services are tailored to meet the unique needs of the youth and family. Often these services will be required during specific times of day (such as in the morning, evening or bedtime) so availability of resources must allow for services to

be provided at the times identified by the caregiver. Structured outings and activities should be scheduled which include both the youth and caregivers, allowing them to demonstrate acquisition of skills and practice applying these skills in real life situations with support and coaching from the TSF, as appropriate. These services are delivered by trained, skilled paraprofessionals.

Dialectical Behavior Therapy (DBT)

Dialectical Behavior Therapy (DBT) is an evidence based outpatient service. It has been empirically validated for adults and the emerging literature shows great promise for treating adolescents. This has been an effective treatment for a variety of conditions such as borderline personality disorder, depression, post-traumatic stress disorder (PTSD), substance abuse, self-injurious behaviors and eating disorders. Treatment is used to aid adolescents in managing problem behaviors (self-harm, self-injury, suicidal planning, gestures, actions, impulsive decision making, and avoidance) used maladaptive to manage stressful life situations. Treatment includes 24/7 phone coaching, 2 group sessions per week, individual, family and parent groups. Average length of stay is 6 to 12 months.

Multi-Systemic Therapy (MST)

Multi-Systemic Therapy (MST) is a home-based intensive family and community-based treatment that addresses multiple aspects of serious conduct related behavior in adolescents. MST typically targets chronic, aggressive youth who are at high risk of out-of-home placement. MST recognizes that many "systems" (family, schools, neighborhood/community, and peers) play a critical role in a youth's world and impacts their behavior. Each system requires attention when effective change is needed to improve the quality of life for youth and their families.

MST strives to promote behavior changes in the youth's natural environment, using the strengths of each system to facilitate change. Therapeutic contacts emphasize the positive and use systemic strengths as levers for change. Interventions promote responsible behavior among family members and are present-focused, action-oriented and developmentally appropriate. In addition, the interventions target specific, well-defined problems and are designed to require daily or weekly effort by family members. They incorporate strategies that promote treatment generalization and long-term maintenance of therapeutic change. Service is available 24/7 (on call system). Average length of stay is 3 to 5 months with an average of 2-4 hours of direct service per week.

Family Based Mental Health Services (FBMHS)

The Family Based Mental Health Services are designed to service children between 3 and 17 years of age and living with their parents, guardians, or caretakers and have a serious mental illness or emotional disturbance. These children are also at risk for out-of-home placement into residential treatment facilities, psychiatric hospitals or foster placements due their symptomatic behaviors and/or the dysfunction of the family system that contributes to the behaviors. Family Based Mental Health Services (FBMHS) are able to treat these children and adolescents in their homes, communities and schools thus allowing the youth to remain in the home.

FBMHS is a team delivered service rendered in home, community and school settings. It is designed to integrate mental health treatment, the family, family support services, the surrounding system, and casework so that families may continue to care for their children and adolescents with a serious mental illness or emotional disturbance in their home. These children and adolescents experience depression, anxiety, chronic acting out behaviors, aggression, social, coping and skill deficits, drug and alcohol abuse, and school truancy. These children are frequently described as "hard to manage" by their parents. Often times, their personality traits and their parents' management skills are frequently in conflict with each other which lead to a youth/family's involvement with multiple systems. Services are available 24 hours per day and 7 days a week via on call therapist from the FBMHS program. Average length of stay is 32 weeks.

Functional Family Therapy (FFT)

Functional Family Therapy (FFT) is a short-term, family-focused, community-based treatment for youth who are either "at risk" for, or who manifest, antisocial behavioral problems such as conduct disorder, oppositional defiant disorder, disruptive behavior disorder, violent acting-out and substance abuse disorders. Co-morbid behavioral or emotional problems, such as anxiety or depression, may also exist as well as family problems, such as communication and conflict issues. FFT has been applied to a wide range of families with at-risk, pre-adolescent and adolescent youth in various multi-ethnic, multicultural contexts. Interventions are conducted at home, in school, in or outpatient settings and at times of transition, from a residential placement.

FFT incorporates specific intervention phases which include engagement, motivation, assessment, behavior change and generalization. FFT is designed to improve within-family attributions, family communication and supportiveness while decreasing intense negativity and dysfunctional patterns of behavior. Parenting skills, youth compliance, and the complete range of behaviors (cognitive, emotional, and behavioral) domains are targeted for change based on the specific risk and protective factor profile of each family. FFT provides approximately 2.5-3 hours of service weekly which includes face to face and collateral contact, travel, case planning. Average length of stay is 3 to 4 months.

Day Treatment, Mental Health

Day Treatment is a 5-full-day intensive program that provides developmentally appropriate treatment for children or adolescents with moderate to severe behavioral health disorders who are unable to fulfill the functional requirements without this level of intensive service.

The program is available as clinically appropriate and is open approximately 250 days per year and provides no less than 5 hours of direct service per day. Activities are also provided in afternoons and/or evenings to assure that working parents are able to participate in treatment. Activities occur both on-site at the program and in the youth's natural environment. Average length of stay is 1 to 3 months.

Partial Hospital Program (PHP)/Day Hospital

Day Hospital is a 5-full-day intensive program that provides developmentally appropriate intervention for seriously disturbed children or adolescents who are unable to fulfill the functional requirements of his/her

developmental stage without this level of intensive service. This level of care provides support and psychiatric services five days per week to clients living at home or in other residential settings. Average length of stay is 1 to 2 weeks.

Inpatient Hospital

Inpatient treatment services provide an out-of-home, twenty-four hour psychiatric treatment milieu under the direction of a physician. Within the medical context of an inpatient facility, clients can be safely evaluated, medications can be prescribed and monitored, and treatment interventions can be intensively implemented. Inpatient treatment services represent the most restrictive and intensive intervention available within the DPBHS continuum of services. Average length of stay is 3 to 10 days.

Rehabilitative Residential Treatment (RRT)

Rehabilitative Residential Treatment (RRT) provides a 24 hour, supervised, non-hospital based residential living arrangement with intensive therapeutic services for children and adolescents. Youth requiring RRT are diagnosed with varying Behavioral Health (Mental Health, Substance Us and Co-occurring) disorders and may present as a risk to themselves or others, require intense supervision, have difficulty self-regulating their behaviors and have not benefited from community based treatment services. Average length of stay is no more than 6 months, which includes a period of community reintegration and transition.

Psychiatric Residential Treatment Facility (PRTF)

A Psychiatric Residential Treatment Facility (PRTF) is defined by the Centers for Medicare and Medicaid Service (CMS) as a "separate, stand-alone entity providing a range of comprehensive services to treat the psychiatric condition of youth on an inpatient basis under the direction of a physician. The purpose of the service is to improve the residents' condition or prevent further regression so that services are no longer necessary". PRTF's provide comprehensive rehabilitative services to assist and support youth, with behavioral health (Mental Health, Substance Use and Co-occurring MH/SA) disorders, in the development of positive personal and interpersonal skills, daily living skills, and behavior management skills; to improve functioning and meet the youth's developmental needs; and to enable youth to identify, adjust, and manage symptoms. Individual and group activities and programming must consist of services to develop skills in functional areas that interfere with the youth's ability to live in the community; participate in educational activities; develop or maintain social relationships; or enhance participation in social, interpersonal, recreational, or community activities.

PRTF level of care is designed for high-risk youth that have been diagnosed and present with complex conditions that require extended treatment in a structured setting in order to more adequately treat their psychiatric and psychosocial needs. These residential programs can improve outcomes for youth both by providing a course of active psychiatric treatment within a structured residential treatment setting and by providing or facilitating access to community-based aftercare mental health services through linkages to schools, community resources, and family/natural supports. This service provides support and assistance to the youth and the family. PRTF facilities will be staffed 24 hours a day, 7 days a week, provide treatment under the daily supervision of a physician and provide a high level of nursing and/or specialized staff to meet the diverse needs of the target population. PRTF services are delivered in secure or non-secure settings. PRTF's are required to provide educational services for the youth residing in their facility.

Residential Transition Service
Residential Transition Services (RTS) are ancillary services provided in preparation for a child's return home from a residential facility and continue, with the same provider, after the child has transitioned back to the home. Services are designed to work with the family and child prior to discharge. The service will identify natural and community supports and plan for these resources to be utilized to promote positive transitions home. Average length of stay is 3 to 4 months.

Transition Support Service (TSS)
Transitional Bed Service (TBS) services provide supervised, supported care, including overnight, for youth with emotional disturbance or behavioral health issues. Transition Support Service may provide: short-term stabilization; a safe, structured environment for youth awaiting placement. Youth utilizing these services must be active with DPBHS and the use of the service must support a positive transition to an appropriate longer-term service or placement. The use of this service can significantly reduce stress in the family, enhance the family's ability to keep their child/youth at home in the community, and prevent or delay the use of more restrictive behavioral health services for the child. The use of a Transition Support Services may be planned in advance or be offered as an option in emergent situations; and should **not** to be used in lieu of a crisis residential service, inpatient care or residential treatment. These beds are not designed to provide 1:1 supervision and should not be considered for youth requiring this level of observation. Average length of stay is 1 to 3 days.

Mobile Response and Stabilization Services
Mobile Response and Stabilization Services staff receive crisis calls directly from the published crisis number and respond in-person to crises as appropriate. Mobile Response and Stabilization Services begin with the first face-to-face contact response with a child/youth experiencing a mental health emergency involving up to three contacts (face to face interactions) within a 72 hour period. Stabilization services can continue for up to 30 days. Mobile Response and Stabilization Services are community based (home, school) intensive (an unlimited number of contacts per week, with 24-hour availability), short term therapeutic intervention to assist the child and their family to improve coping mechanisms, identify and address the issues that precipitated the crisis, and plan in conjunction with DPBHS for further treatment if necessary. Average length of stay is 2 to 4 weeks.

Crisis Residential Service
Crisis Residential Services provide a temporary supervised setting which provide safety, supervision and treatment and for a child in a crisis situation. Average length of stay is 1 to 3 days.

13 AUTHORIZATION PROCESS

Service Admission Form (SAF)

DPBHS will notify the named agency's business contact to verify that service for a child and family has been authorized. DPBHS and will provide an authorization number for use in the billing process. Written notice of this authorization will be provided.

The Provider must call the identified CFCC within 24 hours (or the next working day) to notify DPBHS of the child and family's acceptance of service from the provider (Failure to advise DPBHS of the acceptance of service may result in the lack of or delay payment to the provider).

The SAF often includes a comprehensive list of client and family-specific Presenting Problems. The Provider is not expected to address all the Presenting Problems stated in the SAF in the Comprehensive Treatment Plan. The focused goals of the treatment plan will be determined by the youth, family and provider and progress toward achieving these focused goals will be reported to CFCC at the Child and Family Team Meetings (CFTM).

Retroactivity - Retroactive authorization and/or payment will not be made. Providers are responsible to submit appropriate documentation within sufficient time frames for the authorization process to be completed. DPBHS has no obligation to reimburse unauthorized services.

Accredited Hospitals - The initial authorization for accredited hospitals is contingent on the provider's timely submission of a provider Certificate of Need on the approved DPBHS form. Please refer to the Schedule of Deliverables in this Manual.

Authorization of Continued Treatment - DPBHS only requires providers to complete progress reviews for children/youth assigned to Tier 2 and 3. Children/Youth assigned to Tier 4 and Tier 5 no longer require providers to complete progress reviews. Updates and progress in treatment for Tier 4 and Tier 5 clients will be communicated in the Child and Family Team Meetings (CFTM). The CFCC will obtain clinical information needed to complete the progress review in FACTS and services will be re-authorized as indicated. It is the provider's responsibility to provide relevant information to allow the CFCC to accurately complete the review and re-authorize services. CFTMs are scheduled in advance, shall take place prior to service authorization expiration and providers may participate in person (billable) or by phone (non-billable).

Notification of Service Re-authorization - The CFCC will give verbal notification of re-authorization within two business days. In addition, written notifications of authorizations will be delivered to providers on a weekly basis. DPBHS has no obligation to reimburse unauthorized services.

14 TREATMENT PROTOCOL

Written information for children and families is provided upon admission. Providers will meet with children and families to discuss their rights and responsibilities, procedures and expectations. Providers will have a

system for documenting child and family receipt of such information (e.g. progress note, signatures, etc.). This information will include, but not necessarily be limited to, the following:

- General service orientation
  - Provider Complaint/Grievance Procedures
  - During and After Hours Emergency Procedures (must include emergency procedure protocol and/or a number to call in case of emergency)
  - Prevention Resources Information
- Consent to Treat
- Client Rights and Responsibilities
- Confidentiality
- Additional Information for Clinical Record

Consent to Treat

If a child is prescribed psychotropic medication, the provider shall ensure that written informed consent is obtained from the parent, legal guardian or other individual with legal authority to make such decisions, prior to the implementation of the medication treatment. At a minimum, such informed consent shall indicate the drug and dosage, likely benefits, potential risks and side effects of the prescribed medication. Such informed consent shall also inform, to the extent permitted by law, the child, their parents, legal guardians and other individuals with legal authority to give such consent, of their right to refuse specific medication or treatment procedures (see applicable DELACARE Requirements for Residential Child Care Facilities, § 213; DELACARE Requirements for Day Treatment Programs 215(e); 16 Del. C. 5161(b) (3), (5); DFS policies # 3045, 3046, 3047).

Delaware's Relative Caregiver statute allows relative caregivers to consent to lawful medical treatment for minors if the relative caregiver is in possession of a valid affidavit of establishment of power to consent to medical treatment. For further information please see:

- http://www.dhss.delaware.gov/dhss/dsaapd/caregive.html

In mental health emergencies when a minor is exhibiting behaviors of such severity that failure to provide an immediate mental status examination and follow-up would result in imminent harm to the child, evaluations may be performed by the DPBHS Mobile Response and Stabilization Services without initial written parental consent, if reasonable efforts have been documented to contact parents, legal guardians or other legally authorized caregivers. All follow-up treatment provided by Mobile Response and Stabilization Services must be with the appropriate signed consent-to-treat.

A representative of the Division of Family Services (DFS) may sign consent to treat in all levels of DPBHS services with the exception of psychiatric hospital and/or the provision of psychotropic medication, if the child is in the custody of DFS, the parent cannot be contacted or reached and reasonable effort has been documented to notify the parent, legal guardian or legally authorized caregiver that the child has been admitted to those services.

Consent to Treat for Youth age 14 and older

In accordance to 16 Delaware Code § 2210, Chapter 22 "Substance Abuse Treatment Act", voluntary treatment for substance abuse, youth ages 14 and older may sign consent for treatment for alcohol or drug addiction without parental consent, for all levels of care excluding Residential Treatment Services for Substance Abuse. DPBHS highly recommends that every effort be made to work with such a youth to involve parents, legal guardian or legally authorized caregiver as soon as possible in the treatment process. If parents sign consent to treat, it is not required that the youth do so, although involving them in the consent process would be desirable.

DPBHS strongly believes that family participation is an essential component of successful treatment for children and youth, and family involvement is encouraged across all levels of service within the DPBHS service continuum. Parental consent is absolutely necessary for some services, as the primary mode of treatment is family-centered. For DPBHS Care Coordination Services (Administrative, Acute, Non-Intensive or Intensive), DPBHS requires parental consent for youth 14 years and older, in addition to the consent of the participating youth.

DPBHS's contracted community providers will develop their own policies and procedures around consent for treatment of youth 14-18 years of age in accordance with 16 Del. C. §5003 (below):
§ 5003 Voluntary admission procedure:

Voluntary outpatient treatment — A person between 14 and 18 years of age, who is in need of mental health treatment, may request voluntary outpatient treatment from a licensed treatment facility or community provider. If the individual in need of treatment is a minor under 14 years of age, a parent, legal custodian, or legal guardian shall make the request for voluntary outpatient mental health treatment and give written consent for treatment.

a. If a minor is 14 years of age or over, then either the minor, or a parent, legal custodian, or legal guardian may give written consent to a treatment facility or community provider for voluntary, outpatient treatment.
b. Consent so given by a minor 14 years of age or over shall, notwithstanding the minor's minority, be valid and fully effective for all purposes and shall be binding upon such minor, the minor's parents, custodian, and legal guardian as effectively as if the minor were of full legal age at the time of giving such written consent. The consent of no other person or court shall be necessary for the treatment rendered such minor.
c. A minor's consent is not necessary when a parent, legal custodian, or legal guardian of an individual less than 18 years of age provides consent to voluntary outpatient mental health treatment on behalf of the minor.
d. A minor, including those age 14 and older, may not abrogate consent provided by a parent, legal custodian, or legal guardian on the minor's behalf. Nor may a parent, legal custodian, or legal guardian abrogate consent given by a minor age 14 and older on his or her own behalf.

e. This section does not authorize a minor to receive psychotropic drugs without the consent of the minor's parent, legal custodian, or legal guardian. Only a parent, legal guardian, or legal custodian may provide consent for the administration of such medication.

Client Rights and Responsibilities
The Provider will have policies and procedures addressing clients' rights and responsibilities. These policies will conform to the DPBHS policy on rights and responsibilities. Documentation that the client has been informed of these rights in a language they can understand will be contained in the clinical record.

DPBHS will make available to providers copies of the DPBHS Child/Family Handbook. The provider will maintain copies at sites where individuals are served so that they are accessible upon request.

Confidentiality
The provider will have written policies and procedures to assure that staff comply with state and federal laws and with appropriate professional practice regarding the handling of confidential client information, including release of information. These policies and procedures will specify the condition under which client information will be disclosed and the procedures for releasing such information. All DPBHS providers will follow DSCYF (No. 205) and DPBHS (CS002) and will be in compliance with HIPAA 45 CFR. Policies on confidentiality are available on the Department and Division web sites. Releases will be time-limited for periods not to exceed one year and have specific beginning and ending dates.

Substance Abuse - Written policies and procedures shall specify how confidentiality relates to the individuals receiving substance abuse treatment. All statements of confidentiality, releases and client rights must include reference to the Federal confidentiality standards sited in 42 CFR Part 2, Confidentiality of Alcohol and Drug Abuse Patient Records and will also be in compliance with HIPAA 45 CFR.

Additional Documentation for the Clinical Record
Providers will include any applicable seclusion/restraint procedures.

Non-Residential substance abuse treatment providers will inform primary caretakers about the potential dangers and signs of alcohol and/or drug overdose and how to obtain medical treatment.

For Mobile Response and Stabilization Services, providers will review with children and families, and provide a copy of the DPBHS Child/Family Entering Care Handbook for that level of service. The signed form indicating the child has received this document must be contained in the record.

If a child is open for more than one year in any outpatient service treatment episode, documentation that he/she has been re-informed of her/his rights and responsibilities (e.g. HIPAA, consents), the complaint procedure and emergency procedures must appear in the record.

Initial Intake Assessment

Mental health providers will use their own assessment form. Initial Assessments must include the following information:

- Date of assessment
- Client full legal name
- Date of Birth
- Race/ethnicity
- Biological gender
- Identified gender
- Home address
- Phone
- Caregiver (legal) name and contact info, include relationship and attach court documents as indicated
- Additional family information (including who else lives in the home, other relevant family dynamics)
- Client and family strengths
- Presenting problems
- Insurance Information
- Client's Treatment History (date ranges, types of service, agency providing the service)
- Developmental History- include full or pre-term, complications with pregnancy or birth, description of achievement of milestones or developmental delays or challenges
- Family history – include description of family unit and how client acclimates to the family structure. Include family history of domestic violence, substance abuse, sexual/physical/emotional abuse, trauma, housing stability. Relevant parent history of suicide, substance use, mental health disorders, incarceration, medical ailments/disease.
- Social history – description of how child socializes with peers. What are the client's favorite activities or areas of interest? Is there any gang involvement? Aggression toward others?
- Cultural/Spiritual/Religious – describe the role of culture/spirituality/religion in the client and family's life. Is this an area of conflict within the family or community? Please note relevant information regarding culture or religion that would be helpful for those interacting with the child or family to know/respect/understand.
- Physical history – please note any current or past conditions (seizures, traumatic brain injury, tics, sleep problems, allergies, enuresis/encopresis, sexual activity, history of pregnancy)– date ranges, treating physician, detail. Note current or past medications- date ranges, treating physician, provide detail. Obtain contact information of physicians or psychiatrists. Weight, nutrition. Sexual identity or gender factors to be considered?
- Educational history – please include school, grade, educational classification, if there is an IEP or 504 plan, overall school performance or any sudden changes in school performance. Include behavior problems, client's general perception of school. Include vocational plans.
- Safety – Include history of self-injury or danger to others. If there is a history of safety concerns or threats/ideation/attempts, please note time periods, type of threat or injury, frequency/severity of threat or injury. Include <u>present</u> risk to self or others. Fire setting, cruelty toward animals, victimization, aggression, bullying, substance use (type, frequency, quantity, last use) will all be assessed. Is there are history of runaway? Suspicion client may be a victim of human trafficking? Include a safety plan as indicated (instances of suicidal or homicidal ideation/threats or attempts, self-injury, Inappropriate Sexual Behavior, AWOL, severe substance use). Safety plan must

address family's perception of the safety risk, ability to monitor and supervise, resources to ensure safety.

- Trauma history (complete the UCLA Trauma Index as indicated) Include reports of physical, sexual, emotional abuse, exposure to or victimization of domestic or community violence, recent losses. Include any behaviors of concern.
- Legal history- has the child been arrested? Include dates, charges, sentences as relevant. Does the child have pending charges? Is the child on probation? Name probation officer and provide contact information.
- Mental status – include present appearance, behavior, intellectual functioning, mood/affect, thought/perceptual content
- Client and family goals of treatment – what does the child/family hope to accomplish in treatment? What do they identify as the presenting problems?
- Diagnostic Impressions
- Person completing the assessment with credentials/date/agency

When assessments indicate exposure to abuse or trauma, the provider will complete a UCLA and, if indicated, make a DFS abuse report as warranted and/or mandated by law. Upon completion of the UCLA, if a client has multiple (more than 1) symptoms in two domains, the CFCC team should be advised. If the client has already received treatment for trauma and this is not a current issue, then no additional treatment will be required. If appropriate for treatment, the therapist shall provide TF-CBT or discuss with the CFCC team how to best manage the child's needs. Therapists providing TF-CBT are responsible to provide to the CFCC team the pre & post UCLA score with the Discharge Summary.

Comprehensive Treatment Plan

Mental health providers will complete a Comprehensive Treatment Plan. This document will be consistent with the level of care and with the areas of need identified in the CASII. The treatment plan is developed with the child and family, it is written in the child and family's words (quotes) and includes their signatures. The treatment plan also requires signatures of the primary therapist, the unlicensed therapist's supervisor when applicable, and the psychiatrist as indicated. The Comprehensive Treatment Plan must be received by DPBHS within 30 days (excluding for Mobile Response and Stabilization Services in which a more detailed plan must be received within 7 days). Providers can choose to use either the DPBHS Comprehensive Treatment Plan or their own version.

As appropriate for the level of care, the treatment plan will be reviewed and revised whenever new goals and objectives are added; or when identified goals or objectives are accomplished; or no less often than every 90 days. If goals are added to the treatment plan or other significant changes are made, it is necessary for the provider to add pages to the plan or to write a new plan, depending on the agency format for this purpose. Significant treatment plan changes will be communicated with the DPBHS CFCC. Significant changes include but are not limited to:

- Client changes level of care;
- Specific behaviors targeted for change;

- The community activities in which the child will be engaged in order to change the identified behaviors. (There must be a relationship between the target behaviors and the activities. For example, a child whose problems involve relationship problems with peers should be engaged in social activities in which he/she can practice positive peer interaction.); and
- Frequency and type of community interventions to be provided.

When a client moves through levels of care within one agency, the agency will need to submit a revised treatment plan for the new level of care within 10 days.

All Treatment Plans must include the following:

- Client Name;
- Service Type;
- DSM 5/ ICD 10 Diagnosis which is the focus of treatment;
- Goals (limit to only a few); and
- Objectives.

All rehabilitative services are to be provided according to an individualized treatment plan. The activities included in the service must be intended to achieve identified treatment plan goals or objectives. The treatment plan should be developed in a person-centered manner with the active participation of the individual, family and providers and be based on the individual's condition and the standards of practice for the provision of these specific rehabilitative services. The reevaluation of the treatment plan should involve the individual, family and providers and include a reevaluation of plan to determine whether services have contributed to meeting the stated goals. A new treatment plan should be developed if there is no measureable reduction of disability or restoration of functional level. The new plan should identify a different rehabilitative strategy with revised goals and services.

Mobile Response and Stabilization Services Plan for Safety

The purpose of Mobile Response and Stabilization Services treatment plan is to mobilize the family's helping network, both informal and professional, in order to minimize risk while decisions are made about next steps for treatment. This is to be completed before the end of the first crisis session. At minimum an Individualized Crisis Plan (ICP) will include:

- Risk factors as determined from the initial assessment, how they will be monitored and by whom;
- Realistic and detailed plan for the safety of the client and/or the community if applicable;
- Specification of the persons responsible for implementing each part of the plan;
- Specification of the number of treatment sessions to be provided within the crisis period;
- Criteria for discharge from crisis service;
- DSM 5/ICD-10 Diagnosis; and
- Signature of primary therapist, licensed supervisor, parent/caregiver and child.

Progress Notes

A progress note is required to document, in the client's record, all direct and indirect services by a Behavioral Health Professional. There must be a corresponding progress note for every claim for service. At a minimum, progress notes must include:

- Client identifier;
- Medicaid number;
- Date;
- Time;
- Location of service;
- Service provided
- Session attendees (if group note, other client names/initial are not used); and
- Content information:
    - Progress notes for direct services shall be written in an acceptable format, which may include: Data, Assessment, Plan (DAP), Subjective Data, Objective Data, Assessment, Plan (SOAP) or Goal, Intervention, Response, Plan (GIRP). Please see Appendix 9 for samples of these formats;
    - If a particular evidence based practice or treatment modality is being utilized, that should be included in the note;
    - Session content must be linked to goal on the client's treatment plan and/or other clinical intervention as appropriate; and
    - Changes in presenting problems, medications, treatment plan revisions, results of relevant screenings or tests, change in diagnosis, etc. should be documented in the progress note.
- Legible signature and credentials of the Behavioral Health Professional conducting the session must be present for each note. It is suggested that the Behavioral Health Professional type or print their name and credentials below their signature line. Sessions conducted by an unlicensed Behavioral Health Professional must also have a clinical record review no less than every 90 days by a licensed supervisor. Notes of these reviews should be in the chart.

Progress notes must be in chronological order in the client's record. If sessions are being provided simultaneously, a note for each session must be present in the record in order for a claim to be made.

Progress notes for indirect services are not required to follow the format above but date, time, length of contact, participants and signatures are required.

The progress notes should "stand on its own" by supporting the clinical necessity for the service, identifying the clear link to the client's objectives and goals of treatment. **The progress note must support the code being billed.**

Progress notes are part of the client's clinical record and may be requested at any time.

The client/family/Behavioral Health Professional should not be referred to by name in the progress note. "Mother", "father", "sibling" or "client" shall be used to refer to the child and family members. The

Behavioral Health Professional should be referred to as "this writer" or "this therapist/clinician/Behavioral Health Professional" in the progress note.

When using an abbreviation, a reference for what that abbreviation represents must be provided in each note or appear on the list of acceptable abbreviations which is found in Appendix 4. For example, when referring to a "MT" in a note, the writer must spell out Mobile Therapist (MT) and include the abbreviation to be used throughout the remainder of the progress notes the first time the reference is used in a particular note.

If an error is made on a handwritten document or progress note, a single line is to be used to cross through it so the mistake is still legible. The word "error" is to be written and the person crossing out the wording in the document must initial next to the word "error". No white out is to be used in the client's record.

If there is any unused space on an unused portion of a line or page of the progress note in a client record, the writer must "x" out or write a line across any unused space so the record cannot be altered.

Progress notes should be completed and filed within 48 hours of the service provided. Progress notes must be complete and legible to be considered as appropriate documentation of the delivery of service.

Discharge/Transition Planning

Discharge/Transition planning begins at admission and all treatment provided should be goal driven towards treatment success. Discharge/Transition planning is a process which continually assesses the child and family needs. This planning process involves the team including: the child, family, provider, DPBHS and any informal or community supports as identified by the family. Discharges/Transitions cannot be made independently. Members of the team should be included in the discussion and planning process to change level of service or provider. Providers and DPBHS will support the child's transition to new services or service providers. DPBHS has no obligation to reimburse unauthorized services.

Within 7-days of discharge, the provider will complete a Discharge Summary (it not required to use the DPBHS form), a copy of which will be retained in the clinical record. The Discharge Summary will include, but not necessarily be limited to, the following:

- Date of discharge;
- Type of PBH service;
- Client full legal name;
- Date of Birth;
- Reason for discharge:
    - Successfully completed treatment, client reached maximum benefit from service, Child/Youth and Family refused services, Administrative Discharge, Client successfully transitioned to an appropriate service, Discharged to Juvenile Justice/Detention, Client AWOL;
- Status of presenting problems identified at admission (no progress, slight progress, moderate progress, significate progress, problem not addressed in treatment, regression, etc.);

- Status of problems that emerged during course of treatment;
- Strengths child/family developed during course of treatment;
- Continued challenges faced by child/youth and family;
- Summary of treatment and client/youth and family response;
- Areas requiring continued intervention; and
- Diagnostic impressions at discharge

The Discharge Summary will be submitted to DPBHS as indicated in Document Submission section below, and will be made available to subsequent treatment providers upon request and appropriate signed release.

Providers of routine outpatient services outside of what is covered by the MCO will send a Discharge Form to DPBHS within 18 days of the last direct face-to-face contact. If a child stops attending sessions and the therapist wishes to follow up to try to re-engage the child and family, this must be done within the 18-day timeframe. DPBHS clients may not simply be administratively discharged without follow-up attempts being documented.

Where applicable, the care coordinator, in conjunction with the provider, will plan for transition to adult services and the CFCC will document efforts to implement this plan.

Agencies are not expected to complete an updated assessment or admission summary for the new level of care nor are they expected to complete a discharge summary for the previous level of care.

If the child/youth is on medication at the time of discharge, the provider shall ensure that a record of all current medications is given, including dosage and administration instructions. The documents shall be made available at the time of discharge to the parent or legal guardian, DPBHS and appropriate receiving agencies and personnel.

Transfer Instruction Sheet will be completed upon transition. A copy will be kept for the provider record, a copy will be given to the family, and with appropriate consent, a copy will be provided to the new provider.

Document Submission

Each provider will send copies of child-specific clinical reports to DPBHS. These may include, but are not limited to safety plans, admission summaries, treatment plans, transfer instruction sheet, and discharge summaries. See the schedule of clinical documentation deliverables that follow for specific requirements. The required clinical reports will be sent or faxed to the DPBHS Records Technician 302-622-4470.

SCHEDULE OF DOCUMENT DELIVERABLES - CLINICAL INFORMATION FOR MENTAL HEALTH OR SUBSTANCE ABUSE SERVICES

# Days after completion to be Rec'd by DPBHS	CLINICAL DOCUMENTATION TO BE SENT TO DPBHS	Community Based Services	Residential Services	Inpatient	Mobile Response and Stabilization Services
5	Provider Certificate of Need Form			•	
1	Admission Paperwork			•	
1	Crisis Assessment Tool (CAT)				•
1	Individualized Crisis Plan (ICP)				•
1	Safety Plan	As Indicated	As Indicated		•
10	Initial Intake Assessment	•	•		
30	Comprehensive Treatment Plan	•	•		
7 Days after discharge	Discharge Summary	•	•	•	•
Within 10 days of revision	Updated/Revised Treatment Plan	•	•		•

ROUTINE OUTPATIENT SERVICES ONLY

DOCUMENT	OUTPATIENT DOCUMENTATION TO BE SENT TO DPBHS	Received at DPBHS
Initial Request for Service Authorization	Admission to Mental Health or Substance Abuse Outpatient Services	Immediately after 1st Session

Request for Continued Service Authorization	Revised/current Treatment Plan Request for Re-authorization	By Expiration Date or by use of last units authorized
Discharge	Discharge Form	Within 18 days after discharge

*Transfer instruction sheet and safety plan are not required to be sent to DPBHS as a deliverable but should be kept in the client chart.

SCHEDULE OF DOCUMENT DELIVERABLES - ADMINISTRATIVE INFORMATION

ADMINISTRATIVE DOCUMENTATION	Provider Manual Reference	SUBMISSION TO
Incident Reports	DSCYF Operating Guidelines	Quality Services Administrator at E-Fax 1-302-661-7270 or secure e-mail at DSCYF_DPBHS_QI@state.de.us within 72-hours of the incident.
Provider Documentation • Business License, if applicable • Insurance: Proof of commercial liability and motor vehicle insurance, as applicable • Licenses as applicable • Most recent accreditation letter and certificate, survey results and PPR, ACQR, or self-studies completed for accrediting agencies. • Providers' contract manager information • Provider's contact for billing and authorization • Provider's Remittance Address • Documentation or assurance of Provider approval to provide special education from the state in which the Provider does business • Documentation or assurance that the Provider's teachers are qualified to serve students with disabilities in the State in which the Provider does business • Audited Financial Statements, if available If these are checked on the DSCYF Document Checklist) • DSCYF Rate Certification Form • DSCYF HCFA Sanctions Certification Form • Copy of Agency Operating License(s) Criteria for Provision of Inpatient Psych Services for Individuals under Age 21.	DSCYF Document Checklist *Enclosed Annually with Contract*	Submit with the signed contract to: DSCYF Contracts Unit 1825 Faulkland Road Wilmington, Delaware 19805

Annual Provider Documentation • Business License, if applicable • Insurance: Proof of commercial liability and motor vehicle insurance, as applicable • Licenses as applicable • Documentation or assurance of Provider approval to provide special education from the state in which the Provider does business • Documentation or assurance that the Provider's teachers are qualified to serve students with disabilities in the State in which the Provider does business		Submit annually to: DSCYF Contract Administrator 1825 Faulkland Road Wilmington, Delaware 19805
Change in Documentation status including: ○ Business License, if applicable ○ Insurance coverage ○ Licenses as applicable ○ Accreditation		Submit any changes or notices of investigations promptly by FAX to: the DPBHS Manager of Quality Improvement: (302) 622-4475

MIXING

The primary purpose of Mixing is to ensure the safety and best interests of non-adjudicated children placed in State residential care, excluding children admitted into a Crisis Residential Service and/or Inpatient Hospital. Mixing, which is an assessment, considers if (1) the child offender does not present an unreasonable and unmanageable physical risk to the other children in the facility, and (2) that such placement is not contrary to the best interests of the other children in the facility [Title 10, c009, sc1009; Title 10, c090, sc9003 (11), (14)]. Therefore, when an adjudicated youth has to be placed with non-adjudicated youth, DSCYF is required by policy and statute to assess that placement consideration. Mixing is also required when a youth is charged with a felony or serious misdemeanor AND the youth will be placed with non-adjudicated youth. Once it is determined that Mixing is required, then the level of approval is determined. In the event a dependent or neglected youth with no adjudications enters a facility with adjudicated youth, all the adjudicated youth will then require a Mixing request. Division staff would contact the Office of Case Management (OCM) for direction in conducting a placement under these circumstances. There are some special circumstances in which mixing is not required; if a youth is being placed in an out-of-state facility **or** if all the residents in the Delaware facility or foster home have been charged or adjudicated.

Mixing Levels and Approvals

Level 1: Any offense constituting a felony under the laws of Delaware or any other State of the US. Requires judicial approval.

Level 2: Repeat offenders with 3 or more serious misdemeanors within 24 months prior to the Mixing request. Requires division approval.

Level 3: Any serious misdemeanor or VOP in which the underlying charge is a serious misdemeanor. Requires division approval.

The Mixing process is initiated by the Child and Family Care Coordinator completing the Mixing request and sending the request to the Team Leader for review. Supervisory approval is then completed by the Regional Supervisor and sent for director approval which is completed by the Division Designee/Division Director. At this stage, depending on the level of approval required, the process proceeds as follows.

Once the mixing has been approved, the placement can be made. The OCM Mixing Specialist will complete a formalized review within 5 business days of the placement. A copy of this review will be forwarded to the Child Placement Review Board (CPRB) as well as to the facility and to the approving judicial officer if applicable. All subsequent reviews will be conducted by the CPRB after the child is in the placement for 2 months. Additional regular reviews will be conducted if the child remains in the placement longer. The CPRB is mandated to review all youth in placements beyond 60 days. A Mixing case is closed once the youth leaves the placement, no longer meets the delinquent status requirements for Mixing, or reaches the age of 18.

15 SECLUSION AND RESTRAINT PHILOSOPHY STATEMENT[1]

The Division of Prevention and Behavioral Health Services (DPBHS) is committed to the effective implementation of trauma-informed care across its continuum of services for children and youth. Trauma-informed care requires that we first acknowledge the overwhelming stress and trauma so common in the lives of children and families we treat. Trauma-informed care is an approach to organizing treatment that integrates an understanding of the impact and consequences of trauma into all clinical interventions as well as all aspects of organizational function.[2]

Safety—physical, emotional, and psychological—are critically important in supporting recovery from trauma. Treatment programs seek to provide safe, comfortable, and nurturing environments where children and youth can work through issues and develop new skills. Yet, some interventions such as restraint and seclusion may have the unintended consequence of triggering traumatic memories or re-traumatizing the child or youth.

Some individuals enter the behavioral health system for help in coping with the aftermath of traumatic experiences. Others enter the system in hope of learning how to control symptoms that have left them feeling helpless, hopeless and fearful. Many enter the system involuntarily. Any intervention that recreates aspects of previous traumatic experiences or that uses power to punish is harmful to the individuals involved. In addition, using power to control an individual's behavior or to resolve arguments can lead to escalation of conflict and can ultimately result in serious injury or even death. “A trauma-informed mindset assumes that: ‘bad behavior’ is a result of unmet needs; in fact there is ‘no such thing as a bad child’; children and youth are doing the best they can; and if they are not doing well, there is a reason related to how well they are able to think about and process their immediate circumstances”.[3]

DPBHS is committed to the continued prohibition against seclusion and reduction in the use of restraint in its facilities. This goal is consistent with a mental health system that treats people with dignity, respect and mutuality, protects their rights, provides the best care possible, and supports them in their recovery. DPBHS understands that achieving this goal may require changes in the culture of the clinical environment and the ways in which the physical milieu environment is managed.

DEFINITIONS:
Restraint: Any manual method, physical intervention, or equipment that immobilizes the ability of a patient to move his or her arms, legs, body or head freely. In addition, a pre-authorized drug intervention can be administered to deescalate behaviors while or before restraints.

Seclusion: The involuntary confinement of a patient alone in a room or area from which the patient is physically prevent from leaving. Seclusion does NOT include confinement on a locked unit where the patient is with others.

DPBHS recognizes that many individuals who have been recipients of mental health services consider restraint and seclusion abusive, violent and unnecessary. For more than 35 years, the consumer/survivor movement has continuously voiced its opposition to restraint and seclusion in documents, forums and protests. This movement has consistently championed the development of gentle, voluntary, empowering and holistic alternatives.

To accomplish the goal of eliminating the use of restraint and seclusion in its facilities, DPBHS endorses and promotes a public health model that values input from patients, families, staff and advocates, and that emphasizes:

- *Primary Prevention*: *preventing* the need for restraint or seclusion;
- *Secondary Prevention*: *early intervention* which focuses on the use of creative, least restrictive alternatives, tailored to the individual, thereby *reducing* the need for restraint or seclusion; and
- *Tertiary Prevention*: *reversing* or *preventing* negative consequences when, in an emergency, restraint or seclusion cannot be avoided.

Furthermore, the public health model uses feedback from each stage to inform and improve subsequent actions. This is a strength-based, patient-driven approach that focuses on enhancing self-esteem, thereby promoting each individual's goals toward recovery. DPBHS strongly believes this approach is essential in establishing a culture that is proactive, responsive and collaborative, rather than reactive. Comprehensive training, education, modeling, mentoring, supervision and ample support mechanisms foster a therapeutic and healing environment for patients and a supportive environment for staff.

Such a therapeutic and healing environment must take into account the experiences of the clients, families and staff. Staff must be given opportunities to increase their empathy for and awareness of the client's and

family's subjective and objective experience, including that of mental illness and the physical and emotional impact of restraint and seclusion.

Post Debriefing- Debriefing following the use of a restraint or seclusion is important to further reduction of these events. The patient and staff participate in debriefing sessions following the episode. The debriefing occurs as soon as possible, if appropriate, but no longer than 24 hours after the event.

DPBHS recognizes that in an emergency situation where less restrictive alternatives have failed, the judicious and humane use of restraint may be necessary to prevent the imminent risk of harm. In these instances, staff must use these interventions for the least amount of time and in the least restrictive way, taking into consideration the patient's history, preferences and cultural perspective. Intensive de-briefing is expected to promote greater understanding of the potential causes of the child's/youth's behavior, as well as to identify alternative supportive responses in the future.

The DELACARE Requirements under Chapter 9: Restrictive Procedures can be accessed through the Office of Child Care Licensing (OCCL) website. In addition, Policies and Procedures Governing the Appropriate Use of Restrictive Procedures (c9, pgs72-79) can be found at:

- http://kids.delaware.gov/pdfs/occl_reqs_rccdtf.pdf

DPBHS is committed to the continuous evaluation of restraint and seclusion data, and to the ongoing use of targeted performance improvement initiatives. These actions will reinforce the prevention model, improve practice, lead to better outcomes and support the goal of eliminating the use of restraint except for rare circumstances of imminent serious harm in DPBHS facilities.

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[1]DPBHS gratefully acknowledges that most of this Philosophy Statement was taken from the Seclusion and Restraint Philosophy Statement of the Commonwealth of Massachusetts/Department of Mental Health, September 18, 2007.

[2]Redefining Residential: Trauma-informed Care in Residential Treatment (Adopted December, 2010). American Association of Children's Residential Centers. Milwaukee, WI.

[3]American Association of Children's Residential Centers.

16 COMPLAINTS AND APPEALS

Complaints about DPBHS

The DPBHS complaint policy ensures an accessible and fair process for resolving the concerns of providers and child, their parents, relative caregivers, guardians, custodians, or their authorized representatives. It is the intent of DPBHS to resolve concerns without the use of formal processes where possible. However, if a concern cannot be resolved to the satisfaction of the aggrieved individual or entity, they may file a complaint with the appropriate DPBHS Manager of Quality Improvement.

- Step #1
  Complaint is presented to the Coordinator. If your issue is not settled, go to Step #2.
- Step #2
  Complaint is presented to the Team Leader. If your issue is not settled, go to Step #3.
- Step #3
  Complaint is presented to the Regional Psychologist for the county in which they live. For New Castle County the Regional Psychologist may be contacted at (302-781-6145) and for Kent and Sussex counties you may call the Regional Psychologist at (302-526-5608). If your issue is not settled, go to Step #4.
- Step #4
  Complaint is presented to the Director of the Child and Family Care Coordination Unit at (302 633-2611). If your issue is not settled, contact the DPBHS Quality Improvement Manager (302-683-8569). An Independent Review Panel is selected to consider your complaint. See the DPBHS website below for policy and procedure or ask your Care Coordinator for a copy.

➢ http://www.kids.delaware.gov

Complaints about DPBHS Providers

Family or child complaints about DPBHS service providers should always be addressed first to the service provider. If a DPBHS staff member is notified of a complaint about a provider, the DPBHS staff will direct the aggrieved individual to the appropriate person at the provider organization. If assigned, the Care Coordinator may support to the family when addressing their concern with the provider.

- Step #1
  Complaint is presented to the Treatment Provider. The Care Coordinator will support the child and family if requested. If the issue is not settled, go to Step #2.
- Step #2
  Complaint is presented to DPBHS Child and Family Care Coordination Team Leader. If the issue is not settled here, go to Step #3.
- Step #3
  Complaint is presented to DPBHS Quality Improvement Manager (302) 633-2738 who will notify the Program Administrator assigned to the Provider.

If at any point a child or family is concerned about any issue other than those listed above for appeals, they may go directly to the Manager of Quality Improvement at (302) 633-2738. However, we recommend that efforts be made to resolve the concern at the lowest level first.

Clients with Medicaid may also appeal directly to the Medicaid office if their concern is with the level of care that has been authorized. Custodians may appeal to the DHSS Medicaid Office by calling the Health Benefits Manager at 1(800)996-9969, Medicaid Customer Service at 1(800)372-2002 or ask for the Fair Hearing Officer at (302)577-4900. Custodians may write to: DSS Fair Hearing Officer, 1901 N. DuPont Highway, PO Box 906-Lewis Building, New Castle, DE 19720. See the PBHS website for policy and procedure or ask your coordinator for a copy.

17 REIMBURSEMENT

Payment Methodology

For Current Procedural Terminology (CPT) codes, Medicaid rates are calculated as 98% of the Medicare rates. Physicians and licensed psychologists are reimbursed 100% of the Medicaid rate (98% of the Medicare rate) and Licensed Behavioral Health Professionals are reimbursed at 75% of the Medicaid rate.

For Healthcare Common Procedure Coding System (HCPCS) codes, rates were developed using a cost model methodology. Factors considered in the development include: billable hours, travel, client absentee rate, supervision and training, documentation, phone contact/unbillable case management, and employee compensation.

For current DPBHS approved codes and applicable rates please visit:

- http://kids.delaware.gov/pbhs/pbhs_providers_billing.shtml

DPBHS makes every effort to process bills and authorize reimbursement so that payment may be obtained in less than the thirty days. If, however, the Provider submits bills which are inaccurate, illegible, are for unauthorized services, have calculation errors or are otherwise problematic, providers may see a delay and/or reduction in payment.

Providers must submit bills within 6 months of the date of service. Any claim or bill submitted outside of that timeframe will not be paid unless the provider can demonstrate proof of timely submission.

Claim Addresses and Telephone Numbers

Billing Unit Manager	Kimberly Scully 302-892-6433
Claim submission address	Delaware Department of Services for Children, Youth and Their Families Attn: DPBHS Billing Unit 1825 Faulkland Road Wilmington, DE 19805
Secure Fax Number	302-622-4475

Acceptable claim and bill submission formats

1. Secure Email - Providers can email their claims or bills to their billing representative, as long as their submission is encrypted via use of secure email.
2. Secure Fax - Providers can send their claims or bills to our secure fax number. Please put Attention Billing Unit on the fax cover sheet. 302-622-4475
3. Mail - Providers can mail their claims or bills to the attention of the Billing Unit at the Delaware Department of Services for Children, Youth and Their Families, 1825 Faulkland Road Wilmington, DE 19805
4. In Person - Providers can bring bills to the Administration Building for the Department of Services for Children, Youth & Their Families at the address listed above. **However, due to increased security measures in the building, you must use the external phone to gain access the building. Please have the receptionist call to your billing representative to drop off the bills. Visitors may not walk throughout the building without a DSCYF employee present.**

Please note if claims and bills are not submitted to this address, DSCYF and DPBHS can make no guarantee that payment will be received in a timely fashion and could delay the processing and payment of the claims and/or bills will be returned to the sender.

DPBHS Billing Representatives:

Adriane Crisden	302-892-6464
Eartha Hopkins	302-633-2570
Elaine Wilson	302-633-2574

Receiving and Screening Claims

When claims are received by a billing representative within DPBHS, they are then screened for missing information. Only "clean claim(s)" will be processed for payment. A clean claim is defined as a claim that can be processed without obtaining the "**required information**" listed below. An incomplete claim is a claim or a bill that lacks the "**required information**" listed below. As such, that claim will be returned to the provider with a Return to Provider (RTP) letter. The claim will NOT be entered into the claims

processing system. The provider will have to enter the missing information using the Re-Submission Form and resubmit the claim.

Required information

- Billing Month;
- Provider Name
- Service type (e.g. RTC, IP, OP);
- Client Full Name (First Name, Middle Name, and Last Name);
- Authorization Number;
- Service Date(s);
- Units of Code;
- Unit cost as specified in executed contract (not your usual and customary rates);
- Client Date of Birth;
- CPT code or HCPCS code;
- Admission date;
- Billing activity date from; and
- Billing activity date to.

Billing Summary

A billing summary form **MUST** accompany all monthly bills specifying the type of service authorized, number of children seen per month and a total amount of the claims submitted. The billing total on this form must equal the total of the claims being submitted.

Processing of Claims

Once a claim or bill has passed the screening as a "clean claim", it is sent for processing. One of the following actions will happen:

Payment - The provider will be reimbursed for payment based on contractual specifications.

Denial - The claim or bill is denied payment because it does not meet program criteria and contractual specifications. Next, the provider will receive an exception report that details the reason(s) why the claim was denied in whole or part. It is the provider's responsibility to follow up with the required information, fix any errors that may have resulted in the denial, and resubmit the bill. The re-submitted bill must be re-submitted using the re-submission forms. The bill must be re-submitted within **the identified timely claim submission guidelines**.

Partial payment - Only a portion of the bill can be paid. Full payment cannot be made because the information supplied indicates the claim or bill does not meet program criteria or contractual specifications. Next, the provider will receive an exception report that details the reason(s) why the claim was denied in whole or part. It is the provider's responsibility to follow up with the required information, fix any errors

that may have resulted in the denial, and resubmit the bill. The bill must be re-submitted within **the identified timely claim submission guidelines**.

Exception Reasons for denial or partial payment

- Service date not authorized
  - Admission
  - Discharge
  - Authorization expired
  - End fund date expired
- Duplicate claim submission; previously paid
- Error in total amount billed
- Not authorized for that service
- Agency not authorized for that service
- Billed at incorrect rate
- Not a DPBHS client
- Service authorization gap

Electronic Billing - electronic direct submission providers can request to have direct bill processing access to our billing payment system. Any provider who is considering electronic billing must have a minimum of three months of "clean" bills before considering electronic bill submission. DPBHS reserves the right to:

1. Revoke electronic bill submission if a provider demonstrates an inability to accurately submit electronic billing after several training(s) and information has been provided; and
2. Deny a providers request to start electronic billing.
   Basic Requirements
   - Ask and receive approval from your Program Administrator
   - Contact your DPBHS Billing Representative
   - Provider must have direct deposit set-up
   - Provider must identify only 2 users within their agency to enter claims
     - One (1) user is the primary billing person and the second person is the back-up
   - Both users must sign into the system at least once per month or the account will be suspended for inactivity and eventually deleted
   - Complete three forms and one training

Timely Claim Submission Requirements

DPBHS requires that bills and claims must be submitted within six (6) months of the original date of service. Bills and claims submitted after this time frame may be denied. This may include resubmitted claims.

Coordination of Benefits/Secondary Claims Submission

- DPBHS reimbursement is the lessor of: the patient's responsibility or Medicaid allowed amount minus the Third Party Liability paid amount.
- If the primary insurance carrier denies the claim as a non-covered service, DPBHS may consider the service for primary benefits.

Please note, it is the provider's responsibility, to obtain the primary insurance carrier's explanation of benefits (EOB) or the remittance advice for services rendered to clients that have other insurance coverage, in addition to DPBHS. Providers must bill and obtain an Explanation of Benefits (EOB) from any other insurance or source of health care coverage prior to billing DPBHS. The primary carriers' EOB or remittance advice and the Delaware Medicaid Explanation of Medical Benefits form **MUST** accompany any secondary claims submitted to DPBHS for payment. A detailed explanation of how the claim was paid or denied should be included if not evident from the primary carrier's EOB or remittance advice. This information is essential for DPBHS Coordination of Benefits.

The EOB and claim must be submitted within 6 months from the date of the service. Claims will be denied if they are submitted without an EOB, or if the other insurance carriers' requirements are not met.

As per Delaware Medicaid General Provider Manual 4.1.3 "In order for claims with TPL to be considered for payment, the patient responsibility must be greater than zero. Patient responsibility is calculated by adding together any co-payments, co-insurance and deductible. Claims that do not contain a patient responsibility will deny.

When calculating payment methodology for claims with TPL primary, Medicaid will pay the lesser of patient responsibility or Medicaid allowed amount minus TPL paid amount."

Resubmitting Claims vs. Reconsideration

Providers have 6 months from the date of service to correct and resubmit claims or bills that received an exception report with the "required information". Thus, the provider is re-submitting a claim or bill with the information we require that was missing from the bill or claim. A "reconsideration" is the process a provider uses when he/she has a dispute with the payment of a claim. Reconsideration is the DPBHS billing appeal process.

Resubmission- A claim originally denied because of missing documentation, incorrect coding, etc., that is being resubmitted with the required information

Reconsideration- A request for the review of a claim that a provider believes was paid incorrectly or denied because of processing errors. Please see the Appeal process for detailed information for reconsideration

A resubmission must be on the resubmission form.

Claim Inquiries

DPBHS billing unit accepts telephone, written, and e-mailed inquiries from providers concerning claim or billing issues as long as all forms of communication are in compliance with HIPAA standards and maintain appropriate confidentiality.

Time intervals

For CPT and HCPCS codes there are specified units and time intervals built into the actual description of these codes. For a detailed list of the codes by service level, please refer to the approved CPT & HCPCS codes on the PBHS website:

- http://kids.delaware.gov/pbhs/pbhs_providers_billing.shtml.

Billing Monitoring and Documentation

DPBHS monitors provider billing on an annual basis. DPBHS requires each claim or bill submitted for payment have documentation to verify the claim. Thus, DPBHS requires the progress note to include the following items for billing documentation only (for clinical expectations, please refer to the treatment services sections of the Provider Manual):

- Date(s) of service delivery;
- Client Name;
- Medicaid Identification;
- Objective Intervention and Response;
- Subservice Type/CPT or HCPCS codes billed;
- Start time;
- End time; and
- Number of units billed.

Flex Funding

DPBHS staff may have access flex funding to cover other expenses necessary to provide services within a system of care framework. DPBHS staff must indicate they have accessed all available resources first in order to validate the approval of flex funds, including the 21st Century Fund. Flex funds may be used for:

1. Reimbursement for psychotropic medication. The CONTRACTOR will document that there is no other available resource for the purchase and that the agency psychiatrist has prescribed and continues to monitor its use;
2. Community-Based Activities.

Additionally, for flex fund reimbursement, DPBHS requires that documentation will be in the client chart. DPBHS requires the documentation for flex funds to have:

- Date(s) of service delivery;
- Client Name;
- Subservice Type;

- Start time;
- End time;
- Number of units billed; and
- Name of DPBHS representative who authorized/approved flex fund expenditure.

Please note, each individual client sub-service is considered a claim. Each claim **MUST** have documentation to support its existence on the date billed for the number of units billed to DPBHS. It is also the expectation of DPBHS that ALL required documentation be in the client chart within 72 hours of the service provided.

Urine Drug Screens

For Substance Abuse services including drug screens as a subservice, please use the assigned HCPCS codes. Drug screens will be reimbursed as the standard rate or at cost with proper supporting documentation.

Please note that without proper documentation, a claim cannot be verified; as a result, the money paid for that claim must be returned. Returning the money paid for these claims resolves only the overpayment. It does not impact any other investigation relating to the particular claims identified, nor will it impact any resulting civil, criminal or administrative action undertaken.

Provider Claim or Bill Appeal Process

A provider may submit a claim for reconsideration. This claim reconsideration must be submitted within 30 days after the initial denial is received. The first step in disputing a claim payment or decision is to contact their billing representative. Generally the billing representative can resolve the billing dispute within 5-7 business days.

Level 1 Appeal

If the provider is not satisfied with the reconsideration decision made by the billing representative, they must file a written Level 1 Appeal to the Billing Manager. Please submit this appeal using the Level 1 Appeal Form. Please send this appeal within 30 days of the initial denial from the billing representative. Send the form and any supporting documentation to:

Delaware Department of Services for Children, Youth and Their Families
Attention: Billing Manager
1825 Faulkland Road
Wilmington, DE 19805

DPBHS will notify providers of the Level 1 decision in writing within 30 days of receipt of the appeal, unless we request additional information. If we need additional information we will send the Level 1 Appeal decision within 30 days of receipt of the additional requested information. If the Level 1 Appeal decision is in the providers' favor, we will recalculate and reprocess the claim or bill affected by the

decision. If the Level 1 Appeal decision upholds DPBHS's original position, the provider can appeal to Level 2.

Level 2 Appeal

If the provider is not satisfied with the Level 1 Appeal decision, they must file a written Level 2 Appeal to the Manager of Provider Services. Please submit this appeal using the Level 2 Appeal Form. Please send this appeal within 30 days of the Level 1 Appeal denial letter. Send the form and any supporting documentation to:

Delaware Department of Services for Children, Youth and Their Families
Attention: Manager of Provider Services
1825 Faulkland Road
Wilmington, DE 19805

DPBHS will notify providers of the Level 2 decision in writing within 30 days of receipt of the appeal, unless we request additional information. If we need additional information, we will send the Level 2 Appeal decision within 30 days of receipt of the additional requested information. If the Level 2 Appeal decision is in the providers' favor, we will recalculate and reprocess the claim or bill. The decision of the Level 2 Appeal is the final decision.

Provider Errors and Notification to DPBHS

If a provider realizes that they have submitted a bill for payment in error, they must contact the Billing Manager ***as soon as they have become aware*.** These errors include incorrect; units, dates, sub service or clients etc. The provider is required to use the "Submitted in Error" form. The provider may also be required to return payment to DPBHS for the claim or billing error. The two payback options would be recoupment through future claims and documented by exception report, or through direct check made payable to The State of Delaware and in the memo line, the client's initial and date of service that was billed in error. For multiple errors and multiple dates billed in error, a letter must accompany the check to specify what the check covers (which clients, which dates of service, etc.).

The risk of improper payments to behavioral health providers is real and can pose problems for the provider. According to the annual Payment Error Rate Measurement (PERM) report, nearly 89 percent of Medicaid Fee-For-Service (FFS) improper payments resulted from documentation errors, number of units billed errors, and policy violations. A 3-year summary of similar data also revealed that mistakes in the number of units billed accounted for the highest dollar errors among mental health services claims. Billing for the correct number of units according to established Medicaid policies improves the timeliness of your reimbursement and the overall integrity of Medicaid. Understanding the cause of these errors and addressing them can ensure reduction in improper payments.

Documentation Errors

The most common documentation errors are missing progress notes, physician orders, and plans of care. Providers should develop and maintain paper or electronic documentation that is sufficient to support each

service, therapy, or activity they bill. Documentation for behavioral health services should include a plan of care that describes the:
Specific services to be provided;
Services schedule;
Types of providers who will deliver the services; and
Patient reevaluation and the plan of care update schedule.

As providers implement the plan, they should keep a timely record of:
Services they provide to the beneficiary;
Relevance of those services; and
Beneficiary's progress toward achieving the plan goals.

Providers should review the plan of care regularly to determine if services are still necessary. Check the State's Medicaid regulations for the required frequency of this review. If the plan of care needs revision, the care team should provide a detailed explanation about the need for additional or revised services, the frequency of those services, and their relationship to the treatment goals listed in the plan of care.

Medicaid has rejected many claims because the provider either did not have a plan of care on file, did not have progress notes for a specific date of service, or they failed to provide them in a timely manner in an audit or review.

Number of Units Errors

A number of units error represents a miscalculation of the time or quantity of a service, item, or medication. Examples of this type of error include:

- Using a 1-hour code for a 15-minute procedure;
- Billing for three units of service when only two are in the documentation; and
- Billing a prescription for 30-days when the pharmacy dispensed only a 14-day supply.

Policy Violation Errors

Federal and State entities expect providers to know the policies that govern the services they furnish to Medicaid beneficiaries. This includes documentation rules and proper coding procedures, what services are covered, and who is eligible for those services.

- Under-coding - Under-coding occurs when a provider intentionally leaves out a procedure code from a superbill, or codes for a less serious or extensive procedure than the patient received. Under-coding may be done to avoid audits for certain procedures, or to try and save money for the patient. This process is illegal, and counts as a type of fraud.
- Up-coding - Like under-coding, this is a fraudulent process wherein the provider intentionally misrepresents the work they performed on a patient. In up-coding, a practice enters codes for services a patient did not receive, or codes for more intensive procedures then the provider actually performed. Up-coding is typically done in an attempt to receive more money from a

payer. This, like under-coding, is a fraudulent practice, and should be noted and reported immediately.

For additional resources and information on PERM, please visit:

- https://medicaid.dhss.delaware.gov/provider/Home/PERMLanding/tabid/2101/Default.aspx
- https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicaid-and-CHIP-Compliance/PERM/lawsandregulations.html

* For a list of what can providers do to AVOID and CORRECT errors, please see Appendix 10.

Fiscal Year End Close Out

At the end of each fiscal year (June) our fiscal department *closes down*. This means they cannot process payments until the fiscal system *opens back* up in mid to late July. DPBHS will notify providers in advance by e-mail and at the provider forums. It is the provider's responsibility to adhere to the dates and requirements to ensure proper and timely payment during this period. Please be advised no advance payment can be made for future claims.

Unit Cost Contracts

Community-Based - Bills will be submitted with the below information and accompanied by a standard Billing Summary Sheet at the face of each package of client billing forms. All information must be completed (e.g., dates of authorization, diagnosis).

All Other Unit-Cost Contracts - At minimum, bills must contain:

- Client name;
- Client date of birth;
- Admission date;
- Each date billed in that month on which units of service were provided and for which the unit cost is being charged, along with a subtotal for each client;
- Provider of the service (primary therapist);
- Dates of authorization and the authorization number;
- DSM-5 diagnosis; and
- Cover sheet with total being billed for the program/service level.

Bills for each service must be submitted separately.

Submission of Electronic Billing - Please refer to the DPBHS Electronic Billing Procedure for detailed instructions on how to use electronic billing. Providers must be trained prior to participation in electronic billing. Contact DPBHS at (302) 892-6433 to inquire about the training.

All providers must also complete any billing/activity data entry by entering their data into FACTS no later than 4:30 PM on the tenth working day of the month following the close of the month being billed. Bills not entered by 4:30 PM on the tenth working day of the month will be submitted in the next month's bill.

Providers do not have to submit a hardcopy bill if participating in electronic billing.

Direct Deposit - DSCYF offers direct deposit for vendor checks. To find out more about the direct deposit option or to enroll call the DPBHS Fiscal Agent at 302-892-4533. The State of Delaware W-9 form can also be completed at:

- https://w9.accounting.delaware.gov/W9form.aspx

Electronic payment benefits cited include quicker receipt of payment, elimination of lost checks in the US mail service and time saved on payment questions.

18 FEEDBACK AND SUGGESTIONS

This Manual is updated regularly as requirements are added or changed. DPBHS welcomes feedback and suggestions for improvement from providers and the public at large. Please direct any questions or comments to:

Mental Health Program Administrator II
1825 Faulkland Road
Wilmington, DE 19805
(302) 633-2600

NOTE:
Any references to DSCYF and DPBHS policies and procedures, and/or forms for various purposes can be found on the DSCYF Website.

- http://kids.delaware.gov/

Necessary Forms, e.g. Billing, Outpatient Forms, Standardized Forms, Human Resources Forms can be found on the DPBHS website in the special section for providers.

- http://www.kids.delaware.gov/pbhs/pbhs_providers.shtml

19 REFERENCE LIST

American Psychological Association. (2010). *Ethical principles of psychologist and code of conduct*. Washington, DC: Author.

Corey, G., Corey, M.S., & Callahan, P. (2007) *Issues and ethics in the helping professions* (7th ed.). Belmont, CA: Brooks/Cole/Thomson Learning.

Kuhithau, K., Bloom, S. Van Cleave, J., Knapp, A., Romm, D., Kiatka, K., Homer, C., Newacheck, P., & Perrin, J. (2011). Evidence for family-centered care for children with special health care needs: a systemic review. *Academy of Pediatrics, 11(2),* 136-143.

Welfel, E. R. (2010). *Ethics in counseling and psychotherapy*. Independence, KY: Cengage Learning.

Appendix 1 – DSCYF Overview

The Delaware Department of Services for Children, Youth, and Their Families' (DSCYF) primary responsibility is to provide and manage a range of services for children who have experienced abandonment, abuse, adjudication, mental illness, neglect, or substance abuse. Its services include prevention, early intervention, assessment, treatment, permanency, and after care. The mission of the DSCYF is to assist children, youth and families in making positive changes through services that support child and public safety, behavioral health and individual, family and community well-being. The Department leads a system of care approach that is child centered and assures effective, timely and appropriate support for Delaware's children. The Department is comprised of four divisions. There are three service divisions and one management support division. They are as follows:

Division of Management Support Services (DMSS)

DMSS exists primarily to provide support and advocacy on behalf of the department's three operating divisions – to be the "*lifeline to the frontline*." DMSS primarily provides administrative support, consultation, and technical support throughout the Delaware Children's Department in critical areas such as human resources, information technology, facilities management, and a range of fiscal management services. In carrying out those services, DMSS is the principle contact with the State's central agencies and governmental offices. DMSS also provides education to youth who are served in a range of residential and day treatment programs. Please refer to the website for a more complete description of services.

- http://kids.delaware.gov/mss/mss.shtml

Division of Family Services (DFS)

DFS investigates child abuse, neglect and dependency, offers treatment services, foster care, adoption, independent living and child care licensing services. Over 300 staff members are dedicated to protecting children and helping them gain a sense of well-being and to achieve permanency. DFS works closely with the other divisions, other state and federal agencies and community child welfare partners to ensure the lives of children and families who need services are transformed for the better. Please refer to the website for a more complete description of services.

- http://kids.delaware.gov/fs/fs.shtml

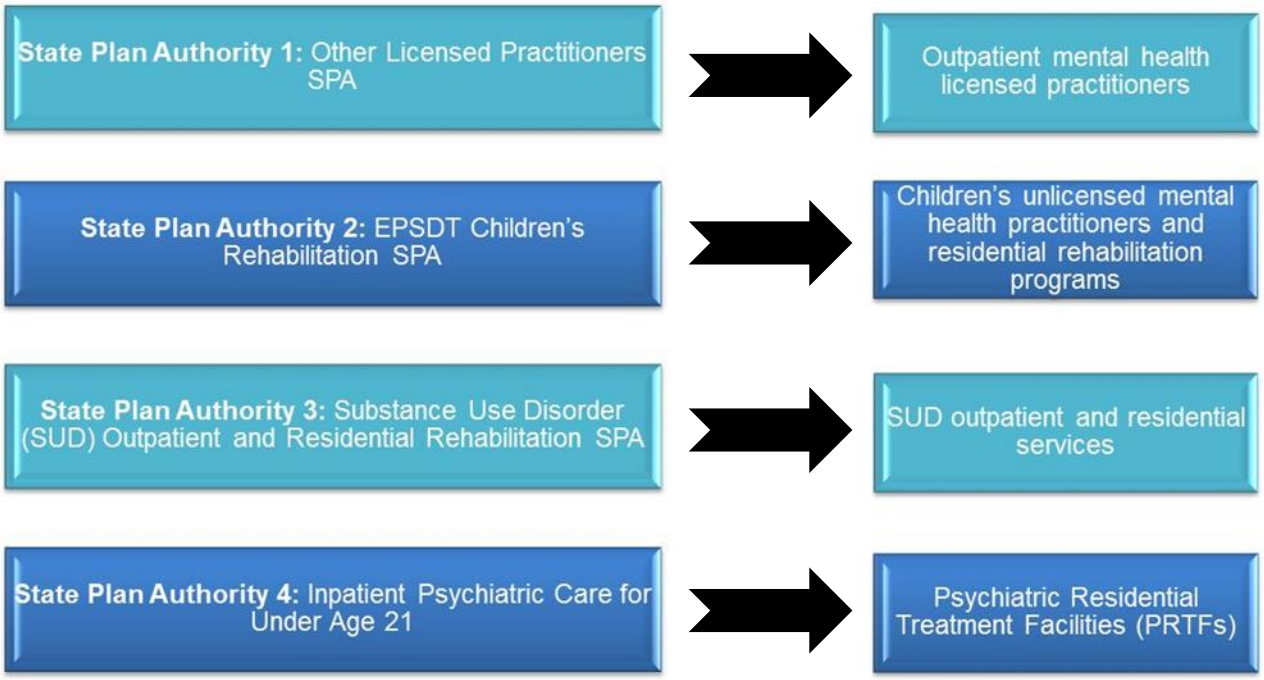
Division of Youth Rehabilitative Services (DYRS)

DYRS provides services including detention, treatment, probation and aftercare services to youth in the State of Delaware who are ordered to its care by Family Court. DYRS is responsible for assessing the individual needs of youth and collaborates with their families, schools and our community partners. The goal is to coordinate services and resources in an effort to rehabilitate youth into becoming positive citizens within their communities. Please refer to the website for a more complete description of services.

- http://kids.delaware.gov/yrs/yrs.shtml

Appendix 2 – Delaware State Plan Overview

How DSCYF Services are authorized under Medicaid:



State Plan Authority 1 – Other Licensed Practitioners

Non-physician licensed behavioral health practitioners (LBHP) provide individual, family, and group outpatient psychotherapy as well as mental health assessment, evaluation, and testing. To differentiate between mental health providers and substance use providers, information regarding licensed chemical dependency professionals (LCDP) are included in the SUD and Addiction Services section instead of within this section. LCDP codes can be utilized within any setting, including skilled nursing facilities.

This Medicaid reimbursement authority reimburses qualified LBHPs providing services within their scope of practice, in a variety of settings and is billed using CPT codes.

- LBHP authority outlines the practitioner type licensed under state law and any prohibitions under Medicaid reimbursement.
- LBHP is the authority that covers the services provided by the LBHP listed in this section of the State Plan.

State Plan Authority 2 - EPSDT Children's Rehabilitation Services

DPBHS authorizes these services as Therapeutic Support for Families. Billed using OLP and CPST coding according to the licensed, MA or BA practitioner qualifications with paraprofessionals using the PSR coding.

The medical necessity for these rehabilitative services must be determined by and services recommended by a Licensed Behavioral Health Practitioner (Licensed Psychologist, Licensed Clinical Social Worker, Licensed Professional Counselor of Mental Health, or Licensed Marriage and Family Therapist), Physician, Nurse Practitioner, or Physician assistant who is acting within the scope of his/her professional license and applicable state law and furnished under the direction of one of the above listed licensed practitioners, to promote the maximum reduction of symptoms and restoration of an individual to his/her best age-appropriate functional level.

Any unlicensed practitioner providing behavioral health services to children must operate within an agency licensed by DSAMH or otherwise qualified under DSCYF through its contracting/designation process. Any entity providing Substance Use Disorder (SUD) treatment services must be certified by Delaware Health and Social Service (DHSS) or its designee, in addition to any required scope of practice license required for the facility or agency to practice in the State of Delaware.

State Plan Authority 3 – Substance Use Disorder (SUD) Outpatient and Residential Rehabilitation

Addiction services include an array of individual-centered outpatient and residential services consistent with the individual's assessed treatment needs, with a rehabilitation and recovery focus designed to promote skills for coping with and managing substance abuse symptoms and behaviors. Hereinafter, throughout this manual, whenever substance use or substance use disorder (SUD) is referenced, gambling disorder, as an addiction disorder recognized under the DSM 5[1], may be used as an eligible condition for purposes of certification and reimbursement for services.

Outpatient addiction services include individual-centered activities consistent with the beneficiary's assessed treatment needs with a rehabilitation and recovery focus designed to promote skills for coping with and managing symptoms and behaviors associated with SUD. These activities are designed to help beneficiaries achieve and maintain recovery from SUDs. Outpatient SUD services include medically necessary care according to assessed needs including: (1) assessment and clinical treatment plan development; (2) skill development for coping with and managing symptoms and behaviors associated with SUD; (3) counseling to address a beneficiary's major lifestyle, attitudinal, and behavioral problems; and (4) medication assisted therapies (MAT) when medically necessary.

Counseling should address a beneficiary's major lifestyle, attitudinal and behavioral problems that have the potential to undermine the goals of treatment. Outpatient activities are delivered on an individual, family, or group basis in a wide variety of settings including site-based facility, in the community, or in the beneficiary's place of residence. These services may be provided on site or on a mobile basis. The setting will be determined by the goal which is identified to be achieved in the beneficiary's written treatment plan.

State Plan Authority 4 – Inpatient Psychiatric Care for Under 21

Psychiatric Residential Treatment Facilities are required to ensure that all medical, psychological, social, behavioral and developmental aspects of the recipient's situation are assessed and that treatment for those needs are reflected in the POC per 42 CFR 441.155. In addition, the PRTF must ensure that the resident receives all treatment needed for those identified needs. In addition to services provided by and in the

facility, when they can be reasonably anticipated on the active treatment plan, the PRTF must ensure that the resident receives all treatment identified on the active treatment plan and any other medically necessary care required for all medical, psychological, social, behavioral and developmental aspects of the recipient's situation. The facility must provide treatment meeting State regulations per LAC 48:I. Chapter 90.

To access the Delaware Medicaid State Plan in its entirety, please visit:

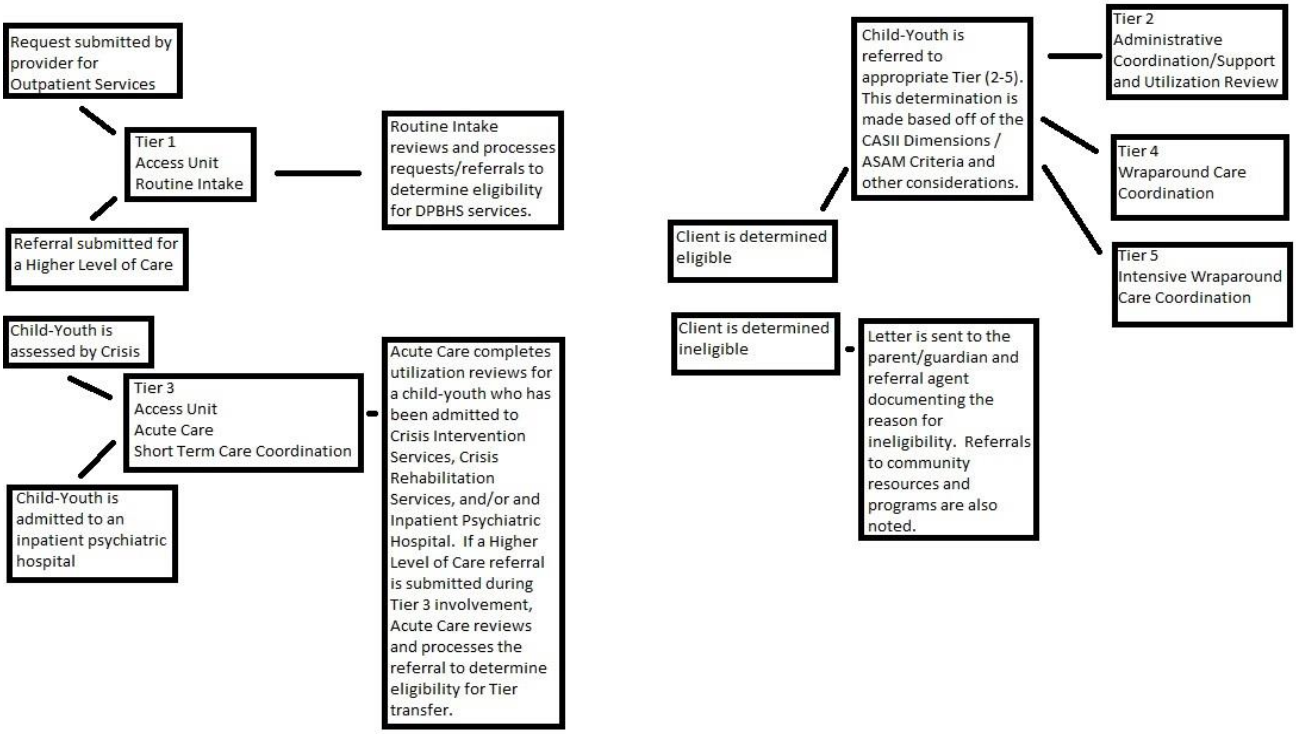
- http://dhss.delaware.gov/dhss/dmma/state_plan.html

Appendix 3 – Acronyms and Definitions

Term	Acronym	Definition
Behavioral Health Disorder		Mental health and/or substance use disorders.
Boarder		A client who no longer meets clinical necessity for the service they are receiving
Building Bridges Initiative	BBI	Building Bridges Initiative
Child and Family Care Coordination Team	CFCC	Provides care coordination for DPBHS eligible child/youth and their families who are receiving DPBHS services.
Child and Family Care Coordination Team Leader	CFCCTL	Oversees the CFCC, PSW III and FSA.
Child and Family Team Meeting	CFTM	Team meetings which include the child/youth, parents/primary caregivers, divisional agencies, the CFCC and additional community and natural supports.
Centers for Medicare & Medicaid Services	CMS	
Delaware Health and Social Services	DHSS	
Department	DSCYF	Department of Services for Children, Youth and Their Families
Diamond State Health Plan	DSHP	Delaware's Medicaid Managed Care Program
Division of Prevention and Behavioral Health Services	DPBHS	DPBHS provides a statewide continuum of prevention services, early intervention services, behavioral health treatment programs for children and youth in Delaware
Division of Substance Abuse and Mental Health	DSAMH	Serves the adult population in need of publically funded behavioral health services in Delaware. DSAMH licenses SUD providers contracted with DPBHS.
Early and Periodic Screening, Diagnostic, and Treatment	EPSDT	Provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. Mental health is included under the EPSDT benefit.
Evidence Based Practices	EBP	Practices that integrate the best available research, clinical expertise and client preference for which there is evidence showing they improve client outcomes.

Fee for Service	FFS	A system in health care by which particular services are paid for individually rather than provided as part of a comprehensive plan
Family Services Assistant	FSA	Serves as part of a Care Coordination Team.
Licensed Behavioral Health Practitioner	LBHP	Licensed Clinical Social Worker, Licensed Marriage and Family Therapist, Licensed Professional Counselor of Mental Health, Licensed Chemical Dependency Professional
Medical / Clinical Necessity		Justified as reasonable, necessary, and/or appropriate, based on evidence-based clinical standards of care
Medication Assisted Therapies	MAT	
Payment Error Rate Measurement	PERM	
Plan of Care	POC	A document developed after a child/family assessment which includes treatment needs, goals and authorized services.
Psychiatric Social Worker III	PSW III	Serves as part of a Care Coordination Team.
Psychiatric Residential Treatment Facility	PRTF	Facilities will be staffed 24 hours a day, 7 days a week, provide treatment under the daily supervision of a physician and provide a high level of nursing and/or specialized staff to meet the diverse needs of the target population. PRTF services are delivered in secure or non-secure settings.
Rehabilitative Residential Treatment	RRT	Provides a 24 hour, supervised, non-hospital based residential living arrangement with intensive therapeutic services for children and adolescents. Youth requiring RRT are diagnosed with varying Behavioral Health disorders and may present as a risk to themselves or others, require intense supervision, have difficulty self-regulating their behaviors and have not benefited from community based treatment services.
State Medicaid Agency	SMA	
Substance Used Disorder	SUD	Term used by the American Psychiatric Association to officially define both substance addiction and clinically significant substance abuse
Telemedicine		Services rendered using interactive telecommunication equipment

Appendix 4 – Access to DPBHS Services Flow Chart



Note: A child-youth and family may transition between Tiers 2-5 based off of an ongoing assessment of the child-youth and the families need for a more or less intensive level of Care Coordination and Support.

Appendix 5 – Phases of Wraparound (Tier 4 and Tier 5)

Contact Frequency:

- Informal contact (i.e., call, text, email) bi-weekly with family (child and caregiver).
- **Face to face family** (child and caregiver) contact at least once a month and PRN for a review of progress and family satisfaction.
- Informal contact once a month and PRN with service providers and division agencies to ascertain progress toward identified goals on the Plan of Care (POC).
- If crises arise, the family will be contacted within one business day and a CFTM held within three business days.
- CFTM every 90 days (tier 4) and PRN. CFTM every 30 days (tier 5) and PRN.

Phase 1: Engagement (first 30 days)

- CFCC meets with family to develop abridged *Family Story* (including family needs, strengths), *Family Vision* and *Targeted Intervention Plan*.
- CFCC completes CANS assessment.
- CFCC reviews *Family Story/Family Vision* with supervisor.
- CFCC presents *Family Story/Family Vision* to family for approval.
- CFCC meets with family to develop a list of natural supports.
- CFCC schedules CFTM (contact frequency determined by Tier 4 or 5).

Phase 2: Initial Plan Development

- Team Mission is developed (Tier 5 only).
- CFCC and family share Family Story, Family Vision and Strengths.
- CFCC facilitates the gathering of team strengths and add to the list of family strengths (Tier 5 only).
- CFCC reviews needs statements and team prioritizes needs (Tier 5 only).
- CFCC and family brainstorm strategies to support the child/youth and family in addressing the reason for the referral.
- CFCC creates a *Plan of Care (POC)* based on input from others in the CFTM.
- CFCC establishes *Outcome Statements.*
- CFCC and family review the *Targeted Intervention Plan* and make modifications based on input from others in the CFTM.
- CFCC reviews POC with Team Leader for signature.
- CFCC sends out signed POC to entire CFTM within 7 business days

Phase 3: Plan Implementation and Ongoing Care Coordination

- Contact Frequency expectations are continued (frequency determined by Tier 4 or 5).
- CFCC gathers updates from provider(s), divisional agencies and natural supports, if applicable, to document progress towards *Family Vision, Outcome* and *Family Satisfaction.*
- CFTM reviews successes and challenges.
- *Targeted Intervention Plan* is reviewed and revised as needed.
- POC is updated and service(s) is reauthorized as appropriate.
- Continue to identify additional natural supports.
- Goal of increasing natural supports membership to 80% of the CFTM (Tier 5 only).

- CANS/CASII/ASAM assessment is completed by CFCC every 90 days.

Phase 4: Transition and Discharge

- CFCC ensures the POC is evolving over time.
- CFCC supports child and family in managing services and connecting them with resources.
- CFTM reviews referral issue and progress towards goals.
- Discharge is indicated when there is an absence of critical events, no more than one crisis contact within the past 3 months, child/youth is maintaining in a school setting and child/youth has not incurred any legal charges for at least three months (Tier 5 only).
- Identify Transition/Discharge Date.
- Develop written *Transition Plan* which should be signed by the Team Leader and distributed to the family and CFTM within 7 business days.
- CFTM develops a sustainable crisis plan.
- CFTM develops a plan for future needs (Tier 5 only).
- Celebrate Success.
- Update the *Family Story*.
- CANS/CASII/ASAM assessment is completed by CFCC.
- Transition to a lower level of clinical care/Discharge.

Appendix 6 – Steps in the Ethical Decision-Making Process[1]

Here are a few key points regarding ethical decisions.

- Responsible practice requires that you:
  - base your actions on informed, sound, and responsible judgment
  - consult with colleagues or seek supervision
  - keep your knowledge and skills current
  - engage in a continual process of self-examination
  - remain open
- In making ethical decisions, as much as possible and when appropriate, include your client in this ethical decision-making process.
- Clients need enough information about the therapeutic process to be able to make informed choices.
  - The informed consent process begins with the intake interview and continues for the duration of the therapeutic relationship.
  - The aim is to involve clients in a collaborative partnership.
- The key is to make ethical decisions *with* clients, not simply for them. Get clients actively involved in the process to the extent possible and appropriate. Respecting the autonomy of your clients implies that you do not decide for clients, nor do you foster dependent attitudes and behaviors.

Eight Steps in Making Ethical Decisions

Ethical decision-making should be a collaborative process between client and counselor, rather than a counselor making decisions for the client. Below are the steps, with suggested questions, to assist you in thinking through an ethical dilemma. This is one of several decision-making models which can be utilized. The steps taken may not always follow the same order shown and steps may be repeated several times in the process.

1. Identify the problem or dilemma.
   - Does a problem or dilemma actually exist?
   - Is this an ethical, legal, moral, professional, or clinical problem?
   - Is it a combination of more than one of these?
   - How can you know the nature of the problem?
   - Would you consult at this early stage as you are identifying the problem?
   - How might you begin the process of consultation with your client about the nature of the problem?
2. Identify the potential issues involved.
   - How might you best evaluate the rights, responsibilities, and welfare of all those involved and those who are affected by the decision, including your own welfare as a practitioner?
   - How can you best promote your client's independence and self-determination?
   - What actions have the least chance of bringing harm to your client?
   - What decision will best safeguard the client's welfare?

- How can you create a trusting and collaborative climate where your clients can find their own answers?
- What principles can you use in prioritizing the potential issues involved in this situation?
- Are there any ways to encourage the client to participate in identifying and determining potential ethical issues?

3. Review the relevant ethical codes.
   - What guidance can you find on the specific problem under review by consulting with the professional codes?
   - Are your values in agreement with the specific ethical code in question?
   - How clear and specific are the codes on the specific area under consideration?
   - Are the codes consistent with applicable state laws?
4. Know the applicable laws and regulations.
   - Are there any laws or regulations that have a bearing on the situation under consideration?
   - What are the specific and relevant state and federal laws that apply to the ethical dilemma?
   - What are the rules, regulations, and policies of the agency or institution where you work?
5. Obtain consultation.
   - Do you know where to go to obtain consultation with professionals who are knowledgeable about ethical issues?
   - Assuming that you will consult with a colleague or a supervisor, what would you expect from this consultation?
   - What kinds of questions do you want to ask of those with whom you consult?
   - With whom do you seek consultation? Do you consult only with those who share your orientation, or do you look for consultants with different perspectives?
   - How can you use the consultation process as an opportunity to test the justification of a course of action you are inclined to take?
   - What kinds of information do you document when you consult?
   - When you do make use of a consultation process, do you inform your client about this? Are there any ways you might include the client in this consultation process?
6. Consider possible and probable courses of action.
   - What are some ways that you can brainstorm many possible courses of action?
   - Do you have a systematic method for analyzing ethical obligations and possible courses of action?
   - Are you willing to involve your client in the discussion of the various courses of action?
   - What might you document pertaining to discussions with your client about probable courses of action?
7. Enumerate the consequences of various decisions.
   - How can you best evaluate the potential consequences of each course of action, before implementing a particular action plan?
   - Are you willing to involve your client in the discussion of the implications of each course of action for the client?
   - What ethical principles can you use as a framework for evaluating the consequences of a given

course of action?

- Examine the consequences of various decisions for your client, for you as counselor, and for the profession in general.

8. Decide on what appears to be the best course of action.
   - After carefully considering all the information you have gathered, how do you know what seems to be the best action to take?
   - Do you solicit the input of your client in making this decision at this phase?
   - Once you have formulated a plan of action, do you ask for feedback from a colleague or supervisor?
   - Once the course of action has been implemented, what are some ways that you might evaluate the course of action?
   - Are you willing to follow up to determine the outcomes and see if further action is necessary?

[1] Adapted from Corey, G., Corey, M, & Haynes, R. (1998). Student workbook for Ethics in Action. Pacific Grove, CA: Brooks/Cole.

Appendix 7 – Service Descriptions and Clinical Necessity Criteria

Outpatient Services, Mental Health

Outpatient therapy is an individualized treatment which provides services in the least restrictive environment possible (office, home or community settings) to address a wide variety of concerns, from behavior problems, relational conflicts to mood issues like depression or anxiety. Presenting problems and symptoms are the focus of treatment, with discharge when the youth is stable and treatment goals have been reasonably achieved. Outpatient therapy is intended to restore and enhance the youth's capacity to find solutions, identify and utilize available resources. Family members and/or other caregivers are encouraged to participate in these services. Outpatient therapy providers will continually assess client needs and make referrals to community resources as appropriate as the client's needs change.

Providers of Outpatient Therapy will embrace the System of Care (SOC) core principles, which include: Practice is Individualized; Services are Appropriate in Type and Duration; Care is Child-Centered, Youth-Guided and Family-Focused; Care is Community-Based; Care is Culturally Competent; Care is Seamless, within and across Systems; and Teams Develop and Manage Care.

Goals of Outpatient Therapy, Mental Health:

- Resolve concrete problems that impact the youth's daily living;
- Reduce symptoms resulting from thoughts, feelings, interpersonal disturbances, and /or experiences;
- Improve family and peer relationships;
- Strengthen coping skills;
- Manage emotions and behavior;
- Educate youth and families on the youth's diagnosis and symptomatology; and
- Identify and utilize formal and informal supports.

Service Components may include:

- **Assessment.** Continuous assessment of client and family needs is expected and adjustments to treatment approach, planning, duration and frequency shall reflect the client and family's changing needs.
- **Treatment planning.** This will occur in complete collaboration with the youth, family and other formal/informal supports identified. Youth/families will be active participants in establishing and prioritizing treatment goals.
- Individual, family and group therapy. Intensity and frequency of Outpatient Therapy will be based on the youth/family clinical needs. Most often sessions will occur at least once per week but more or less frequent sessions will be provided based on the individual's clinical need as determined by the Therapist and Care Coordination Team.
- **Crisis intervention and planning**. This includes development of safety plans with all youth and families entering services. The provider will establish a process for responding to after hour calls or emergencies. This process will be defined in agency policy and will be shared with DPBHS and all youth and families upon admission to this service.
- **Case management.** Case management is an element of Outpatient Therapy and should be coordinated with the DPBHS CFCC and/or other agencies and supports involved with the youth and family.

- **Advocacy and education.** Outpatient Therapy providers will advocate on behalf of the clients and families in service and provide them education on varying topics, such as available community resources, medication side effects and compliance, symptoms and diagnosis, etc.

Anticipated Length of Stay (LOS): LOS will vary based on clinical necessity, which will be routinely assessed.

PROVIDER QUALIFICATIONS

- At a minimum, Outpatient therapists will possess a Masters or Doctoral degree in psychology, social work, or other human service field. The degree held must qualify for licensure as one of the following in the State of Delaware: Licensed Clinical Social Worker (LCSW), Licensed Professional Counselor of Mental Health (LPCMH), Licensed Marriage and Family Therapist (LMFT) or Licensed Psychologist. It is expected that individuals who do not possess a license are in the process of obtaining required clinical supervision hours toward their professional licensure;
- Licensed Mental Health providers will be enrolled and paneled with Delaware Medicaid;
- Unlicensed therapists must participate in weekly clinical supervision provided by a licensed mental health professional. Documentation of weekly supervision is required and will be presented to DPBHS upon request;
- Therapist training and certifications will be documented and presented to DPBHS upon request. This includes documentation of reported degrees by accredited universities and certifications to deliver evidence based practices, etc.;
- Maintain professional boundaries and behavior, as specified by their professional Code of Ethics/Conduct, during interactions with all staff and clients;
- Possess a valid drivers' license;
- Be properly insured to provide contracted services;
- Pass a criminal background check as required in the contract; and
- Comply with additional requirements as stated in the DPBHS Provider Manual.

Outpatient therapy providers will possess the following skills and abilities:

1. Knowledge of major psychotropic medications and side effects and ability to convey this information to children and families;
2. Utilize crisis intervention skills with individuals/families in crisis;
3. Counseling skills and experience in providing individual, family and group therapy;
4. Develop and implement individualized treatment plans based on clinical experience and knowledge and revise the treatment plan in accordance with client/family's changing needs;
5. Knowledge of psycho diagnostics and ability to accurately diagnose utilizing the DSM 5.
6. Demonstrate ability to maintain knowledge of current trends in the field;
7. Utilize evidence based and best practice approaches to treatment;
8. Performs timely utilization reviews and obtains proper authorization to insure continued services;
9. Engage and counsel significant others (identified by the youth), as appropriate, to assist them in understanding, coping with, and supporting clients;
10. Knowledge of family systems and their impact on mental health within the family;
11. Skill in working with a variety of cultures;
12. Complete clinical documentation in a timely manner;
13. Be aware of community referral sources and refer when necessary;
14. Secure client information per HIPAA standards; and

15. Willingness to collaborate treatment and client care with other service providers and informal supports as identified by the youth/family and DPBHS as appropriate.

ADMISSION CRITERIA - *The youth must meet **all** criteria below to be admitted to this level of service:*

1. Youth ages birth-17 who meet DPBHS eligibility criteria for services;
2. The youth's parent/guardian/custodian provides voluntarily consent to treatment;
3. The CASII and/or other relevant information indicate that the youth's condition requires a coordinated course of treatment, consisting of psychotherapeutic services and, if clinically indicated, psychiatric services, to maximize functioning;
4. The youth presents with symptomatology consistent with an ICD 10 / DSM 5 diagnosis that requires a therapeutic intervention at this level of intensity;
5. The youth's symptoms interfere with the youth's ability to function in at least one area; and
6. There is an expectation that the youth has the capacity to make progress toward treatment goals, or treatment is necessary to maintain the current level of functioning.

CONTINUED STAY CRITERIA – ***All** criteria below are necessary for continuing treatment at this level of service:*

1. The CASII and other relevant information indicate that the youth continues to need the Outpatient level of care;
2. The severity of the behavioral disturbance continues to meet the criteria for this level of care and does not require a more intensive level of care and no less intensive level of care would be appropriate;
3. Progress in relation to specific symptoms or impairments is clearly evident and can be described in objective terms. However, some goals of treatment have not yet been achieved; and adjustments to the treatment plan are indicated to address the lack of progress and efforts to transfer to alternative services are documented when indicated; and
4. There is documented evidence of active, individualized discharge planning.

DISCHARGE CRITERIA - ***Any** of the following criteria is sufficient for discharge from this level of service:*

1. The youth and family have reasonably met and sustained a majority of the treatment goals and are equipped to adequately manage symptoms;
2. The CASII and other relevant information indicate that the youth no longer needs the outpatient level of care;
3. Few of the overarching goals have been met. Despite consistent and repeated efforts by the therapists and supervisor to overcome the barriers to further success, the treatment has reached a point of diminishing returns for the additional time invested. That is, the youth and family have not benefited from treatment despite documented efforts to engage and there is no reasonable expectation of progress at this level of care;
4. Individuals have a history of noncompliance with treatment, and specific efforts to engage the youth and family have been well documented in the youth's clinical record.
5. The youth and/or the parent withdraw consent for treatment and there is no court order requiring such treatment; and
6. The youth meets criteria for a more intensive level of care.

EXCLUSION CRITERIA- ***Any** of the following is sufficient for exclusion from this level of service:*

1. The youth does not meet DPBHS eligibility criteria;

2. The CASII and other relevant information indicate that the youth's treatment needs are not consistent with an outpatient intensity of service, as they need a more intensive therapeutic service;
3. The youth's parent/guardian/custodian does not voluntarily consent to treatment;
4. The behavioral symptoms are the result of a medical condition that warrants a medical setting for treatment; and
5. The youth has been diagnosed with a sole diagnosis of Autism Spectrum Disorder or an Intellectual Developmental Disorder and there is no co-occurring DSM 5 diagnosis or symptoms/behaviors consistent with a DSM 5 Diagnosis.

Outpatient Services, Substance Abuse

Outpatient therapy is an individualized treatment which provides services in the least restrictive environment possible (office, home or community settings) to addresses a wide variety of concerns, from substance use, behavior problems, and relational conflicts to mood issues like depression or anxiety. Presenting problems and symptoms are the focus of treatment, with discharge when the youth is stable and treatment goals have been reasonably achieved. Outpatient therapy is intended to restore and enhance the youth's capacity to find solutions, identify and utilize available resources. Family members and/or other caregivers are encouraged to participate in these services. Outpatient therapy providers will continually assess client needs and make referrals to community resources as appropriate as the client's needs change.

Providers of Outpatient Therapy will embrace the System of Care (SOC) core principles, which include: Practice is Individualized; Services are Appropriate in Type and Duration; Care is Child-Centered, Youth-Guided and Family-Focused; Care is Community-Based; Care is Culturally Competent; Care is Seamless, within and across Systems; and Teams Develop and Manage Care.

Goals of Outpatient Therapy, Substance Abuse:

- Resolve concrete problems that impact the youth's daily living;
- Reduce symptoms resulting from thoughts, feelings, interpersonal disturbances, and /or experiences;
- Reduce frequency of substance use;
- Improve family and peer relationships;
- Strengthen coping skills;
- Manage emotions and behavior;
- Educate youth and families on the youth's diagnosis and symptomatology; and
- Identify and utilize formal and informal supports.

Service Components may include:

- **Assessment.** Continuous assessment of client and family needs is expected and adjustments to treatment approach, planning, duration and frequency shall reflect the client and family's changing needs.
- **Treatment planning.** This will occur in complete collaboration with the youth, family and other formal/informal supports identified. Youth/families will be active participants in establishing and prioritizing treatment goals.
- **Individual, family and group therapy**. Intensity and frequency of Outpatient Therapy will be based on the youth/family clinical needs. Most often sessions will occur at least once per week but more or less frequent sessions will be provided based on the individual's clinical need as determined by the Therapist and Care Coordination Team.
- **Crisis intervention and planning.** This includes development of safety plans with all youth and families entering services. The provider will establish a process for responding to after hour calls or emergencies. This process will be defined in agency policy and will be shared with DPBHS and all youth and families upon admission to this service.
- **Case management.** Case management is an element of Outpatient Therapy and should be coordinated with the DPBHS CFCC and/or other agencies and supports involved with the youth and family.

- **Advocacy and education.** Outpatient Therapy providers will advocate on behalf of the clients and families in service and provide them education on varying topics, such as available community resources, medication side effects and compliance, symptoms and diagnosis, etc**.**

Anticipated Length of Stay: Actual LOS will vary based on clinical necessity, which will be routinely assessed.

PROVIDER QUALIFICATIONS

- At a minimum, Outpatient therapists will be a Certified Alcohol and other Drug Abuse Counselor (CADC), or possess a Masters or Doctoral degree in psychology, social work, or other human service field. The degree held must qualify for licensure as one of the following in the State of Delaware: Licensed Clinical Social Worker (LCSW), Licensed Professional Counselor of Mental Health (LPCMH), Licensed Marriage and Family Therapist (LMFT), Licensed Psychologist or a Licensed Chemical Dependency Professional (LCDP). It is expected that individuals who are not certified and do not possess a license are in the process of obtaining required clinical supervision hours toward their professional licensure and/or certification.
- Providers will be enrolled with Delaware Medicaid and Licensed Mental Health Professionals will be paneled with the Delaware Medicaid MCO's.
- Providers of Outpatient Therapy, SA must have either a CADC or LCDP available on staff to provide supervision and to sign assessments and treatment plans of substance using youth.
- Unlicensed therapists must participate in weekly clinical supervision provided by a CADC, Licensed Mental Health Professional or a Licensed Chemical Dependency Professional. Documentation of weekly supervision is required and will be presented to DPBHS upon request.
- Therapist training and certifications will be documented and presented to DPBHS upon request. This includes documentation of reported degrees by accredited universities and certifications to deliver evidence based practices, etc.
- Maintain professional boundaries and behavior, as specified by their professional Code of Ethics/Conduct, during interactions with all staff and clients.
- Possess a valid drivers' license.
- Be properly insured to provide contracted services.
- Pass a criminal background check as required in the contract.
- Comply with additional requirements as stated in the DPBHS Provider Manual.

Outpatient therapy providers will possess the following skills and abilities:

1. Knowledge of major psychotropic medications and side effects and ability to convey this information to children and families.
2. Utilize crisis intervention skills with individuals/families in crisis.
3. Counseling skills and experience in providing individual, family and group therapy.
4. Develop and implement individualized treatment plans based on clinical experience and knowledge and revise the treatment plan in accordance with client/family's changing needs.
5. Knowledge of psycho diagnostics and ability to accurately diagnose utilizing the DSM 5.
6. Demonstrate ability to maintain knowledge of current trends in the field.
7. Utilize evidence based and best practice approaches to treatment.
8. Performs timely utilization reviews and obtains proper authorization to insure continued services.
9. Engage and counsel significant others (identified by the youth), as appropriate, to assist them in understanding, coping with, and supporting clients.
10. Knowledge of family systems and their impact on mental health within the family.

11. Skill in working with a variety of cultures.
12. Complete clinical documentation in a timely manner.
13. Be aware of community referral sources and refer when necessary.
14. Secure client information per HIPAA standards.
15. Willingness to collaborate treatment and client care with other service providers and informal supports as identified by the youth/family and DPBHS as appropriate.

ADMISSION CRITERIA - *The youth must meet **all** criteria below to be admitted to this level of service:*

1. Youth ages birth-17 who meet DPBHS eligibility criteria for services.
2. The youth's parent/guardian/custodian provides voluntarily consent to treatment. Youth 14 years of age and older may consent to Outpatient Therapy, SA without signed consent from a parent/guardian/custodian.
3. The ASAM/CASII and/or other relevant information indicate that the youth's condition requires a coordinated course of treatment, consisting of psychotherapeutic services and, if clinically indicated, psychiatric services, to maximize functioning.
4. The youth presents with symptomatology consistent with an ICD 10/DSM 5 diagnosis that requires a therapeutic intervention at this level of intensity.
5. The youth's symptoms interfere with the youth's ability to function in at least one area.
6. There is an expectation that the youth has the capacity to make progress toward treatment goals, or treatment is necessary to maintain the current level of functioning.

CONTINUED STAY CRITERIA – ***All** criteria below are necessary for continuing treatment at this level of service:*

1. The ASAM/CASII and other relevant information indicate that the youth continues to need the Outpatient level of care.
2. The severity of the behavioral disturbance continues to meet the criteria for this level of care and does not require a more intensive level of care and no less intensive level of care would be appropriate.
3. Progress in relation to specific symptoms or impairments is clearly evident and can be described in objective terms. However, some goals of treatment have not yet been achieved; and adjustments to the treatment plan are indicated to address the lack of progress and efforts to transfer to alternative services are documented when indicated.
4. There is documented evidence of active, individualized discharge planning.

DISCHARGE CRITERIA - ***Any** of the following criteria is sufficient for discharge from this level of service:*

1. The youth and family have reasonably met and sustained a majority of the treatment goals and are equipped to adequately manage symptoms;
2. The ASAM/CASII and other relevant information indicate that the youth no longer needs the outpatient level of care;
3. Few of the overarching goals have been met. Despite consistent and repeated efforts by the therapists and supervisor to overcome the barriers to further success, the treatment has reached a point of diminishing returns for the additional time invested. That is, the youth and family have not benefited from treatment despite documented efforts to engage and there is no reasonable expectation of progress at this level of care;
4. Individuals have a history of noncompliance with treatment, and specific efforts to engage the youth and family have been well documented in the youth's clinical record;

5. The youth and/or the parent withdraw consent for treatment and there is no court order requiring such treatment; and
6. The youth meets criteria for a more intensive level of care.

EXCLUSION CRITERIA- **Any** of the following is sufficient for exclusion from this level of service:

1. The youth does not meet DPBHS eligibility criteria.
2. The ASAM/CASII and other relevant information indicate that the youth's treatment needs are not consistent with an outpatient intensity of service, as they need a more intensive therapeutic service.
3. The youth (14 years and older) and/or parent/guardian/custodian does not voluntarily consent to treatment.
4. The behavioral symptoms are the result of a medical condition that warrants a medical setting for treatment.
5. The youth has been diagnosed with a sole diagnosis of Autism Spectrum Disorder or an Intellectual Developmental Disorder and there is no co-occurring DSM 5 diagnosis or symptoms/behaviors consistent with a DSM 5 Diagnosis.

Therapeutic Support for Families (TSF)

Therapeutic Support for Families provides psycho-educational, therapeutic and supportive services for parents/ caregivers and youth who are eligible for services from the Division of Prevention and Behavioral Health Services. TSF services are typically delivered in conjunction with other treatment services but may, in some instances, be the only service provided by DPBHS. TSF goals will be included in the youth and family's treatment plan and will include the projected frequency and length of service along with the specific interventions and activities (with purpose) to be incorporated in the attainment of these goals.

TSF services may be provided individually or in family and/or group settings. TSF services are tailored to meet the unique needs of the youth and family. Often these services will be required during specific times of day (such as in the morning, evening or bedtime) so availability of resources must allow for services to be provided at the times identified by the caregiver. Structured outings and activities should be scheduled which include both the youth and caregivers, allowing them to demonstrate acquisition of skills and practice applying these skills in real life situations with support and coaching from the TSF, as appropriate. These services are delivered by trained, skilled paraprofessionals.

Goals of Therapeutic Support for Families:

- Children will remain in their homes with caregivers, reducing out of home placements.
- Caregivers will build and maintain positive relationships with their children.
- Caregivers will gain knowledge and strengthen parenting practices, allowing them to successfully manage challenging behaviors and situations.
- Caregivers will build confidence in their parenting abilities and be provided support when challenges occur.
- Ability to identify precursors and triggers that result in impairment.
- Youth will develop effective and meaningful ways to manage their behaviors and appropriately express their emotions.
- Development of creative approaches to strengthen, achieve and practice proper use of coping and social skills in natural settings to promote positive peer and family relationships.
- Assist caregiver/family in preparation for a youth's return home and provide added support during periods of transition.
- Model positive skills and pro-social behaviors.
- Identify and connect caregivers with needed resources. This may include referring them for their own mental health or substance abuse treatment, assistance with meeting the family's basic needs (such as food closets, clothing resources, utility assistance) and aiding them in strengthening their own natural support network (connecting them with support groups, community resources, churches, etc).

Length of Stay: LOS will vary by case. Projected time limitations will be specified for each goal in the treatment plan and continuation of service must be justified by clinical need.

PROVIDER QUALIFICATIONS:

- Bachelor degree or higher in social work, psychology or a related human services field. Applicants with associates degrees and a minimum of 2 years of relevant work experience may be considered. Weekly supervision by a licensed mental health professional is required.
- Availability to provide services during daytime, evening and weekend hours as agreed upon by the CONTRACTOR and family.
- Possess a valid State of Delaware drivers' license and an active/adequate automobile insurance policy. Documentation must be maintained in the employee's personnel file.
- Pass a criminal background check.
- Complete the following trainings within the first year of employment:

    - Mandatory Reporting - Abuse and neglect
    - Risk management and safety planning;
    - Field safety;
    - Trauma informed care;
    - Family engagement;
    - Ethics/ Maintaining Professional Behavior and Boundaries
    - Domestic violence; and
    - Child development (basics)

    ** Trainings provided by the CONTRACTOR must meet DPBHS requirements for content and documentation..

Providers of Therapeutic Support for Families will possess the following skills and abilities:

- Strong communication skills (verbal, writing, reading).
- Understanding of child development.
- Knowledge and practice of positive parenting techniques.
- Ability to build rapport, connect and create trusting relationships with others.
- Capacity to teach and/or model positive behavior, techniques and skills.
- Effective stress management, de-escalation and crisis intervention practices.
- General behavior intervention techniques and ability to adequately assess youth/caregiver needs.
- Knowledge of available community resources and ability to access resources.
- Knowledge/practice of financial and household management.

ADMISSION CRITERIA – *The youth must meet all criteria below*

1. Youth meets DPBHS eligibility criteria.
2. The ASAM/CASII and/or other relevant information indicate that the youth/family's condition requires a coordinated course of treatment to maximize functioning.
3. The youth presents with symptomotology consistent with an ICD10 / DSM 5 diagnosis and/or a behavioral and emotional disturbance that requires a therapeutic intervention at this level of intensity.
4. Youth and family are actively participating in a DPBHS treatment service.
5. The symptoms interfere with the youth/family's ability to function in at least one area.

6. There is an expectation that the youth/family has the capacity to make progress toward treatment goals, or treatment is necessary to maintain the current level of functioning.

CONTINUED STAY CRITERIA – *All criteria below are necessary for continuing treatment at this level of service:*

1. The ASAM/CASII and/or other relevant information indicate that the youth./family continues to need this level of service
2. The severity of the behavioral disturbance continues to meet the criteria for this level of service and does not require a more intensive level of service and no less intensive level of service would be appropriate.
3. Progress in relation to specific symptom or impairments is clearly evident and can be described in objective terms. Some goals of treatment have not yet been achieved and adjustments to the treatment plan are indicated to address the lack of progress and efforts to transfer to alternative services are documented when indicated.
4. There is documented evidence of active, individualized discharge planning.

DISCHARGE CRITERIA- *Any of the following criteria is sufficient for discharge from this level of service:*

1. The youth and family have reasonably met and sustained a majority of the treatment goals.
2. The ASAM/CASII and/or other relevant information indicate that the youth/family no longer needs this level of service.
3. The family is able to effectively manage any recurring problems.
4. The youth/family is making reasonable improvements in identified treatment goals. The youth/caregiver is able to demonstrate acquisition of skills.
5. Few of the overarching goals have been met. Despite consistent and repeated efforts by the provider to overcome barriers to further success, the treatment has reached a point of diminishing returns for the additional time invested. That is the you and family have not benefited from the treatment despite documented efforts to engage and there is no reasonable expectation of progress at this level of care.
6. Individuals have a history of noncompliance with treatment and specific efforts to engage the youth/family have been well documented in the clinical record.
7. Youth/family withdraw consent for treatment.
8. Youth meets criteria for a more or less intensive level of service.

EXCLUSION CRITERIA – ***Any*** *of the following is sufficient for exclusion from this level of service:*

1. The youth does not meet DPBHS eligibility criteria.
2. The youth has a sole diagnosis of Autism Spectrum Disorder and there is no co-occurring DSM 5 diagnosis or symptoms/behaviors consistent with a DSM 5 diagnosis.
3. The youth has a sole diagnosis of Intellectual Developmental Disorder and there is no co-occurring DSM 5 diagnosis or the symptoms/behaviors consistent with a DSM 5 diagnosis.
4. The ASAM/CASII and/or other relevant information indicate that the youth/family's treatment needs are not consistent with this level of service.

5. The youth and/or caregiver do not voluntarily consent to treatment.
6. The behavioral symptoms are the result of a medical condition that warrants a medical setting for treatment.

Dialectical Behavior Therapy (DBT)

Dialectical Behavior Therapy (DBT) is an evidence based outpatient service. It has been empirically validated for adults and the emerging literature shows great promise for treating adolescents. Dialectical Behavior Therapy was developed by Linehan (1993) and Associates. This has been an effective treatment for a variety of conditions such as borderline personality disorder, depression, post-traumatic stress disorder (PTSD), substance abuse, self-injurious behaviors and eating disorders. Treatment is used to aid adolescents in managing problem behaviors (self-harm, self-injury, suicidal planning, gestures, actions, impulsive decision-making, and avoidance) used maladaptive to manage stressful life situations.
A comprehensive DBT program consists of the following core components:

- Skills training groups
- Individual therapy
- Parent Group
- Phone coaching
- Consultation team

The overall purpose of DBT is to help the youth create a life worth living goal. What makes a life worth living varies from client to client. While individual's goals will differ, all clients have in common the task of bringing problem behaviors, especially behaviors that are life threatening, under control. Once identified, these behaviors can be targeted for positive change. Youth use self-monitoring via diary cards to keep daily records of emotions, urges, and behaviors. In individual therapy and group sessions, participants learn and practice skills to aid in managing emotions, urges, and behaviors tracked on diary cards. Group consists of three modules total. Each module has core mindfulness taught as both a general technique and applied skill in three categories: Distress Tolerance (how to tolerate emotional pain in difficult situations, not change it), Interpersonal Effectiveness (how to ask for what you want and say no while maintaining self-respect and relationships with others) and Emotion Regulation (how to change emotions that you want to change). These skills will aid in the process of decreasing self-judgment, self-criticism and increase self-validation and acceptance while working on change.

DBT is divided into four stages of treatment. Stages are defined by the severity of the client's behaviors, and therapists work with their clients to reach the goals of each stage in their progress toward having a life that they experience as worth living.

1. In Stage 1, the client is suffering as life is currently being lived and their behavior is out of control: they may be experiencing suicidal ideation, engage in self-harming, self-injury, or self-destructive behaviors, and/or be abusing substances. When clients first start DBT treatment, they often describe their experience of their mental illness as "being in hell." The goal of Stage 1 is for the client to move from being out of control to achieving behavioral control.
2. In Stage 2, they're living a life of quiet desperation: their behavior is under control but they continue to suffer, often due to past trauma and invalidation. Their emotional experience is inhibited. The goal of Stage 2 is to help the client move from a state of quiet desperation to one of full emotional experiencing. This is the stage in which post-traumatic stress disorder (PTSD) would be treated as well as secondary targets.
3. In Stage 3, the goal is to learn to live an ordinary life and problem solve relationship conflict, dissatisfaction, career goals, etc. This work can happen in therapy or sometimes without therapy.
4. In Stage 4, the goal is to find happiness, completeness, and connection. Linehan has posited a Stage 4 specifically for those clients for whom a life of ordinary happiness and unhappiness fails to meet a further goal of spiritual fulfillment or a sense of connectedness of a greater whole. In

this stage, the goal of treatment is for the client to move from a sense of incompleteness towards a life that involves an ongoing capacity for experiences of joy and freedom.

A full time outpatient therapist can maintain a maximum case-load of 15 hours of DBT treatment on their case load. These hours include groups and individuals. Adolescent DBT treatment consists of a one-hour individual session per a week, two hours of group therapy sessions per week, family sessions as indicated, and monthly parent group. Phone coaching, which does not involve face-to-face occurrences, are available 24 hours per day, including weekends and holidays. If face-to-face intervention is needed during a phone coaching call the local mental health emergency hotline or the local emergency room will be utilized. DPBHS strongly encourages providers of DBT to have a collaborative relationship with a psychiatry provider to deliver psychiatric services. Please note, psychiatric services will be billed directly to the MCO.

Length of Stay: Average of 12 months. One round of DBT comprehensive treatments lasts six months. Most participants complete two 6 months rounds of treatment. A third round of individual only treatment can be offered by the consultation team.

Due to the variability in learning abilities, there are exceptions in order to provide the most effective treatment for the youth. For example, a fourth round of individual only has been offered to aid the client in moving through stage 3 because their processing and comprehension requires repetition outside of the average length of stay. Or, some clients cannot tolerate going directly into group and will receive skills training on an individual basis. The goal would be for them to complete a round and transition into the group setting and complete up to two rounds of group skills training.

MONITORING AND ASSESSMENT OF SERVICE DELIVERY

Safety/Risk Management Events

- Allegations of abuse, cutting, suicidal attempts, hospitalization, frequency and type of impulsive and destructive behaviors, and police involvement/assistance are tracked via a risk management system and quality improvement strategies are considered during team and management meetings.
- Staff clinical competence is ensured through monitoring at regular intervals by the quality improvement and human resources team through a fidelity audit annually; this is done internally. At least one video a year is reviewed by the clinical director for each staff.

Outcome Monitoring of Client Care

Outcomes of care are monitored at admissions, three months, six months, nine months, and 12 months. If youth is in the program longer than one year monitoring continues at three month intervals. Every youth and guardian/parent will complete a Child Behavior Check List (CBCL) every three months. Additional globalized and specialized assessments are utilized per the youth's needs. Data is analyzed annually.

BILLING

DBT is a comprehensive service at the outpatient level. Youth with only medical assistance shall not bill for other behavioral health services while in DBT, with the exception of psychiatric evaluation and medication management. Only with the care manager's approval and authorization youth may receive other behavioral health services in addition to DBT. An approved list of applicable codes is attached.

Youth with primary commercial insurance may opt to seek ancillary services in addition to DBT. For example, movement therapy, art therapy and family therapy. DBT therapist will collaborate when participation is warranted or necessary.

PROVIDER QUALIFICATIONS:

- A minimum of a Masters degree in psychology, social work, or other human service field is required. The degree held must come from an educational program at a regionally accredited institution of higher education.
- Therapists must be a State of Delaware licensed, independent mental health practitioner with an unrestricted license in order to provide DBT therapy. Conditional licenses/certificates that require supervision to work as a mental health professional are not acceptable.
- Licensed Mental Health providers will be enrolled and paneled with Delaware Medicaid MCO's.
- Therapists will have a minimum of 2 years of experience working in a therapeutic setting.
- Therapists will participate in 6-8 month comprehensive training and achieve a passing score of 80% or above on a final exam, or have completed comprehensive training in DBT and provide certificates of training, proof of pedigree and references, or complete the exam scoring 80% or better.
- Therapist pedigree letter and or proof of training will be documented and presented to DPBHS upon request. This includes the credentialing results performed by the provider.
- Possess a valid drivers' license.
- Be properly insured to provide contracted services.
- Pass a criminal background check as required in the contract.
- Comply with additional requirements as stated in the DPBHS Provider Manual.

ADMISSION CRITERIA: *The youth must meet **all** criteria below to be admitted to this level of service:*

1. Youth is between the ages of 13-17 years of age and meets DPBHS eligibility criteria. Some 11 and 12 years old may qualify and this will be assessed per an individual basis at the interview process and with consultation team review.
2. Youth must pass the pretreatment interview that last, on average, between 3 to 4 sessions.
3. Youth and family are willing to commit to attendance requirements of DBT treatment.
4. The CASII and other relevant information indicate that the youth needs the DBT level of care.
5. The youth manifests behavioral symptoms consistent with the diagnostic criteria for Borderline Personality Disorder (BPD) in ICD 10/ DSM5; meeting at least 5 out of the 9 criteria. Youth are not required to have a BPD diagnosis. These symptoms can manifest as multiple problems in multiple areas of life functioning.
6. Have mental health needs that cannot be met with other available community-based services or that need services provided concurrently with other community-based services.
7. Be at risk of **one** of the following, as recorded in the client's record:
    a. A need for a higher level of care, such as hospitalization or partial hospitalization
    b. Intentional self-harm (suicidal and non-suicidal) or risky impulsive behavior or be currently having chronic self-harm thoughts or urges (suicidal or non-suicidal) although the client has managed to not act on them.
    c. A mental health crisis
    d. Decompensation of mental health
8. Understand and be cognitively capable of participating in DBT

9. Be able and willing to follow program policies and rules assuring the safety of self and others

CONTINUED STAY CRITERIA: ***All*** *of the following criteria are necessary for continuing treatment at this level of service*:

1. The CASII and other relevant information indicate that the youth continues to need the DBT level of care.
2. Be actively participating and engaged in the DBT program, its treatment components and its guidelines in accordance with treatment team expectations
3. Have made demonstrable progress as measured against the client's baseline level of functioning before the DBT intervention. Examples of demonstrable progress include:
    a. Decreased self-destructive behaviors
    b. Decreased acute psychiatric symptoms with increased functioning in activities of daily living
    c. Objective signs of increased effective engagement
    d. Reduced number of acute care services, such as emergency department (ED) visits, Mobile Response and Stabilization Services and hospital admissions
    e. Application of skills learned in DBT to life situations
    f. Continue to make progress toward goals but have not fully demonstrated an internalized ability to self-manage and use learned skills effectively
    g. Be actively working toward discharge, including concrete planning for transition and discharge
    h. Have a continued need for treatment as indicated in the above criteria and by ongoing documented evidence in the recipient's record

DISCHARGE CRITERIA*: **Any** of the following criteria is sufficient for discharge from this level of service:*

1. The client's individual treatment plan goals and objectives have been met, or the client no longer meets continuing-stay criteria.
2. The client's thought, mood, behavior or perception has improved to a level for which a lesser level of service is indicated.
3. The client chooses to discontinue treatment.
4. The provider concludes from the ongoing clinical assessment that the client no longer meets admission criteria or that another treatment modality would be more effective.
5. A client who is unable to maintain adherence to the treatment regimen can be considered for discharge after conflict resolution steps are exhausted.

EXCLUSION CRITERIA: ***Any*** *of the following is sufficient for exclusion from this level of service:*

1. Client is 10 years of age or younger.
2. Client behaviorally does not meet at least 5 out of the 9 diagnostic criteria for Borderline Personality Disorder, regardless if they have the diagnosis.
3. Client/family does not consent for treatment.
4. Client's Intellectual Developmental Disorder impairs their ability to participate in DBT.
5. Client/family is unable or unwilling to make an attendance commitment.
6. Client is unwilling to make an elimination agreement to take suicide, self-harm, and self-injury off the table.

Family Based Mental Health Services (FBMHS)

The Family Based Mental Health Services are designed to service children between 3 and 17 years of age and living with their parents, guardians, or caretakers and have a serious mental illness or emotional disturbance. These children are also at risk for out-of-home placement into residential treatment facilities, psychiatric hospitals or foster placements due their symptomatic behaviors and/or the dysfunction of the family system that contributes to the behaviors. Family Based Mental Health Services (FBMHS) are able to treat these children and adolescents in their homes, communities and schools thus allowing the youth to remain in the home. Services are available 24 hours per day and 7 days a week via on call therapist from the FBMHS program.

FBMHS is a team delivered service rendered in home, community and school settings. It is designed to integrate mental health treatment, the family, family support services, the surrounding system, and casework so that families may continue to care for their children and adolescents with a serious mental illness or emotional disturbance in their home. These children and adolescents experience depression, anxiety, chronic acting out behaviors, aggression, social, coping and skill deficits, drug and alcohol abuse, and school truancy. These children are frequently described as "hard to manage" by their parents. Often times, their personality traits and their parents' management skills are frequently in conflict with each other, which leads to a youth/family's involvement with multiple systems.

Children and adolescents referred for FBMHS may experience multiple challenges which make it hard for them to be successful in school, home, have positive relationship in the community, accomplish age defined developmental and emotional goals, and social and academic achievements. Additionally the parent, guardian, caretaker may experience their own challenges in decision-making, problem-solving, regulating emotions and maintaining attachment with their child and functioning as the executive. Caregivers feel overwhelmed by parenting responsibilities and may feel as though they have "failed as a parent."

FBMHS treatment is driven by the Ecosystemic Structural Family Therapy model (ESFT) that incorporates the use of the emotional relational process between the therapist and family and within the family system isomorohpically. The goal is to block negative family patterns of behaviors and forge new family patterns. Behavioral principles aid in driving the shaping and development of new behaviors in the family system. Individual, family, parents, couples, sibling and community approaches are integrated to address identified needs through the model. The treatment planning process is strength based, youth specific and focused on the achievement of individual and family goals in order to maintain the family together in the community. Family systems therapy, parent skills training and sibling counseling are mutually supportive of each other in facilitating family stability, healing and behavioral improvement. DPBHS strongly encourages providers of FBMHS to have a collaborative relationship with a psychiatry provider to deliver psychiatric services. Please note, psychiatric services will be billed directly to the MCO.

Components of FBMHS:

- **Treatment Planning:** FBMHS team develops the treatment plan in active collaboration with parents and client creating specific goals and objectives to be worked on during the course of the program. Thereafter treatment planning occurs monthly.
- **Family Therapy:** Occurs in the home and is conducted by two master level clinicians. The FB team typically provides family therapy at least one time a week depending on family-client needs and availability to meet with the FB team. On average a session lasts 2.5 to 3 hours (which may

include travel time). During family therapy the therapeutic system is constructed, a meaningful focus for treatment is agreed upon, key growth promoting interpersonal experiences are facilitated by the FB team, and the changes are solidified and extended.

- **Individual Therapy:** Supports the family therapy process. It may be provided to the authorized youth or any family member in support of strengthening the family system and well-being of the authorized youth. Therapy may be provided by either FBMHS team member in accordance with the skill set of the particular therapist, and the input of the clinical supervisor. The frequency and focus of individual therapy is unique to each family and is determined collaboratively by the family and FB team. Individual therapy works to strengthen the individual members of the family system to promote new family patterns. Interventions may include evidenced-based therapy, psycho-education, coaching, person-centered therapy and skills training approaches. These are offered in the home, school or community.
- **Sibling Therapy:** Sibling therapy is subordinate to family therapy in terms of overall service provided and is consistent with and supports the progress towards family therapy goals. Sibling interventions may be team or individual delivered. Either team member may provide sibling interventions. Counseling can include directive social skills work, interactive counseling, modeling and sibling ordeals or homework to be practiced during the week.
- **Parenting/Couples Therapy:** FBMHS recognized the 'client-family' as the treatment focus. Within this concept there is a place for working with the guardian/parent-couple to:
  - Help identify problems and barriers to a stronger co-parenting alliance and increased executive functioning so that they can increase attachment in the family system and emotional regulation.
  - Discover ways in which to use the strengths of the guardian/spousal relationships to support the wellbeing of the youth and family.
  - Accept adjustments to guardian/spousal relationship that will support wellbeing of youth and family.
  - Locate and access professional marriage counseling if problems and FB team expertise are beyond the scope of the first three.
  - FBMHS staffs are not trained marriage counselors. However, they can identity family systems, spousal dyad barriers, and 'deadlocked' communication patterns that contribute to the core negative patterns in the family system being addressed by the FBMHS.
  - Interventions are grounded in an emotional relational process and may include evidenced-based therapy, psycho-education, coaching, person-centered therapy and skills training approaches to increase consistency in parenting intervention.
- **Interagency Team Meeting:** Are held at the beginning and end of treatment, and as needed throughout treatment to strengthen the ecosystem surrounding the family. Members of the meeting include the team, the client, and the family, in addition to other systems or supportive community members who are involved (school, CYS, JPO, neighbor, religious leaders, extended family, etc.). The purpose of these meetings is to strengthen the family by teaching them how to turn to others and advocate for their needs, and more specifically the needs of their child.
- **Case Management:** FBMHS provides necessary case management (CM) to link the client-family to resources in the community. The purpose is to gain improvements in client-family needs in the community-region in which the client-family live. Resources start with meeting the basic safety, sustenance and shelter requirements for stable life, based on the Maslow need hierarchy. It is also community based in terms of tapping into the natural support systems of communities. Specific aspects of CM include:

- Basic services (food, clothing, shelter) support
- Recreation support
- Spiritual support
- Healthcare support
- Educational support
- Social skills support
- Vocational skills support

- **Skills Training:** Skills training are an integral part of FBMHS and is applied in the family system and all subsystems based on the skills deficits and needs of the particular family. Skill categories proceed from Maslow's hierarchy of needs and may include discussing with and teaching:
  - Parents to manage basic financial and material needs of the family.
  - Parents to identify and obtain means of family and self-support.
  - Parents to understand misbehavior as an attempt to get their needs met.
  - Parents to address youth's psychological needs of belonging and competency.
  - Parents to intervene effectively
  - Children to identify behavioral antecedents and new behavioral responses.
- **School consultation:** The FBMHS team maintains contact with all relevant members of the interagency team, which the school is a part of, to discuss necessary matters of treatment support the youth in school. The FBMHS team may:
  - Provides observation and treatment to the child in the school
  - Provide supportive mental health services for crises when requested by school officials
  - Provides consultation or suggestion requested through the interagency team process.
- **Community Integration:** Parents and guardians are encouraged to determine their children's interest and learn how to be involved as a family in their community. FB staff help the parents to weigh the pros and cons for their decisions, but ultimately the clients must make their own decisions as to what is worthwhile for their children based on feedback from the team. The following are suggested for discussion:
  - Art
  - Boy/girl Scouts
  - Music enrichment program
  - Recreational activities
  - Physical fitness
  - Other services – medication management, physical health etc.
- **Crisis Management:** Crisis management is addressed in the FB treatment plan, which includes a crisis plan that is proactive and individualized for each client-family in a collaborative manner with the team. All relevant emergency and crisis phone numbers are provided to the client-family. After hours (5pm-9am M-F and weekends) crisis and mental health emergencies are handled by on-call FB staff member. The client-family is given the on-call phone number at the start of FBMHS. The goal of the on-call response is to help caregivers to move through crisis and have the process of change develop in order to resolve the symptomatic situations in their homes and communities rather than contact police and seek hospitalization for the youth.

Goals of Family Based Mental Health Service:

- Prevent psychiatric hospitalization for children and adolescents enrolled in the program.
- Prevent out of home placements for children and adolescents enrolled in the program.

- Maintain children and adolescents with emotional and mental health problems within intact families and enable family members to continue as active participants in their local communities.
- Offer therapeutic contact needed that is best tailored to meet the needs of individual members of families.
  - Provide a mental health service that is an alternative to traditional outpatient service allowing families more opportunities to participate in designing interventions that best meet their family's needs.
  - Offer expertise in developing transitional services to families to better enable them to obtain community supportive services after discharge from FBMHS
  - Foster safe, structured home environments through parent training, support and consultation during times of crisis while maintaining increased sense of personal achievement and family connectedness.
  - Utilization of multi learning approaches to promote personal connectedness, effectiveness, accountability, motivation and safety in the delivery of services.
  - Promote physical wellbeing, emotional stability and skills development in children, adolescents and families.

Each FBMHS team may carry a maximum of 8 clients and families at a time and is required to have a minimum of 1 face-to-face family contact per week. Contacts are regularly scheduled as well as emergency based. FBMHS are available 24 hours a day, 7 days a week via an on-call system. After hours responses by phone and in-person are a key component of this service.
Length of Stay: 32 weeks

MONITORING AND ASSESSMENT OF SERVICE DELIVERY

- The Center will collect and report outcome information through the various collaborative development and integrated mechanisms in place to monitor outcomes (incident data base, Performance Improvement Plan, program scorecard, quality QM audits, compliance audits, and supervision). Outcome variables include:
- Length of Stay – discharge planning starts upon admission. FBMHS may be approved for up to 8 months. Additional time may be requested and approved after review by the State HMO.
- Discharge placement based on level of care. Services are identified and in place at time of discharge along with an overlap in services to support a smooth transition of services.
- The FBMHS Director follows the course of treatment for each client-family in weekly supervision and along with the FBMHS team determines response to treatment.
- Monitoring of outcomes of care using the Modified Family Assessment of Functioning (MFAF) at admissions and discharge.
- Client/family satisfaction surveys: Feedback will be elicited from children/adolescents, family members, caregivers, and agencies. Data will be used to drive the performance improvement process at the Center and when identified at the program level.

BILLING
Family Based Mental Health Service is a comprehensive service. FBMHS shall not be billed with other behavioral health services with the exception of psychiatric evaluation and medication management. An approved list of applicable codes is attached

PROVIDER QUALIFICATIONS:

1. FBMHS therapists will possess a Masters or Doctoral degree in psychology, social work, or other human service field. The degree held must qualify for licensure as one of the following in the State of Delaware: Licensed Clinical Social Worker (LCSW), Licensed Professional Counselor of Mental Health (LPCMH), Licensed Marriage and Family Therapist (LMFT) or Licensed Psychologist. Licensed Mental Health providers will be enrolled and paneled with Delaware Medicaid MCO's.
2. FBMHS therapists will participate in a 3-year core training program in Ecosystemic Structural Family Therapy (ESFT) provided by the Philadelphia Child and Family Therapy Training Center (PCFTTC). All FBMHS staff must enroll in this program and complete the required clinical and didactic learning experience yearly. The model is essentially a relational and experiential family systems approach to promoting change within families and symptomatic children. Upon completion of the core program individuals must pass a Philadelphia Child Family Therapy Training Center (PCFTTC) competency evaluation.
3. The FBMHS supervisor will be a Licensed Mental Health Professional and is responsible for providing weekly team supervision of all teams/staff. The FBMHS supervisor works closely with the Philadelphia Child Family Therapy Training Center (PCFTTC) and staff to effectively teach and supervise the ESFT model through team, group and in-home supervision utilizing videos of sessions as teaching tools. Documentation of supervision is required and will be presented to DPBHS upon request.
4. Therapist training and certifications will be documented and presented to DPBHS upon request. This documentation of reported degrees includes by accredited universities and certifications to deliver evidence based practices, etc.
5. Possess a valid drivers' license.
6. Be properly insured to provide contracted services.
7. Pass a criminal background check as required in the contract.
8. Comply with additional requirements as stated in the DPBHS Provider Manual.

ADMISSION CRITERIA - *The youth must meet **all** criteria below*

1. Youth ages 3-17 who meet DPBHS eligibility criteria for FBMHS services.
2. The youth's parent/guardian/custodian provides voluntarily consent to treatment.
3. The CASII and/or other relevant information indicate that the youth's condition requires service at this level of intensity.
4. The youth presents with symptomatology consistent with an ICD 10/ DSM 5 Diagnosis and/or ICD 10 Diagnosis where a behavioral or emotional disturbance places the youth at risk of out-of-home placement.
5. The symptoms interfere with the youth's ability to function in at least one area.
6. There is an expectation that the youth has the capacity to make progress toward treatment goals, or treatment is necessary to maintain the current level of functioning.

CONTINUED STAY CRITERIA — ***All** criteria below are necessary for continuing treatment at this level of service:*

1. The CASII and other relevant information indicate that the youth continues to need FBMHS level of care.
2. The severity of the behavioral disturbance continues to meet the criteria for this level of care and does not require a more intensive level of care and no less intensive level of care would be appropriate.

3. Progress in relation to specific symptoms or impairments is clearly evident and can be described in objective terms. However, some goals of treatment have not yet been achieved; and adjustments to the treatment plan are indicated to address the lack of progress and efforts to transfer to alternative services are documented when indicated.
4. There is documented evidence of active, individualized discharge planning.

DISCHARGE CRITERIA - **Any** of the following criteria is sufficient for discharge from this level of care:

1. The youth and family have reasonably met and sustained a majority of the treatment goals.
2. The CASII and other relevant information indicate that the youth no longer needs the outpatient level of care.
3. The family is able to effectively manage any recurring problems.
4. The youth is making reasonable improvements in identified treatment goals. The therapists and supervisor believe that the caregivers have the knowledge, skills, resources and support needed to handle subsequent problems.
5. Few of the overarching goals have been met. Despite consistent and repeated efforts by the FB team and supervisor to overcome the barriers to further success, the treatment has reached a point of diminishing returns for the additional time invested. That is, the youth and family have not benefited from treatment despite documented efforts to engage and there is no reasonable expectation of progress at this level of care.
6. Individuals have a history of noncompliance with treatment, and specific efforts to engage the youth and family have been well documented in the youth's clinical record.
7. The youth and/or the parent withdraw consent for treatment and there is no court order requiring such treatment.
8. The youth meets criteria for a more intensive level of care.

EXCLUSION CRITERIA- ***Any*** *of the following is sufficient for exclusion from this level of care:*

1. The youth does not meet DPBHS eligibility criteria.
2. The CASII and other relevant information indicate that the youth's treatment needs are not consistent with this intensity of service, as they need a more or less intensive therapeutic service.
3. The youth's parent/guardian/custodian does not voluntarily consent to treatment.
4. The behavioral symptoms are the result of a medical condition that warrants a medical setting for treatment.
5. The youth has been diagnosed with a sole diagnosis of Autism Spectrum Disorder or an Intellectual Developmental Disorder and there is no co-occurring ICD 10 Diagnosis, or symptoms/ behaviors consistent with an ICD 10 Diagnosis.

Functional Family Therapy (FFT)

Functional Family Therapy (FFT) is a short-term, family-focused, community-based treatment for youth who are either "at risk" for, or who manifest, antisocial behavioral problems such as conduct disorder, oppositional defiant disorder, disruptive behavior disorder, violent acting-out and substance abuse disorders. Co-morbid behavioral or emotional problems, such as anxiety or depression, may also exist as well as family problems, such as communication and conflict issues. FFT has been applied to a wide range of families with at-risk, pre-adolescent and adolescent youth in various multi-ethnic, multicultural contexts. Interventions are conducted at home, in school, in or outpatient settings and at times of transition, from a residential placement.

FFT incorporates specific intervention phases, which include engagement, motivation, assessment, behavior change and generalization. Each phase includes a description of goals, requisite therapist characteristics and techniques. FFT interventions consist of direct contact with the family in person or by phone. FFT is designed to improve within-family attributions, family communication and supportiveness while decreasing intense negativity and dysfunctional patterns of behavior. Parenting skills, youth compliance, and the complete range of behaviors (cognitive, emotional, and behavioral) domains are targeted for change based on the specific risk and protective factor profile of each family.

The FFT intervention consists of five major components, which include: Pretreatment, Engagements phase, Motivation phase, Relational assessment phase, Behavioral change phase and Generalization phase. The family self-reported as they move from one phase to another. These reports are used to track progress.

Goals of FFT include the following:

- Engage and motivate the youth and family to change by decreasing the intense negativity often characteristic of these families. Work to motivate families and youth who (at the outset) may not be motivated or may not believe that they can change.
- Reduce the personal, societal and economic devastation that results from the continuation or exacerbation of the various disruptive behavioral challenges of the youth.
- Reduce and eliminate problem behaviors and family relational patterns that put the family and youth at risk. Develop individualized behavior change plans that focus on improving parenting skills, family communication, conflict resolution and problem solving skills.
- Generalize positive changes across problem situations by increasing the family's capacity to adequately utilize community resources.

Full-time clinicians will maintain an average caseload of 12 "active" cases at any given time and spend an average of 2.5 – 3 hours per family per week for face-to-face contact, collateral services, travel, case planning and documentation. FFT therapists will participate in in school meetings and court appearances as requested. FFT Supervisors may supervise up to 8 FFT therapists.

Length of Stay: An average of 12 sessions over a 3-4 month period.

MONITORING AND ASSESSMENT OF SERVICE DELIVERY

The provider will assess and monitor the delivery of the FFT service via the use of CSS. This is an online data base which has been originated by FFT, LLC. The type of data collected by the CSS includes:

- Assessment of risk and protective factors (Risk and Protective Factors Assessment)
- Relationship assessments (this is embedded in the progress notes)
- Individual functioning (pre- and post-intervention) (OQ-45.2)
- Functioning within the context of assessments (pre-and post-intervention) YOQ2.01 and YOQ SR
- Assessments of family and therapist agreement (Family Self Report)
- Fidelity Ratings (Weekly adherence ratings – by national consultant in Year One and by site supervisor in Year Two and beyond)
- FFT global therapist rating
- Completion rates (CDD closed case summary)
- Drop-out rates (CSS closed case summary)
- Time of drop-out rates (CSS closed case summary or case review report)
- Outcome data (family and therapist perspective) at time of discharge (TOM, COM-A and COM-P)

Each therapist receives a log on and password for the CSS for referencing their own clients only. The provider will receive an administrator/evaluator long on and password. The FFT national consultant will also have access to the data from the CSS. Additional information can be found at www.fftinc.com.

BILLING

FFT is a comprehensive service. FFT will typically not be billed in conjunction with other behavioral health services with the exception of psychiatric evaluation and medication management. An approved list of applicable codes is attached.

PROVIDER QUALIFICATIONS

1. At a minimum, FFT therapists will possess a Masters or Doctoral degree in psychology, social work, or other human service field. The degree held must qualify for licensure as one of the following in the State of Delaware: Licensed Clinical Social Worker (LCSW), Licensed Professional Counselor of Mental Health (LPCMH), Licensed Marriage and Family Therapist (LMFT) or Licensed Psychologist.
2. Unlicensed therapists must participate in weekly clinical supervision provided by a licensed mental health professional. Documentation of weekly supervision is required and will be presented to DPBHS upon request.
3. The Providing agency must be certified as a provider of FFT. The primary goal of the FFT implementation and certification process is the successful replication of the FFT program as well as its long-term viability at individual community sites. The FFT Site Certification is a 3-phase process which includes: Clinical Training (includes training, site visits, ongoing telephone supervision and externship), Supervision Training (development of competent on-site FFT supervision) and participation in the Practice Research Network (partnering relationships to assure ongoing model fidelity, impacting issues of staff development, interagency linking, and program expansion).

ADMISSION CRITERIA - *The youth must meet **1, 2 and 3** and at least **ONE** from **4 through 9.***

1. The youth is between the ages of 11 and 17 (Special consideration may be given to 10 year olds) and meets DPBHS eligibility criteria.
2. The CASII and other relevant information indicate that the youth qualifies for FFT treatment.

3. The youth manifests behavioral symptoms consistent with an ICD 10 / DSM 5 diagnosis that requires FFT intervention (e.g., Conduct Disorder, Oppositional Defiant Disorder, Disruptive Behavioral Disorder NOS, Substance Abuse Disorders, etc.);
   OR
   The youth is "at risk" for developing antisocial behaviors consistent with a diagnosis such as Conduct Disorder, Oppositional Defiant Disorder, Disruptive Behavioral Disorder NOS or Substance Abuse Disorders.

*The youth meets any **ONE** of the following:*

4. The youth manifests delinquent or antisocial behaviors which may include any of the following:
   a. The youth is physically aggressive at home, at school or in the community.
   b. The youth manifests verbal aggression, which may include verbal threats of harm to others.
5. The youth is at imminent risk of out-of-home placement due to his/her behavioral problems.
6. The youth is adjudicated.
7. The youth is a chronic or violent juvenile offender.
8. The youth manifests substance abuse issues in the context of the behavioral problems.
9. The youth is transitioning from a residential placement and his/her behavioral challenges threaten the success of the transition.

CONTINUED STAY CRITERIA - ***All** of the following criteria are necessary for continuing treatment at this level of care*:

1. The CASII and other relevant information indicate that the youth continues to need the FFT level of care.
2. The severity of the behavioral disturbance continues to meet the criteria for this level of care.
3. The youth's treatment does not require a more intensive level of care and no less intensive level of care would be appropriate.
4. A comprehensive treatment plan has been developed, implemented and updated with realistic goals and objectives clearly stated. The treatment plan is based on the youth's clinical condition, his/her response to treatment and the strengths of the family.
5. Individualized services are tailored to achieve optimal results in a time efficient manner and are consistent with sound clinical practice.
6. Progress in treatment is clearly evident in objective terms but goals of treatment have not yet been fully achieved. In addition, adjustments in the treatment plan are evident to address any lack of progress.
7. The family is actively involved in treatment. Or, there are active, persistent efforts being made that are expected to lead to engagement in treatment.
8. When clinically necessary, appropriate psychopharmacological treatment has been initiated.
9. There is documented evidence of active, individualized discharge planning.

DISCHARGE CRITERIA - ***Any** of the following criteria is sufficient for discharge from this level of care:*

1. The youth and family have reasonably met and sustained a majority of the overarching treatment goals.
2. The CASII and other relevant information indicate that the youth no longer needs the FFT level of care.
3. The youth's behavioral problems have improved and the family is able to effectively manage any recurring problems.

4. The youth and the family have functioned reasonably well for at least three (3) to four (4) weeks. The youth is making reasonable educational/vocational efforts. The youth is involved with pro-social peers and is not involved with (or is minimally involved with) problem peers. The therapists and supervisor believe that the caregivers have the knowledge, skills, resources and support needed to handle subsequent problems.
5. Few of the overarching goals have been met. Despite consistent and repeated efforts by the therapists and supervisor to overcome the barriers to further success, the treatment has reached a point of diminishing returns for the additional time invested. That is, the youth and family have not benefited from treatment despite documented efforts to engage and there is no reasonable expectation of progress at this level of care.
6. The youth and/or the parent withdraw consent for treatment.
7. The youth meets criteria for a more (or less) intensive level of care.

EXCLUSION CRITERIA- ***Any*** *of the following is sufficient for exclusion from this level of care:*

1. The youth's parent/guardian/custodian does not voluntarily consent to treatment.
2. There is no identifiable primary caregiver to participate in treatment despite efforts to locate extended family, adult friends and other potential surrogate caregivers.
3. The youth can be safely maintained and effectively treated in a less intensive level of care.
4. The CASII and other relevant information indicate that the youth needs a more (or less) intensive level of care.
5. The youth is actively psychotic or at imminent risk of causing serious harm to self or others, potentially indicating a need for psychiatric hospitalization and stabilization.
6. The youth is experiencing problems that are primarily psychiatric rather than behavioral.
7. The youth has been diagnosed with a sole diagnosis of Autism Spectrum Disorder or an Intellectual Developmental Disorder and there is no co-occurring DSM 5 diagnosis or symptoms/behaviors consistent with a DSM 5 Diagnosis.
8. The youth does not have the cognitive capacity to utilize therapy or have a parent without such capacity.
9. The youth's sole diagnosis is substance abuse, and the emotional or behavioral disturbances appear to be mainly correlated with substance use, either intoxication or acute withdrawal effects of substances being used.
10. The youth is a juvenile sex offender who does not manifest other delinquent or antisocial behaviors.
11. The youth is living independently, or in serial foster care or in a long term residential treatment setting.

Multi-Systemic Therapy (MST)

Multi-Systemic Therapy (MST) is a home-based intensive family and community-based treatment that addresses multiple aspects of serious conduct related behavior in adolescents. MST typically targets chronic, aggressive youth who are at high risk of out-of-home placement. MST recognizes that many "systems" (family, schools, neighborhood/community, and peers) play a critical role in a youth's world and impacts their behavior. Each system requires attention when effective change is needed to improve the quality of life for youth and their families.

MST strives to promote behavior changes in the youth's natural environment, using the strengths of each system to facilitate change. Therapeutic contacts emphasize the positive and use systemic strengths as levers for change. Interventions promote responsible behavior among family members and are present-focused, action-oriented and developmentally appropriate. In addition, the interventions target specific, well-defined problems and are designed to require daily or weekly effort by family members. They incorporate strategies that promote treatment generalization and long-term maintenance of therapeutic change.

Goals of MST include the following:

- Decrease psychiatric symptoms;
- Decrease substance use;
- Increase caregivers' parenting skills and increase resources necessary to help them independently address difficulties that arise;
- Improve functioning by empowering youth to cope with family, peer, school and neighborhood problems;
- Reduce the use of out-of-home placements (e.g., incarceration, residential treatment, hospitalization); and
- Strengthen family relations and improve family functioning.

MST incorporates empirically-based treatments insofar as they exist. MST programs include cognitive behavioral approaches, behavior therapies, behavioral management parent training, pragmatic family therapies, and certain pharmacological interventions that have a reasonable evidence base.

MST is designed to overcome barriers to service, to increase family retention in treatment, to allow for the provision of intensive services (i.e., therapists have low caseloads of 4-6 families each), and to enhance the maintenance of successful behavior changes. MST intervention is available to youth and families 24 hours a day, 7 days a week via an on-call system that is staffed by MST team members. The average client receives 2-4 hours of direct service per week. Length of Service: 3-5 months

MONITORING AND ASSESSMENT OF SERVICE DELIVERY

The licensing agreement and contracts between MST Services, the network partner and the provider include monitoring activities to ensure fidelity to the MST model, as described below. Adherence to the model is monitored through the administration of two measures:

Therapist Adherence Measure-revised (TAM-R)
Supervisor Adherence Measure (SAM)

The online database also collects case-specific information, including the percentage of cases successfully completing MST and whether specific instrumental and ultimate outcomes have been achieved at discharge. The provider will ensure that the MST program collects TAM-R and SAM, as required by the model, and that this data is entered into the online database in a timely fashion.

Every 6 months, a program implementation review is completed by the system supervisor and MST clinical supervisor for each team. This review includes completion of a program review form, a narrative summary of the program's strengths and weaknesses and recommendations. This review is used to monitor the team's fidelity to the model and troubleshoot problem areas.

BILLING

MST is a comprehensive service. MST will typically not be billed in conjunction with other behavioral health services with the exception of psychiatric evaluation and medication management. An approved list of applicable codes is attached.

PROVIDER QUALIFICATIONS:

- MST therapists must possess a Masters degree and receive weekly supervision from a Doctoral or Masters level mental health professional.
- Therapist must attend 5 day MST training on the theory and techniques of the treatment model. Training is provided by The MST Institute (MSTI). All registrants of the training must be part of a licensed MST team or organization.
- MST therapists must be full-time employees assigned solely to the MST program.
- Integrity is supported and reinforced through weekly consultation with an MST expert/consultant.
- Provider must be recognized as a licensed MST team. Licensure indicates an agreement to implement the Multi-Systemic Therapy (MST) model with full fidelity in order to achieve positive outcomes for youth and families. This is accomplished by complying with all of the policies and procedures in the MST Manuals in connection with the training of staff in licensed MST programs. It also indicates an agreement to ensure that all of its employees involved with the MST System are competent and fully trained in the use of the MST System. *Licensure signifies that the Organization has complied with the above standards and has met the required criteria in the following areas: Quality Assurance data collection, program drift monitoring data collection, contract status and payment status.*

ADMISSION CRITERIA – *The youth must meet **1,2 and 3** and at least **ONE** from **4 through 8.***

1. The youth is between the ages of 12 and 17.
2. The CASII and other relevant information indicate that the youth needs MST treatment.
3. The youth manifests behavioral symptoms consistent with an ICD 10 / DSM 5 diagnosis that requires MST intervention (e.g. Conduct Disorder, Oppositional Defiant Disorder, Disruptive Behavioral Disorder NOS, etc.).

The youth meets any **ONE** *of the following:*

4. The youth manifests delinquent or antisocial behaviors which may include any of the following:
    a. The youth is physically aggressive at home, at school or in the community.
    b. The youth manifests verbal aggression, which may include verbal threats of harm to others.

5. The youth is at imminent risk of out-of-home placement due to the delinquent or antisocial behaviors.
6. The youth is adjudicated.
7. The youth is a chronic or violent juvenile offender.
8. The youth manifests substance abuse issues in the context of the delinquent or antisocial behavior problems.

CONTINUED STAY CRITERIA - ***All*** *of the following criteria are necessary for continuing treatment at this level of care*:

1. The CASII and other relevant information indicate that the youth continues to need the MST level of care.
2. The severity of the behavioral disturbance continues to meet the criteria for this level of care.
3. The youth's treatment does not require a more intensive level of care and no less intensive level of care would be appropriate.
4. A comprehensive treatment plan has been developed, implemented and updated with realistic goals and objectives clearly stated. The treatment plan is based on the youth's clinical condition, his/her response to treatment and the strengths of the family.
5. Individualized services are tailored to achieve optimal results in a time efficient manner and are consistent with sound clinical practice.
6. Progress in treatment is clearly evident in objective terms but goals of treatment have not yet been fully achieved. In addition, adjustments in the treatment plan are evident to address any lack of progress.
7. The family is actively involved in treatment. Or, there are active, persistent efforts being made that are expected to lead to engagement in treatment.
8. When clinically necessary, appropriate psychopharmacological treatment has been initiated.
9. There is documented evidence of active, individualized discharge planning.

DISCHARGE CRITERIA - ***Any*** *of the following criteria is sufficient for discharge from this level of care:*

1. The youth and family have met and sustained a majority of the overarching treatment goals.
2. The CASII and other relevant information indicate that the youth no longer needs the MST level of care.
3. The youth's behavioral problems have improved and the family is able to effectively manage any recurring problems.
4. The youth and the family have functioned reasonably well for at least three (3) to four (4) weeks. The youth is making reasonable educational/vocational efforts. The youth is involved with pro-social peers and is not involved with (or is minimally involved with) problem peers. The therapist and supervisor believe that the caregivers have the knowledge, skills, resources and support needed to handle subsequent problems.
5. Few of the overarching goals have been met. Despite consistent and repeated efforts by the therapist and supervisor to overcome the barriers to further success, the treatment has reached a point of diminishing returns for the additional time invested. That is, the youth and family have not benefited from treatment despite documented efforts to engage and there is no reasonable expectation of progress at this level of care.
6. The youth and/or the parent withdraw consent for treatment and there is no court order requiring such treatment.
7. The youth meets criteria for a more (or less) intensive level of care.

EXCLUSION CRITERIA: ***Any*** *of the following is sufficient for exclusion from this level of care:*

1. The youth and/or parent/guardian/custodian does not voluntarily consent to treatment.
2. There is no identifiable primary caregiver to participate in treatment despite efforts to locate all extended family, adult friends and other potential surrogate caregivers.
3. The CASII and other relevant information indicate that the youth needs a more (or less) intensive level of care.
4. The youth is at imminent risk of causing serious harm to self or others, potentially indicating a need for psychiatric hospitalization and stabilization.
5. The youth is actively psychotic or in need of crisis psychiatric hospitalization or stabilization.
6. The youth has been diagnosed with schizophrenia.
7. The youth is experiencing problems that are primarily psychiatric rather than behavioral.
8. The youth has been diagnosed with a sole diagnosis of Autism Spectrum Disorder or an Intellectual Developmental Disorder and there is no co-occurring DSM 5 diagnosis or symptoms/behaviors consistent with a DSM 5 Diagnosis.
9. The youth's level of cognitive ability does not allow him/her to benefit from the MST therapeutic interventions.
10. The youth's sole diagnosis is Substance Abuse, and the emotional or behavioral disturbances appear to be mainly correlated with substance use, either intoxication or acute withdrawal effects of substances being used.
11. The youth is a juvenile sex offender who does not manifest other delinquent or antisocial behaviors.
12. The youth is living in a long term residential treatment setting.
13. The youth can be safely maintained and effectively treated in a less intensive level of care.

Crisis Residential Service Clinical Necessity Criteria

A Crisis Residential Service is a substitute care setting that may be utilized for a period of up to 72 hours, when such substitute care will facilitate effective implementation of crisis intervention services.

Primary Considerations:

I. A crisis residential service should not be used when other appropriate resources, e.g., extended family, are available to provide support and care.

II. The child would be at increased risk for hospitalization or other 24 hour care if the crisis residential service is not utilized.

Mobile Response and Stabilization Services (MRSS)

Service Description

Mobile Response and Stabilization Services are available 24 hours per day, 7 days a week, 365 days per year including weekends and holidays. Mobile Response and Stabilization Services are delivered to youth experiencing escalating emotional symptoms, behaviors or traumatic circumstances, which have compromised or impacted the youth's ability to function at their baseline within their family, living situation, school and/or community environments. These potential, actual or perceived crises arise from situations, events, and/or circumstances that are unable to be resolved with the usual resources and coping abilities. Without Mobile Response and Stabilization Services, the youth's risk of out of home treatment, legal charges, loss of their living arrangement or psychiatric hospitalization increases.

Mobile Response and Stabilization Services are comprised of three components: The initial call (triage), Phase 1 (face-to-face initial mobile response) and Phase 2 (face-to-face stabilization activities and service transition).

Initial Call and Triage

The initial call is made to the 24/7 Mobile Response Hotline at 1-800-969-HELP (4357) by the family or another concerned party. All calls will be screened by trained, qualified call center staff who will obtain parental consent, collect demographic information, conduct a brief safety screen (triage) and complete a Division of Prevention and Behavioral Health Services hotline/crisis intake event in the State database. The safety screen consists of a series of questions to assist the call taker in assessing the current risk and/or climate of the current situation and allows them to triage calls appropriately. The call center staff uses the information obtained along with the caretaker's input to determine the following:

- The need for medical clearance prior to an assessment (may include detoxification services if required);
- If an ambulance or police need to be dispatched in lieu of <u>or</u> in addition to a Mobile Response Worker (call center staff will ensure this connection is made);
- It is in the best interest of the child for a psychiatric facility or Emergency Room to assess the child without Mobile Response and Stabilization Services involvement; or
- If an existing treatment service provider's response may be more suitable for the current situation.
    - For children/youth who are active with the Division of Prevention and Behavioral Health Services., the call center staff will notify the Child and Family Care Coordinator of the call and the Child and Family Care Coordinator will be responsible for follow-up with the current service provider.
    - For children/youth who are not active with the Division of Prevention and Behavioral Health Services, the call center staff will strongly encourage the family to contact the current service provider for follow-up.

For instances when the triage does not warrant dispatch of a Mobile Response Worker, the caller is provided with verbal support and is provided information or referrals to appropriate resources and service(s).

*There is no direct billable code available for use by the provider for this intervention. This component of the service is included in the billable rate for Phase 1.

Phase 1

Cases in which it is determined a face-to-face intervention is appropriate, the call center worker contacts the Mobile Response and Stabilization Service which is designated by the county of origin of the referred child/youth. The call center worker transfers the written and/or electronic Division of Prevention and Behavioral Health Services hotline/crisis intake information to the Mobile Response Worker (this includes demographics, circumstances which prompted call, callers response to the safety screen questions) and whenever possible, includes a "warm hand-off" of the call to the Mobile Response Worker. The "warm hand-off" allows the caller to be directly connected to the Mobile Response Worker who will be responding. A Mobile Response Worker responds within one hour of receiving the dispatch request unless the caller requests a delayed response. The Mobile Response Worker will conduct the

assessment utilizing the Crisis Assessment Tool. At the conclusion of the assessment and prior to determining final disposition, the Mobile Response Worker will consult with a Licensed Supervisor (this may be by phone or in person) and create a safety plan with the family. The Mobile Response Worker will not leave the assessment until the family has the safety plan document. During the initial 72 hours the Mobile Response Worker will also complete the Individualized Crisis Plan. Both the Crisis Assessment Tool and Individualized Crisis Plan will be submitted to the Division of Prevention and Behavioral Health Services and entered into the State's database. These required documents are described below.

Crisis Assessment Tool
The Crisis Assessment Tool is a decision support and communication tool to allow for the rapid and consistent communication of the needs of children/youth experiencing a crisis that threatens their safety or well-being or the safety of the community. A 30-day window is used to make sure the assessment is relevant to the child/youth's present circumstances. The Crisis Assessment Tool triggers modules for further assessment that can be completed at the Mobile Response workers discretion within the 72-hour initial response. The Crisis Assessment Tool provides information necessary to inform the Child and Adolescent Service Intensity Instrument, which is completed by Division of Prevention and Behavioral Health Services if indicated, to determine eligibility for additional behavioral health services.
Additional Assessment Tools: Beck Depression Inventory, Beck Anxiety Inventory, and the Columbia Suicide Severity Rating Scale.

Individualized Crisis Plan
The Individualized Crisis Plan is completed for each youth within 72 hours of the initial response. The plan is completed with input from the child/youth and family and focuses on the strengths and needs of the child/youth and family identified in the Crisis Assessment Tool. The plan is tailored to the needs of the child/youth and family with the goal of the plan to include appropriate interventions that will be useful in deescalating the crisis and promoting stabilization. The Individualized Crisis Plan is a comprehensive plan that describes behaviors, strategies, and desired outcomes that will be useful for resolving the emotional distress or escalating behavior that instigated the initial call. The Individualized Crisis Plan will include a service recommendation for transition to ongoing services as needed.

*Per the Delaware State Plan Amendment, an emergent service is authorized up to (six) 6 hours per episode. However, this may be exceeded based on medical necessity per the Early and Periodic Screening and Diagnostic Testing. Services are authorized by the Division of Prevention and Behavioral Health Services for up to seventy-two (72) hours per episode. An episode is defined as the initial face-to-face contact with the individual until the current crisis is resolved, not to exceed seventy-two (72) hours without prior authorization by the Division of Prevention and Behavioral Health Services. The individual's chart must reflect resolution of the crisis, which marks the end of the current episode. If the individual has another crisis within seven (7) calendar days of a previous episode, it will be considered part of the previous episode and not a new episode. Initial authorizations can be exceeded in all instances where it is medically necessary to do so through prior authorization by the Division of Prevention and Behavioral Health Services.
*The service code used for this service is H2011 and is billed in 15 minute increments.

Phase 2
The second phase of Mobile Response and Stabilization Services includes stabilization interventions which serve as a transition option after Phase 1. The goal of Phase 2 Mobile Response and Stabilization Services is to identify and integrate additional services as needed, and to provide the child/youth and caregiver with short-term service coordination and support where there is no existing clinical care coordination to assist in stabilizing youth in their community setting. Interventions may include, but are not limited to, crisis intervention, counseling and behavioral assistance. Services during this phase are coordinated and delivered consistently through the continued development of a comprehensive Individualized Crisis Plan. Care planning takes a trauma-informed approach and is individualized, collaborative and flexible based on youth and family need. Phase 2 services are grounded in core System of Care

values and principles. Care is strength based, youth centered and family driven, community based, trauma sensitive, culturally and linguistically mindful.

Phase 2 services may be delivered until transfer occurs to another provider for support, not to exceed 30 days. When assessed for care coordination services or other treatment services it is expected that transfer to these supports occurs at the beginning of Phase 2 or as expeditiously as possible. Use of these services will vary by setting, intensity, duration and identified needs. The objective of these services is to stabilize the current crisis and help facilitate the child/youth and caregiver's transition into identified supports, resources and services, which are consistent with their treatment needs and which support a sustainable plan. Continued assessment of the child/youth and family needs will determine which referral(s) will best meet their needs. This may involve linking the family with longer-term care coordination services, outpatient services, evidence-based programs, community-based supports and informal and natural resources. The child/youth must be authorized by a Division of Prevention and Behavioral Health Services worker to receive Phase 2 support.

*Reimbursement for services provided in Phase 2 will be billed utilizing the Division of Prevention and Behavioral Health Services' approved Service Codes. A complete list of the eligible codes can be found on the Division of Prevention and Behavioral Health Services website under the Billing Section: http://kids.delaware.gov/pbhs/pbhs_providers_billing.shtml.

TREATMENT APPROACH:
Mobile Response and Stabilization Services staff are trained in the following evidence informed approaches and promising practices to ensure the needs of the child/family are met:

- Sanctuary Model Approach – represents a theory-based, trauma-informed, trauma responsive, whole culture approach. The aims of the Sanctuary Model are to guide an organization in the development of a trauma-informed culture, which serves goals related to recovery from trauma while creating a safe environment.
- Nurtured Heart – consists of a set of strategies that assists children in further developing their self-regulation and has been found effective with children of all ages. This is aligned with current theoretical perspectives and empirical evidence in family studies and developmental science. The Nurtured Heart approach is a valuable strategy for parents to establish a set of clear rules and consequences.
- Solution Focused Therapy – future focused and goal directed. Focuses on solutions rather than the problems that brought the individual into crisis.
- Brief Therapy – a systematic, focused based process that relies on assessment, client engagement and rapid implementation of change strategies. Providers can affect important changes in client behavior within a relatively short period.
- Strengths Based Approach – concentrates on the inherent strengths of the individuals, families and groups to aid in recovery and empowerment.
- Motivational Interviewing – a client-centered counseling approach for eliciting behavior change by helping the individual to explore and resolve ambivalence. Focused and goal directed.
- Stages of Change – individuals progress through different stages of change at their own rate.

Goals of Mobile Response and Stabilization Services:

- To rapidly respond when the need for Mobile Response and Stabilization Services is indicated.
- Provide immediate intervention to assist youth and their caregivers in de-escalating behaviors, emotional symptoms and/or dynamics impacting the youth's life functioning ability.
- Effectively engage, assess, deliver, and plan for appropriate interventions to minimize risk, aid in stabilization of behaviors, and improve life functioning.
- To support the youth to remain in, or return to, their present living arrangement, function in school and community settings, and maintain the least restrictive treatment setting by providing timely community based intervention, support and resource development.
- Facilitate the youth's and the caregiver's transition into identified supports, resources, and services including, but not limited to, continued Mobile Response and Stabilization Services, Child and Family Care

Coordination Services, outpatient services, evidence-based services, community based supports and natural resources. Eligibility for some services will be determined by the Division of Prevention and Behavioral Health Services Access Unit.

Anticipated Length of Stay:
Phase 1: Up to 72 hours
Phase 2: Up to 30 days. In rare cases, services may be required beyond 30 days. This extension requires prior authorization by the Division of Prevention and Behavioral Health Services.

MONITORING AND ASSESSMENT OF SERVICE DELIVERY

- On-site monitoring.
- Routine chart reviews.
- Analysis of client services through internal Utilization Review processes reported monthly to the Division of Prevention and Behavioral Health Services..
- Client satisfaction surveys.
- Compliance with the Division of Prevention and Behavioral Health Services. requirements are continually evaluated as part of the monitoring process.

BILLING
Only approved codes may be used by the provider based on the qualifications of the individual providing the stabilization services and the type of service being delivered. The selected code must meet the requirements of the service being provided and documentation must support the use of the selected code.
Invoices will be submitted in compliance with the Division of Prevention and Behavioral Health Services Provider Manual.

PROVIDER QUALIFICATIONS

- At a minimum, call center staff will possess a Bachelor's degree in psychology, social work, or other human service field and have a minimum of 2 years experience. Individuals that do not meet the minimum requirements stated above may be considered for employment with Mobile Response and Stabilization Services based on exceptional experience. These applicants' resumes will be reviewed with the Division of Prevention and Behavioral Health Services;
- At a minimum, Mobile Response Workers must possess a Master's or Doctoral degree which qualifies for licensure as one of the following in the State of Delaware: Licensed Clinical Social Worker (LCSW), Licensed Professional Counselor of Mental Health (LPCMH), Licensed Marriage and Family Therapist (LMFT) or Licensed Psychologist. It is expected that individuals who do not possess a license are in the process of obtaining required clinical supervision hours toward their professional licensure. Individuals that do not meet the minimum requirements stated above may be considered for employment with Mobile Response and Stabilization Services based on exceptional experience. These applicants' resumes will be reviewed with the Division of Prevention and Behavioral Health Services;
- Licensed Mental Health providers will be enrolled and paneled with Delaware Medicaid;
- Unlicensed Response Workers must participate in weekly clinical supervision provided by a licensed mental health professional. Documentation of weekly supervision is required and will be presented to the Division of Prevention and Behavioral Health Services upon request;
- Response Workers must be certified in the State of Delaware to provide the service, which includes completion of basic training topics including recovery, resiliency, cultural competency, safety, care coordination, risk management and suicide prevention, post-intervention, person-centered care and de-escalation techniques;
- Training:

  Prior to performing duties described in the Mobile Response and Stabilization Services description, both Call Center and Mobile Response and Stabilization Service Workers must complete the following required trainings:

- Completing a Call Center Triage
- Conducting an assessment utilizing the Crisis Assessment Tool

* Workers will demonstrate their ability to perform these tasks prior to performing these tasks.

In addition to these initial trainings, Call Center and Mobile Response and Stabilization Service Workers will participate in the Legacy Treatment Services' Mobile Response and Stabilization Services training curriculum (currently 12 days). Employees providing Mobile Response and Stabilization Services are to complete this training over the first 12 months of employment (please see training curriculum document). Shadowing and reverse shadowing are required. Providers will require new staff to participate in their agency orientation training.

- Response Workers' training and certifications will be documented and presented to the Division of Prevention and Behavioral Health Services, upon request. This includes documentation of reported degrees by accredited universities and certifications to deliver evidence based practices, etc.;
- Maintain professional boundaries and behavior, as specified by their professional Code of Ethics/Conduct, during interactions with all staff and clients;
- Possess a valid drivers' license;
- Be properly insured to provide contracted services;
- Pass a criminal background check as required in the contract; and
- Comply with additional requirements as stated in the Division of Prevention and Behavioral Health Services. Provider Manual.

ADMISSION CRITERIA: *The youth must meet **all** criteria below:*

1. The youth is between the ages of 0 and 18 and is a resident of Delaware. Eligibility for services is in place until the youth's 18th birthday. *Eligibility for Non-Residents of the State of Delaware – Mobile Response and Stabilization Services may be provided to non-resident children/youth under the age of 18 who are in Delaware.*
2. The youth's caregiver voluntarily consents to treatment. *In instances in which there is an imminent risk of safety and documented good faith attempts have been made to reach the caregiver without success, an initial assessment may be completed without parental consent.*
3. The youth exhibits escalating emotional and/or behavioral needs, which adversely impact the youth's ability to function at their baseline in one or more life domains (family, living situation, school, community).
4. The Call Center's safety screen, triage and other relevant information indicate that the youth needs Mobile Response intervention to prevent further behavioral and/or emotional escalation and the need for a higher intensity of intervention. Response expectation is within 1 hour of dispatch.
5. There is evidence, based on the safety screen, triage, and other relevant information, that urgent intervention can be reasonably expected to:
    - Resolve or prevent further behavioral/emotional escalation or impairment in functioning.
    - Return youth and family to baseline functioning or improve the youth's emotional symptoms and behaviors.
    - Improve coping skills and resources to help preserve optimal functioning in life domains (family, living situation, school, community).

CONTINUED STAY CRITERIA: ***All** of the following criteria are necessary for continuing treatment at this level of care*:

1. The Crisis Assessment Tool, Individualized Crisis Plan and other relevant information indicate that the youth continues to need this level of service.
2. Interventions are focused on reducing risk and behavioral symptoms and on improving caregiver capability.
3. The interventions are focused on reducing the movement of the youth from one living arrangement to another or on maintaining the youth in the community.
4. The mode, intensity and frequency of the interventions are consistent with the intended Individualized Crisis Plan /treatment plan outcomes.
5. There is documented evidence of active, individualized transition planning.

DISCHARGE CRITERIA: ***Any*** *of the following criteria is sufficient for discharge from this level of care:*

1. The youth and family have reasonably met and sustained a majority of the overarching treatment goals outlined on the Individualized Crisis Plan
2. The youth and family have successfully connected with another treatment provider who can reasonably respond to and treat the youth and family's needs.
3. The youth meets criteria for a more (or less) intensive level of care.
4. The Child and Adolescent Service Intensity Instrument and other relevant information indicate that the youth no longer needs this level of care.
5. The youth's behavioral problems have improved and the family is able to effectively manage any recurring problems.
6. The parent withdraws consent for treatment.
7. The youth's physical condition necessitates transfer to a medical, psychiatric, or substance use treatment facility.

EXCLUSION CRITERIA: ***Any*** *of the following criteria is sufficient for exclusion from this level of care:*

1. The safety screen, triage and other relevant information indicate that the youth does not need Mobile Response and Stabilization Services.
2. The youth's caregiver does not voluntarily consent to treatment (beyond the initial response in extenuating circumstances).
3. The youth's caregiver has refused Mobile Response and Stabilization Services. *If call center staff feel the child is in imminent danger to self or others, DFS may be contacted in certain situations.*
4. The emotional and or behavioral symptoms are the primary result of a medical condition that warrants medical treatment.
5. The youth appears to exhibit acute intoxication or withdrawal symptoms related to current, active alcohol and or substance use, which may require medical clearance prior to the child/youth being assessed.

Date of Revision: 5/22/17 *This is the current service description for Mobile Response and Stabilization Services. Any revisions made to this document moving forward will be reflected in the Provider Manual.

Day Treatment, Mental Health and Substance Abuse

Day Treatment Services offer person-centered, culturally and linguistically appropriate, comprehensive, coordinated and structured treatment service and activities. Day treatment services are available a minimum of 4 days per week and up to 7 days per week, providing a minimum of 3 hours of treatment per day. Daily treatment includes no less than 2 hours of individual, group or family therapy and 1 hour of psycho-education or other therapies as appropriate. Services may be delivered during day time hours, after school, in the evening or on weekends. Psychiatric services will be available as a component of Day Treatment.

Day Treatment services are clinical in nature and youth participating in Day Treatment must meet clinical necessity for this service. Day Treatment is time-limited and specific interventions and individualized goals will be clearly documented in the youth's individualized treatment plan.

Day treatment services are designed to be short term with the goal of returning students to their home school as quickly as possible. Evidence that the Day Treatment provider and the youth's school are in continuous, close collaboration in preparation for the youth's transition back to school will be documented in the youth's clinical record. Youth safety is always considered prior to transitioning youth back to their natural school environment. Day Treatment Services will, in collaboration with the youth, family and school, develop a school transition plan and the service is expected to remain active during the youth's return to school, providing adequate support for the youth to ensure a successful transition.

Day treatment capacity and staffing requirements must be in compliance with OCCL standards.

The goals of Day Treatment include the following:

- Support the youth's successful transition back to their home school setting.
- Provide a short-term, time-limited step-down for youth transitioning out of an inpatient or residential treatment setting.
- Minimize the need for higher intensity services (ie. Residential and Inpatient Hospitalization).
- Enhance self-awareness and improve the youth's ability to develop and maintain healthy relationships.

7.1.1.1.1.1 Recommended Duration of Service: Average length of service should be 2-8 weeks. Authorization will be no more than 90 days.

Service Components:

Individual Therapy: All clients of day treatment, mental health services will be seen for a minimum of 2 individual sessions per week. Individual sessions may occur more frequently as clinically appropriate. Therapy is conducted by a Masters level or Licensed Therapist or a CADC for Substance Use services with a focus on the presenting problems identified on the youth's treatment plan. A progress note for this service must be present in the client's record.

Family Therapy: Clients with active and available caregivers will participate in a minimum of one family session per week. "Family" sessions may include the youth's biological family (immediate and/or extended), foster family, residential rehabilitation clinical staff, Division of Family Services for youth in custody of the State, other people the client identifies as "family" and who play a supportive role in the youth's life. Family therapy is conducted by a Masters level or Licensed Therapist or a CADC for

Substance Use services with a focus on the presenting problems identified on the youth's treatment plan. A progress note for this service must be present in the client's record.

Group Therapy: Group therapy is conducted by a Masters level or Licensed Therapist, or a CADC for Substance Use services, with a focus on the presenting problems identified on the youth's treatment plan. A progress note for each Group Therapy session must be present in the client's record.

Psychiatry: Each client will be provided no less than monthly on-site psychiatric services for a minimum of 15 minutes for medication monitoring. New clients will be evaluated by a psychiatrist within 72 hours of admission to the program.

Psycho-education: Clients will participate in Psycho-education as appropriate. Psycho-education is provided by unlicensed staff and are relevant to the client's treatment as stated on the youth's treatment plan. A minimum of 4 hours per week of psycho-education will be provided for each client. A progress note for this service must be present in the client's record.

Psychosocial Rehabilitation (PSR): Clients participating in day treatment services will receive supervision by staff which will comply with OCCL regulations. These services may be provided by individuals with a minimum of a High School Diploma (or equivalent) and be at least 21 years of age.

Transition Support: Day Treatment Service providers will ensure youth are properly transitioned back to their home school settings. Services will be available to support the child and school staff in managing client's behaviors and addressing emotional challenges as the youth engages in the transition. Documentation of these services must be present in the client's record. Transition services may be delivered by a Masters level or Licensed therapist, CADC for Substance Use services, Educational staff or Bachelor level staff as appropriate.

Education: Clients who attend Day Treatment Services may have access to educational support services which will be provided by or coordinated with the youth's home school.

PROVIDER QUALIFICATIONS

- All Day Treatment staff must:
  - Be at least 21 years of age.
  - Possess a high school diploma (or equivalent) at a minimum.
  - Possess a valid drivers' license.
  - Pass a criminal background in compliance with DSCYF standards.
- At a minimum, day treatment therapists will possess a Masters or Doctoral degree in psychology, social work, or other human service field. The degree held must qualify for licensure as one of the following in the State of Delaware: Licensed Clinical Social Worker (LCSW), Licensed Professional Counselor of Mental Health (LPCMH), Licensed Marriage and Family Therapist (LMFT) or Licensed Psychologist. It is expected that individuals who do not possess a license are in the process of obtaining required supervised clinical hours toward their professional licensure.
- For Substance Use Day Treatment, a LCDP or CADC is qualified to provide counseling services.

- Providers will be enrolled with Delaware Medicaid and Licensed Mental Health Professionals will be paneled with the Delaware Medicaid MCO's.
- Unlicensed or uncertified therapists must participate in weekly clinical supervision provided by a licensed mental health professional. For Substance Use, supervision may be provided by a LCDP/CADC. Documentation of weekly supervision is required and will be presented to DPBHS upon request.
- Therapist training and certifications will be documented and presented to DPBHS upon request. This includes documentation of reported degrees by accredited universities and certifications to deliver evidence based practices, etc.
- Psychiatric services will be provided by a Delaware Medicaid paneled and licensed child and adolescent psychiatrist, general psychiatrist, or Advanced Practice Psychiatric/Mental-Health Nurse Practitioner (who has a Collaborative Agreement with a psychiatrist). Assessment, prescribing and treatment practices will be consistent with all of the American Academy of Child & Adolescent Psychiatry Practice Parameters.
- Maintain professional boundaries and behavior, as specified by their professional Code of Ethics/Conduct, during interactions with all staff and clients.
- Providers should be capable of third party billing.
- Be properly insured to provide contracted services.
- Comply with additional requirements as stated in the DPBHS Provider Manual, the DSCYF Operating Guidelines and the Office of Child Care Licensing Regulations for Day Treatment.

ADMISSION CRITERIA: *Youth meets **ALL** criteria 1-4:*

1. Youth is under the age of 18 and is found eligible for DPBHS services;
2. Documentation from a licensed mental health practitioner and the ADT Committee recommending this level of service must be present.
3. Youth is diagnosed with a covered DSM 5 / ICD 10 by a Licensed Mental Health Professional or a LCDP/CADC for Substance Use services.
4. The CASII and other relevant information indicate the youth qualifies for Day Treatment services;

*And **at least one** of the following criteria:*

5. Youth presents with mental health and/or behavioral health challenges which interfere with the youth's ability to achieve success in their traditional school setting;
6. There is reasonable evidence that participation in a Day Treatment Service will improve the youth's ability to function in their traditional school setting.
7. The child's school is agreeable to collaborating with the Day Treatment provider to meet the educational and therapeutic needs of the youth and is agreeable to accept the child back into the youth's home school upon completion of the Day Treatment service.

CONTINUED STAY CRITERIA: ***All** of the following criteria are necessary continuing treatment at this level of care:*

1. Severity of illness and resulting impairment continues to require this level of service;

2. Services are focused on maintaining community based living or reintegration of the individual into the community and improving his/her functioning in order to decrease utilization of more intensive treatment alternatives (i.e. residential or inpatient);
3. Continued progress towards goals;
4. Treatment planning is individualized and appropriate to the individual or family's changing conditions;
5. Participation in the service is expected to improve the youth's ability to manage their behavior and function successfully in a traditional school environment;
6. The youth and family are actively involved in treatment. Or, there are active, persistent efforts being made that are expected to lead to engagement in treatment;

DISCHARGE CRITERIA: ***Any*** *of the following criteria are sufficient for discharge from this level of care:*

1. Individual or family's treatment plan and discharge goals have been substantially met;
2. Consent for treatment is withdrawn;
3. Individual or family meets criteria for a less/more intensive level of care; and/or
4. The child has successfully participated in a minimum of 2 school transition sessions with adequate educational and therapeutic supports present.

EXCLUSION CRITERIA: ***Any*** *of the following criteria are sufficient for exclusion from this level of care:*

1. Individual or family chooses not to participate in program.
2. The individual meets criteria for a more or less intensive level of care.
3. The individual cannot safely be maintained in this level of service.

Day Treatment Clinical Necessity Criteria

Day treatment provides intensive psychiatric services and a milieu facilitating a more successful adaptation to community and regular educational environments when 24 hour care and intensive psychiatric/medical monitoring are not necessary. Services are provided five (5) days a week.

Primary consideration:

I. **At least one of the following:**

A) **Self harm:** The client within the last two years has made a significant suicide attempt or gesture and currently threatens self -harm or self -mutilation, especially in combination with a history of substance abuse, significant depression, borderline personality disorder, or other significant psychiatric conditions.

B) **Danger to others:** The client has a serious psychiatric disorder such as psychosis or major affective disorder and displays behavior related to the psychiatric condition that may result in serious physical assault, sexual assault, or fire setting, or other major harm to others.

C) **Severe or Chronic Psychiatric disorder:** The client exhibits a psychiatric disorder such as major depression or chronic conditions that compromises functioning in multiple areas, and

requires intensive psychotherapeutic intervention and/or a milieu that facilitates social skill development and reintegration into a regular community school environment.

II. **Least restrictive:**
Twenty-four hour inpatient hospitalization or RTC or partial hospital care is not necessary and outpatient treatment (including office or home based services, or crisis intervention) has been attempted or considered and the youth has not made progress, or cannot reasonably be expected to make progress.

III. **Family participation:** Family members and/or significant others, in the client's support network (relatives, case managers, mentors) will commit to regular participation in the treatment process and to the client's return to the community.

Residential Rehabilitative Service (RRS)

Residential Rehabilitative Service (RRS) provides a 24 hour, supervised, residential living arrangement with intensive therapeutic services for children and adolescents with Behavioral Health disorders that impair their ability to be successful in community settings. Youth requiring RRS are diagnosed with varying Behavioral Health disorders and may present as a risk to themselves or others, require intense supervision, have difficulty self-regulating their behaviors and have not benefited from community based treatment services.

Services will be delivered in a trauma informed environment in conjunction with other evidence based practices. The focus of treatment is to resolve the primary presenting problems that necessitated the youth's need for this type of structured residential treatment service. Family involvement and participation in treatment is expected when identified caregivers are involved and community (and school) reintegration shall be supported, as clinically appropriate, for youth in residential care. Research shows improved outcomes with shorter length of stay, increased family involvement and stability and support in the post-residential environment (Walters & Petr, 2008). Services will embrace the following core principles:

- Family Driven & Youth Guided Care
- Cultural & Linguistic Competence
- Clinical Excellence & Quality Standards
- Accessibility & Community Involvement
- Transition Planning & Services (between settings & from youth to adulthood)

Scope of Clinical Service

- Use of evidence based practices provided in trauma informed care setting.
- Comprehensive integrative assessment, utilizing standardized assessment measures.
- Customized, flexible treatment consisting of weekly individual, group and family therapy sessions with the ability to adjust frequency of sessions to meet the particular needs of the youth and family.
- Community integration activities will be provided for youth who can safely participate.
- Crisis management and intervention. Safety Plans will be established in collaboration with youth, family and other supports upon admission.
- Case management services in coordination with Child and Family Care Coordination teams.
- Utilization review will occur regularly with DPBHS and may include consultation with formal and informal supports.
- Comprehensive discharge and aftercare planning in conjunction with the DPBHS.

Goals of Residential Rehabilitative Services (RRS):

- Stabilization of chronic problems and symptoms and adequate resolution to allow safe return of the child to the family and community.
- Design of aftercare treatment plans that can be effectively implemented upon return to the community

- For children in the state's custody, incorporation of permanency goals into the treatment and discharge plans and active coordination with the appropriate Community Based services.
- Reduction of recidivism of admission into acute psychiatric services by providing aftercare services and/or linkages with appropriate community services.
- Promote stability by decreasing frequency, intensity and duration of crisis episodes.
- Develop supports by promoting resiliency, promote age-appropriate functioning and understand the effects of the emotional disturbance or substance use.

Service Components:

- Individual Therapy
- Family Therapy
- Group Therapy
- Psycho-education
- Development of an individualized treatment plan with specific goals and interventions
- Psychiatric Services and Medication Management
- Educational Activities which meet the child's individual educational needs
- Consultations with other professionals in the community
- Discharge and Transition Planning

Recommended Duration of Service: 3-6 months

MONITORING AND ASSESSMENT OF SERVICE DELIVERY

Comprehensive integrative assessment, utilizing standardized assessment measures and tools. Assessment is a continuous process that begins at admission and continues throughout the various stages of treatment. Assessment types may include:

- Achenbach System of Empirically Based Assessment (ASEBA)
- The Addictions Severity Index
- Child and Adolescent Needs and Strengths (CANS)
- Child and Adolescent Service Intensity Instrument (CASII)
- Utilization Review which includes detailed report of child's progress of lack of progress in achieving treatment goals, highlights barriers or perceived barriers to treatment and evaluation of whether the youth meets the continued stay criteria for this level of service.

BILLING

The Provider may only submit claims approved for their use. The contract will specify which applicable codes are available for their use.

RRS per diem rates are not negotiable. RRS per diem rates are determined by the State and claims may only be submitted for the days the client resides in the facility. Clinical services such as individual, family and group therapies, psychiatric services will be billed separately utilizing DMMA approved codes and rates.

Educational costs are to be billed separately.

PROVIDER QUALIFICATIONS:

- Agency qualifications:
  - Facility has 16 beds or less.
  - Providers of Residential Rehabilitative Services will be an enrolled provider of the service with Delaware's Division of Medicaid and Medical Assistance (DMMA).
  - Providers of Residential Rehabilitative Services will be properly licensed with the state in which the facility is located.
  - Providers of Residential Rehabilitative Services will possess adequate professional and liability insurances.
  - Providers of Residential Rehabilitative Services ensure all staff meet the qualifications below. Documentation will be available for DPBHS review in the Employee's personnel file.

- Direct care staff qualifications:
  - Is at least 21 years old
  - Possesses a high school diploma or equivalent
  - Maintain professional boundaries and behavior
  - Possess a valid drivers' license
  - Pass a criminal background check as required in the contract
  - Comply with additional requirements as stated in the DPBHS Provider Manual.

- Therapists qualifications:
  - At a minimum, RRS therapists will possess a Master's or Doctoral degree in psychology, social work, or other human service field. The degree held must qualify for licensure. In the State of Delaware, this includes: Licensed Clinical Social Worker (LCSW), Licensed Professional Counselor of Mental Health (LPCMH), Licensed Marriage and Family Therapist (LMFT), Licensed Psychologist. It is expected that individuals who are not licensed are in the process of obtaining required clinical supervision hours toward their professional licensure.
  - Unlicensed therapists will receive weekly supervision by a licensed mental health professional as required in the DPBHS Provider Manual. Documentation of weekly supervision is required and will be presented to DPBHS upon request.
  - Maintain professional boundaries and behavior, as specified by their professional Code of Ethics/Conduct, during interactions with all staff and clients.
  - Possess a valid drivers' license.
  - Is properly insured to provide contracted services (as applicable).
  - Pass a criminal background check as required in the contract.
  - Comply with additional requirements as stated in the DPBHS Provider Manual.

- Clinical Supervisor qualification:
  - In Delaware, a Licensed Behavioral Health Practitioner (LBHP) includes: Licensed Clinical Social Worker (LCSW), Licensed Professional Counselor of Mental Health (LPCMH), Licensed Marriage and Family Therapist (LMFT), Licensed Psychologist.
  - The LBHP is available 24/7 to provide consultation to unlicensed staff.
  - Provides weekly supervision to all unlicensed staff under their supervision. Documentation of weekly supervision is required and will be presented to DPBHS upon request.
  - Reviews and signs off on assessments, treatment plans and discharge summaries of all unlicensed staff under their supervision.
  - Reviews client records and signs off on all clinical and direct services provided by unlicensed staff under their supervision.
  - Maintain professional boundaries and behavior, as specified by their professional Code of Ethics/Conduct, during interactions with all staff and clients.
  - Possess a valid drivers' license.
  - Is properly insured to provide contracted services (as applicable).
  - Pass a criminal background check as required in the contract.
  - Comply with additional requirements as stated in the DPBHS Provider Manual.

- Medication Management must be performed by an individual with credentials permitting medication management under State law including a licensed psychiatrist, an RN or an LPN. The credentialed professional must be enrolled with Delaware Medicaid. The credentialed professional must be at least 21 years old, be licensed in the State of Delaware or the state in which the facility is located to provide the service, have passed criminal, professional background checks.

ADMISSION CRITERIA: *The youth must meet all criteria below*

1. Youth is 17 years of age or younger and meets DPBHS eligibility criteria.
2. The ASAM/CASII and other relevant clinical information support the need for this level of care.
3. Documentation from a licensed mental health practitioner and the ART Committee recommending this level of service must be present.
4. The youth manifests behavioral symptoms consistent with an ICD 10/ DSM 5 diagnosis that requires residential treatment services.
5. The client's symptoms/behaviors indicate a need for continuous monitoring and supervision by 24-hour staff to ensure safety.
6. The symptoms interfere with the youth's ability to function across multiple domains.
7. Proposed aftercare placement/community-based treatment.
8. A prior authorization for the service is required.

CONTINUED STAY CRITERIA: ***All*** *of the following criteria are necessary for continuing treatment at this level of service*:

1. The CASII and other relevant information indicate that the youth continues to require this level of service.
2. There is adequate documentation from the provider that the member is receiving the scope and intensity of services required to meet the program goals stated in this Service Description.
3. Client is actively participating in treatment, or there are active efforts being made that can reasonably be expected to lead the child to engage in treatment.
4. The family/caregiver is involved in treatment as required by the treatment plan, or there are active efforts being made and documented to involve them.
5. Current/updated treatment plan to address progress or lack thereof warranting continued stay.
6. Current discharge criteria and discharge date and plan are provided.
7. If discharge date changes, an explanation as to rationale for change.

DISCHARGE CRITERIA: *Any of the following criteria is sufficient for discharge from this level of service:*

1. The client's caregiver requests discharge.
9. The goals of the individualized treatment plan have been substantially met and youth no longer meets the continued stay criteria.
10. Transfer to another service is warranted by a change in the youth's condition.
11. The youth has received maximum benefit or has failed to benefit from a reasonable course of RRS care, and documentation supports that a suitable alternative placement is established that will meet the youth's needs, and the discharge plan includes input from the youth, caregiver/legal guardian, and is supported by the Child and Family Team.

EXCLUSION CRITERIA: ***Any*** *of the following is sufficient for exclusion from this level of service:*

1. The youth does not meet DPBHS eligibility criteria.
2. The ASAM/CASII and/or other relevant information indicate that the youth/family's treatment needs are not consistent with this level of service.
4. The Caregiver does not voluntarily consent to treatment.
5. The behavioral symptoms are the result of a medical condition that warrants a medical setting for treatment.

Psychiatric Residential Treatment Facility (PRTF)

A Psychiatric Residential Treatment Facility (PRTF) is defined by the Centers for Medicare and Medicaid Service (CMS) as a "separate, stand-alone entity providing a range of comprehensive services to treat the psychiatric condition of youth on an inpatient basis under the direction of a physician. The purpose of the service is to improve the residents' condition or prevent further regression so that services are no longer necessary".

PRTF's provide comprehensive rehabilitative services to assist and support youth, with behavioral health (Mental Health, Substance Use and Co-occurring MH/SA) disorders, in the development of positive personal and interpersonal skills, daily living skills, and behavior management skills; to improve functioning and meet the youth's developmental needs; and to enable youth to identify, adjust, and manage symptoms. Individual and group activities and programming must consist of services to develop skills in functional areas that interfere with the youth's ability to live in the community; participate in educational activities; develop or maintain social relationships; or enhance participation in social, interpersonal, recreational, or community activities.

PRTF level of care is designed for high-risk youth that have been diagnosed and present with complex conditions that require extended treatment in a structured setting in order to more adequately treat their psychiatric and psychosocial needs. These residential programs can improve outcomes for youth both by providing a course of active psychiatric treatment within a structured residential treatment setting and by providing or facilitating access to community-based aftercare mental health services through linkages to schools, community resources, and family/natural supports. This service provides support and assistance to the youth and the family.

PRTF facilities will be staffed 24 hours a day, 7 days a week, provide treatment under the daily supervision of a physician and provide a high level of nursing and/or specialized staff to meet the diverse needs of the target population. PRTF services are delivered in secure or non-secure settings. PRTF's are required to provide educational services for the youth residing in their facility.

Goals of PRTF:

- Stabilization of chronic problems and symptoms and adequate resolution to allow safe return of the child to the family and community.
- Design of aftercare treatment plans that can be effectively implemented upon return to the community
- For children in the state's custody, incorporation of permanency goals into the treatment and discharge plans and active coordination with the appropriate Community Based services.
- Reduction of recidivism of admission into acute psychiatric or PRTF services by providing aftercare services and/or linkage with appropriate community services.
- Promote stability by decreasing frequency, intensity and duration of crisis episodes.
- Develop supports by promoting resiliency, promote age-appropriate functioning and understand the effects of the emotional disturbance or substance use.

Service Components:

- Diagnostic Assessment
- Development of an individualized treatment plan with specific goals and interventions

- Psychiatric Services
- Nursing Services
- Medication Monitoring and Management
- Evidence Based Treatment Interventions
- Individual Therapy
- Family Therapy
- Educational Activities which meet the child's individual educational needs
- Consultations with other professionals in the community
- Discharge and Transition Planning

Anticipated length of Stay: Children in residential treatment facilities achieve maximum benefit from the service within the first 6 months of treatment. It is expected average LOS to be 3-6 months; however, the length of stay varies depending on the youth's individual diagnosis and treatment needs.

MONITORING AND ASSESSMENT OF SERVICE DELIVERY

Comprehensive integrative assessment, utilizing standardized assessment measures and tools. Assessment is a continuous process that begins at admission and continues throughout the various stages of treatment. Assessment types may include:

- Achenbach System of Empirically Based Assessment (ASEBA)
- The Addictions Severity Index
- Child and Adolescent Needs and Strengths (CANS)
- Child and Adolescent Service Intensity Instrument (CASII)
- Utilization Review which includes detailed report of child's progress of lack of progress in achieving treatment goals, highlights barriers or perceived barriers to treatment and evaluation of whether the youth meets the continued stay criteria for this level of service.

BILLING

The Provider may only submit claims approved for their use. The contract will specify which applicable codes are available for their use.

The facility's per diem rate may be determined following the completion of the DPBHS PRTF survey in which the CONTRACTOR provides service detail as to which services are being purchased and will be delivered to youth placed in this facility.

Educational costs are billed separately.

Pharmaceuticals and physician activities provided to the youth in a PRTF, when on the active treatment plan of care, are components of the Medicaid covered PRTF service. These activities will be paid directly to the treating pharmacy or physician, using Medicaid pharmacy and physician fee schedule rates excluded from the psychiatric residential treatment facility (PRTF) State of Delaware Medicaid per diem reimbursement rates.

DPBHS does not cover medical expenses.

PROVIDER QUALIFICATIONS:

- The facility must be accredited by the Joint Commission or another accrediting organization with comparable standards recognized by the State of Delaware.
- Providers must provide services in accordance with an individualized treatment plan under the direction of a physician. The activities included in the service must be intended to achieve identified treatment plan goals and objectives and be designed to achieve the beneficiary's discharge from inpatient status at the earliest possible time. Services to be provided must be in accordance with the Code of Federal Regulations (CFR).
- Provider of PRTF services will be an enrolled provider of the service with Delaware's Division of Medicaid and Medical Assistance (DMMA).
- Provider of PRTF services will be properly licensed with the state in which the facility is located.
- Provider will be recognized and/or certified as a PRTF by DPBHS/DMMA.
- Facility follows federal requirements for restraint and seclusion. **42 CFR 483 Subpart G Restraint or Seclusion in Psychiatric residential Treatment Facilities Providing Inpatient Psychiatric Services for Individuals Under Age 21**

ADMISSION CRITERIA: *The youth must meet **all** criteria below to be admitted to this level of service:*

1. Youth is 17 years of age or younger and meets DPBHS eligibility criteria.
2. The CASII/ASAM and other relevant clinical information support the need for this level of care.
3. Documentation from a licensed mental health practitioner and/or the ART Committee recommending this level of service must be present.
4. Medical Necessity Criteria for PRTF are met:
   - A substantial risk of harm to self or others, or a child who is so unable to care for his or her own physical health and safety as to create a danger to their life; and
   - The services can reasonably be expected to improve the recipient's condition or prevent further regression so that the services will no longer be needed; and
   - All other ambulatory care resources available in the community have been identified, and if not accessed, determined not to meet the immediate treatment needs of the youth.
   - Proper treatment of the youth's psychiatric condition requires services on an inpatient basis under the direction of a physician.
5. The youth manifests behavioral symptoms consistent with an ICD 10/ DSM 5 diagnosis that requires residential treatment services.
6. The client's symptoms/behaviors indicate a need for continuous monitoring and supervision by 24-hour staff to ensure safety.
7. The client has insufficient or severely limited skills to maintain an adequate level of functioning, specifically identified deficits in daily living and social skills and/or community/family integration.
8. Current symptoms requiring PRTF treatment and symptoms have been occurring within the last 6 months.

CONTINUED STAY CRITERIA: ***All** of the following criteria are necessary for continuing treatment at this level of service*:

8. The CASII and other relevant information indicate that the youth continues to require this level of service.

9. There is adequate documentation from the provider that the member is receiving the scope and intensity of services required to meet the program goals stated in this Service Description
10. Client is actively participating in treatment, or there are active efforts being made that can reasonably be expected to lead the child to engage in treatment.
11. The family/caregiver is involved in treatment as required by the treatment plan, or there are active efforts being made and documented to involve them.
12. Current/updated treatment plan to address progress or lack thereof warranting continued stay.
13. Current discharge criteria and discharge date and plan are provided.
14. If discharge date changes, an explanation as to rationale for change.

DISCHARGE CRITERIA: ***Any*** *of the following criteria is sufficient for discharge from this level of service:*

1. The client's parent/family requests discharge.
2. The goals of the individualized treatment plan have been substantially met and youth no longer meets the continued stay criteria.
3. Transfer to another service is warranted by a change in the youth's condition.
4. The youth has received maximum benefit or has failed to benefit from a reasonable course of PRTF care, and documentation supports that a suitable alternative placement is established that will meet the youth's needs, and the discharge plan includes input from the youth, caregiver/legal guardian, and is supported by the Child and Family Team.

EXCLUSION CRITERIA: ***Any*** *of the following is sufficient for exclusion from this level of service:*

7. The youth does not meet DPBHS eligibility criteria.
8. The ASAM/CASII and/or other relevant information indicate that the youth/family's treatment needs are not consistent with this level of service.
9. The caregiver does not voluntarily consent to treatment.
10. The behavioral symptoms are the result of a medical condition that warrants a medical setting for treatment.

Residential Transition Service (RTS)

Residential Transition Services (RTS) are services provided to prepare for a child's return home from a residential facility and continue, with the same provider, during and after the transition home. Services are designed to begin working with the family and child prior to discharge from the facility with intensified service delivery as discharge approaches. The service identifies natural and community supports and utilizes these resources to promote successful transitions to the home, school and community. Throughout the transition period, the intensity and frequency of the transition service will match the client and family needs as clinically appropriate.

Research shows improved outcomes with shorter length of stay, increased family involvement and stability and support in the post-residential environment (Walters & Petr, 2008). Treatment supports the BBI framework, which ensures closely coordinated partnerships and collaborations between family, youth, community and residential treatment providers, advocates and policy makers. Services will embrace the following Core Principles of BBI:

- Family Driven & Youth Guided Care
- Cultural & Linguistic Competence
- Clinical Excellence & Quality Standards
- Accessibility & Community Involvement
- Transition Planning & Services (between settings & from youth to adulthood)

Target Population

- Male and Female youth ages 12-17 with plans to successfully discharge from a residential service within 30-90 days.
- Youth whom the DPBHS CFCC has determined this level of service is clinically necessary.
- Youth with an identified caregiver who resides within reasonable commuting distance from the facility and who the child will be living with upon discharge.

Service Utilization

- Services will vary in frequency and intensity throughout the transition period.

Scope of Service

- Use of evidence based and best practices, such as:
  - Functional Family Therapy
  - Multi-systemic Therapy
  - Parenting with Love and Limits
  - Trauma-Focused-Cognitive Behavioral Therapy
  - 7 Challenges
  - Collaborative Problem Solving
  - Positive Behavioral Interventions and Support
  - Cognitive Behavioral Therapy

- Continued assessment, utilizing standardized assessment measures. Assessment tools may include:
  - Achenbach System of Empirically Based Assessment (ASEBA)
  - The Addictions Severity Index
  - Child and Adolescent Needs and Strengths (CANS)

- Customized, flexible treatment options to meet the needs of the particular child and family including weekly family and individual sessions, which will occur in the child's home, school and community. Family therapy sessions will increase in frequency and intensity as the youth's transition home approaches.
- Clinical services will be available 24/7. Services will be delivered when the family is available, including evenings, weekends and is available to support he child and family when the child is home on passes.
- Therapies will be conducted by Masters or doctoral level clinician.
- Unlicensed therapists will be supervised by a licensed mental health professional as required in the DPBHS provider manual.
- Psychiatric assessment and medication management by a Delaware Medicaid paneled and licensed child and adolescent psychiatrist, general psychiatrist, or Advanced Practice Psychiatric/Mental-Health Nurse Practitioner (who has a Collaborative Agreement with a psychiatrist). Assessment, prescribing and treatment practices will be consistent with all of the American Academy of Child & Adolescent Psychiatry Practice Parameters.
- Case management by the primary therapist (or designee) in coordination with the DPBHS CFCC.
- Identification of formal and informal resources for child and family to support successful transition.
- Coordination of community integration activities.
- Residential Transition Services begin at least 30 days prior to discharge from the residential facility and continue during the post discharge transition phase as clinically appropriate.
- Therapeutic support to promote successful transition to the school environment.
- Comprehensive discharge and aftercare planning.
- Successful connection with aftercare provider.

Crisis Management

- A crisis response plan, including a safety plan, will be developed in collaboration with the youth and their family. The plan will clearly outline who the family will contact should an emergency arise and specific actions and techniques to utilize to de-escalate the situation and ensure safety.
- Clinical staff will be on call after hours, on weekends and holidays, and available to respond by phone or in person, to conduct risk assessments, provide intervention and assist in de-escalating the emergent situation.
- A referral to Mobile Response and Stabilization Services should be made in cases where the need for inpatient hospitalization or crisis residential service is suspected.

Discharge Planning

- Anticipated discharge date from service will be established upon admission and will be adjusted as indicated based on the child's progress in treatment.
- Ongoing assessment of the child's progress will be made throughout treatment.
- The youth has reasonably achieved the goals established by the client and family as outlined in the treatment plan.
- Connection has been made with next treatment provider or service.
- Youth no longer requires transitional service and is prepared to participate in another service.

Outcomes

- Reunification and maintenance of the youth with identified family or primary caregiver, alternate placement setting, or establishment of independent living arrangement as identified in the discharge plan.
- Continued success and participation in local school, vocational or trade school or other program as defined in the discharge plan.
- Successful transition to and participation in continued behavioral health treatment services and compliance with psychotropic medications as stated in the discharge plan.

Transitional Bed Service (TBS)

Transitional Bed Service (TBS) services provide supervised, supported care, including overnight, for youth with emotional disturbance or behavioral health issues. Transition Support Service may provide:

- Short-term stabilization.
- A safe, structured environment for youth awaiting placement. Youth utilizing these services must be active with DPBHS and the use of the service must support a positive transition to an appropriate longer-term service or placement.
- Occasional periods of overnight care for youth who are active with the provider's Residential Transition Service. The use of this service can significantly reduce stress in the family, enhance the family's ability to keep their child/youth at home in the community, and prevent or delay the use of more restrictive behavioral health services for the child. The use of a Transition Support Services may be planned in advance or be offered as an option in emergent situations.
- Should **not** to be used in lieu of a crisis residential service inpatient care or residential treatment. These beds are not designed to provide 1:1 supervision and should not be considered for youth requiring this level of observation.

Target Population

- Male and Female youth up to age 17.
- Youth with a primary Mental Health diagnosis who are active with DPBHS.
- Youth who are transitioning from one service to another
- DPBHS has determined this level of service is clinically necessary.

Service Utilization: DPBHS and the contractor will collaborate on planned admissions and discharges.

Scope of Service:

- Develop a targeted individualized service plan, specifying goals, objectives and time frame of the TSS stay. The plan will be developed in collaboration with the child, caregiver, CFCC, other involved Divisions and community providers as indicated.
- Provide positive role modeling, guidance and counseling to assist the youth in managing the demands of everyday living.
- Teach and foster the development of adaptive living skills by the youth.
- Provide general care and supervision of the youth.
- Manage emotional and behavioral situations in accordance with the client's plan.
- Maintain a therapeutic living environment that is well structured and designed to nurture and support the youth.
- Work directly with primary caregivers (when involved) to teach and model appropriate social, interpersonal, and parenting skills.
- Participate in meetings with the DPBHS Child and Family Care Coordination Teams and other Divisions for the purpose of planning and monitoring progress.
- The Provider will offer twenty-four hour consultation, support and intervention during the entire term of the client's stay.

Discharge Planning

- Discharge date will be established upon admission and may be adjusted as indicated.
- Service plan goals have been reasonably achieved.
- Youth is connected with a treatment service and an aftercare plan is in place.

Outcomes

- Reunification and maintenance of the youth with identified family or primary care-giver, alternate placement setting, or establishment of independent living arrangement as defined in the discharge plan.
- Return to and continued success and participation in local school, vocational or trade school or other program as defined in the discharge plan.
- Successful transition to and maintenance in continuing behavioral health treatment services as defined in the treatment plan.

Partial Hospitalization Program (PHP)/Day Hospital

Day Hospital is a 5-full-day intensive program that provides developmentally appropriate intervention for seriously disturbed children or adolescents who are unable to fulfill the functional requirements of his/her developmental stage without this level of intensive service. This level of care provides support and psychiatric services five days per week to clients living at home or in other residential settings. This level of care should be used for clients with severe, complex, or chronic psychiatric disorders requiring high intensity psychiatric medical services. This is a staff-secure unlocked facility in which movement inside the facility and egress from the facility is strictly limited by staff and/or by geographical circumstances, although doors can be opened without a key.

Service Components

The program will be available to clients for 12 months of the year and must be open a minimum of 225 days per year for the minimum number of hours of a standard school day for the developmental level of the client served. Activities must also be provided in afternoons and/or evening to assure that working parents are able to participate in treatment. Activities will occur both on-site at the program and in the client's natural environment. They will include but not be limited to:

- Professional diagnostic and therapeutic services, e.g., psychological and psychiatric services, individual and family and family assessment, individual, group and family treatment, medication evaluation/monitoring and case management.
- Activities provided within a therapeutic milieu, e.g., individual and group therapeutic recreation, field trips, parent and school consultation, behavior management, and other psycho-social education activities.
- Crisis response for active clients:
    - The client and/or family will be able to reach a day hospital staff person in an emergency.
    - If the client's behavior appears to signal that he/she may be approaching a crisis, the day hospital staff will alert the DPBHS crisis unit, including instructions for how to contact the day hospital therapist if there is an emergency.
    - If the DPBHS mobile crisis team is contacted at any time, a member of the day hospital staff will be available to make telephone recommendations about disposition.
    - During the regular working day, if an emergency occurs, the day hospital staff will notify the DPBHS CFCC, respond in-person to the crisis if possible, with the DPBHS crisis team if they are dispatched.
- Transportation to and from program activities.
- An educational program appropriate to the level and individual educational needs of the client and which includes classroom education provided by a certified teacher, educational and cultural activities, and physical, occupational and speech therapy as specified on the IEP. Additional requirements of Educational programs follow:
    - Some youth are placed (out of medical necessity or for legal reasons) in programs which inhibit or interfere with participation and attendance at the local sending school. In such cases, the CONTRACTOR is responsible for ensuring that the youth continue to be educated at the appropriate level. To meet this need, CONTRACTORS must ensure compliance with the following processes:
        - Prior to enrollment, the CONTRACTOR will obtain written consent from each parent or legal guardian to obtain records and maintain communication with the sending district.

- Within three business days of admission to the day hospital program, the CONTRACTOR will contact the youth's home school to determine current standing with the school (e.g. enrolled attending; enrolled not attending; officially withdrawn.). Written confirmation of status will be obtained. If the youth is attending school, the CONTRACTOR will obtain course schedule, level of credits and current grades.
- Within five business days, the CONTRACTOR will establish a written agreement with the sending school for 'homebound" instruction to be provided by the school district or the CONTRACTOR.
- At the close of each week and at the conclusion of each month, written documentation will be provided by the CONTRACTOR to the school district regarding each student's participation and assignment completion during "homebound" instruction. This will include documented length of services per day/week and monthly. Course grades and/or actual assignments will be provided to the sending school at the close of each week and month.

- The services provided are in accordance with the student's
  - Grade Level
  - Educational status as either a General or Special Education Student
  - Parent/Guardian Permission(s)
- Students not participating in "homebound" instruction or pursuing a GED must be 16 years or older, have written consent by parent or legal guardian, AND be officially withdrawn from school. CONTRACTORS may receive written notification from the sending district that the youth has legally withdrawn from school. Parents and youth who are identified as needing special education services should receive the special education procedural safeguards prior to making this decision. Such decisions must be evidenced by written notification and parental signatures. (CONTRACTORS will receive training from DSCYF to ensure appropriate understanding of this requirement.)
- <u>Student Records File Folder</u>
  - CONTRACTORS will maintain educational files in a separate, secure (locked) location Educational files shall include the following documents:
    - <u>Section I</u>
      - Signed release of information for educational records and on-going communication
      - Student Records Request form
      - Record Review/Inspection Form
      - Written "Homebound" instruction agreement
      - Telephone/Mail Contact Log Form
        - Weekly/Monthly contact between Agency Teacher and School district
        - Assignment log with due dates
      - Medical Alerts
      - Official withdrawal from school notification
    - <u>Section II</u>- Special Education Students only
      - Evaluation Report/Eligibility
      - IEP/Section 504 Accommodation Form
      - Teacher IEP Review Form

- Section III-
  - Student Progress reports
    - Attendance
    - Grades
    - Assignments Progress
    - Effort
  - Home School District Transcripts/Report Cards

The client attends for a full day (between 6-8 hours per day) 3 - 5 days per week. The program is available to meet with families after hours and in emergencies. The client receives multiple services each day, which are included on a treatment/service plan and may include but are not limited to:

- education
- individual counseling
- family counseling
- supervised daily living
- supervised recreational activities
- medical/psychiatric services including nursing

Services are provided with a team approach. The team must be headed by a clinician with a graduate degree in a behavioral science and includes, at minimum:

- One or more trained clinical staff, e.g. minimum of masters level in some human service discipline, RN, etc., and
- Trained, supervised staff specializing in some aspect of behavior change, e.g. residential childcare workers or non-residential community interventionists, and
- Clinical staff available for consultation, and some intervention, e.g. physicians including psychiatrists and psychologists

Goals of PHP/Day Hospital

- Stabilization of current problems and symptoms and adequate resolution to allow safe return of the child to the family and community.
- Design of aftercare treatment plans that can be effectively implemented upon return to the community.
- Reduction of recidivism of admission into acute psychiatric services by providing aftercare services and/or linkages with appropriate community services.
- Promote stability by decreasing frequency, intensity and duration of crisis episodes.
- Develop supports by promoting resiliency, promote age-appropriate functioning and understand the effects of the emotional disturbance or substance use.

Anticipated Length of Stay

Anticipated length of stay is 1-2 weeks. Length of stay will vary based on the individual's needs. Clinical necessity must support need for extended stays in this level of service.

MONITORING AND ASSESSMENT OF SERVICE DELIVERY

- On-site monitoring.
- Routine chart reviews.

- Compliance with DPBHS requirements are continually evaluated as part of the monitoring process.

Assessment types may include:

- Child and Adolescent Service Intensity Instrument (CASII)
- Utilization Review which includes detailed report of child's progress of lack of progress in achieving treatment goals, highlights barriers or perceived barriers to treatment and evaluation of whether the youth meets the continued stay criteria for this level of service.

BILLING

Reimbursement for private psychiatric hospitals for partial hospital psychiatric services is paid at the current Delaware Medicaid rate for Partial Hospitalization Program (PHP) Level I and II services.

Invoices will be submitted in compliance with the DPBHS Provider Manual.

PROVIDER QUALIFICATIONS:

- The facility must be accredited by the Joint Commission or another accrediting organization with comparable standards recognized by the State of Delaware.
- Providers must provide services in accordance with an individualized treatment plan. The activities included in the service must be intended to achieve identified treatment plan goals and objectives and be designed to achieve the beneficiary's discharge from Day Hospital status at the earliest possible time.
- Services to be provided must be in accordance with the Code of Federal Regulations (CFR).
- Provider of Day Hospital services will be an enrolled provider of the service with Delaware's Division of Medicaid and Medical Assistance (DMMA).

ADMISSION CRITERIA: *The youth must* ***meet 1, 2, 3, 4 and at least ONE*** *from* ***6-9.***

1. Youth is 17 years of age or younger and meets DPBHS eligibility criteria.
2. A prior authorization for the service is required.
3. Twenty-four hour inpatient hospitalization or RTC care is not necessary, and the client has received outpatient treatment (including office or home based services, crisis intervention, and day program) and has not made progress, cannot reasonably be expected to make progress, or is regressing in outpatient treatment, or there is evidence that the client could not be safely be treated in any less restrictive level of care.
4. Family members and/or significant others, in the client's support network (relatives, case managers, or mentors) will commit to regular participation in the treatment process and to the client's return to the community.

The youth meets any ***ONE*** *of the following criteria or a combination:*

5. Self harm: The client has made suicide attempts or credible threats with a plan and means. Risk factors to be considered include, but are not limited to: suicide of significant other, disturbed sense of reality, depression, hopelessness, previous suicide attempts, substance use, and recent losses.
6. Medical risk: The client has exposed himself or herself to medical risk, for example, eating disorders, repeated drug overdoses requiring medical intervention, and noncompliance with medical intervention for serious medical illnesses.

7. Danger to others: The client has a serious psychiatric disorder such as psychosis or major affective disorder and displays behavior related to the disorder that may result in serious physical assault, sexual assault, or fire setting or other major harm to others.
8. Severe, Complex, or Chronic Psychiatric disorder: The client exhibits a severe, complex, or chronic psychiatric disorder that has led to compromised functioning in multiple areas which require frequent or intensive psychiatric or general medical evaluation or intervention which cannot safely or effectively be provided in alternative programs.
9. Psychiatric oversight: Is a necessary part of the client's treatment.

CONTINUED STAY CRITERIA: ***All*** *of the following criteria are necessary for continuing treatment at this level of service*:

1. The CASII and other relevant information indicate that the youth continues to require this level of care.
2. There is adequate documentation from the provider that the member is receiving the scope and intensity of services required to meet the program goals stated in this Service Description
3. Client is actively participating in treatment, or there are active efforts being made that can reasonably be expected to lead the child to engage in treatment.
4. The family/caregiver is involved in treatment as required by the treatment plan, or there are active efforts being made and documented to involve them.
5. Current/updated treatment plan to address progress or lack thereof warranting continued stay.
6. Current discharge criteria and discharge date and plan are provided.
7. If discharge date changes, an explanation as to rationale for change.

DISCHARGE CRITERIA: ***Any*** *of the following criteria is sufficient for discharge from this level of service:*

1. The client's parent/family requests discharge.
2. The goals of the individualized treatment plan have been substantially met and youth no longer meets the continued stay criteria.
3. Transfer to another service is warranted by the change in the youth's condition.
4. The youth has received maximum benefit or has failed to benefit from a reasonable course of PRTF care, and documentation supports that a suitable alternative placement is established that will meet the youth's needs, and the discharge plan includes input from the youth, caregiver/legal guardian, and is supported by the Child and Family Team.

EXCLUSION CRITERIA: ***Any*** *of the following is sufficient for exclusion from this level of service:*

1. The youth does not meet DPBHS eligibility criteria.
2. The youth has a sole diagnosis of Autism Spectrum Disorder and there is no co-occurring ICD 10 / DSM 5 diagnosis or symptoms/behaviors consistent with a DSM 5 diagnosis.
3. The youth has a sole diagnosis of Intellectual Developmental Disorder and there is no co-occurring ICD 10/DSM 5 diagnosis or the symptoms/behaviors consistent with a DSM 5 diagnosis.
4. The ASAM/CASII and/or other relevant information indicate that the youth/family's treatment needs are not consistent with this level of service and it is expected the child will not benefit from this level of service.
5. The caregiver does not voluntarily consent to treatment.
6. The behavioral symptoms are the result of a medical condition that warrants a medical setting for treatment.

Inpatient Hospitalization

Inpatient treatment services provide an out-of-home, twenty-four hour psychiatric treatment milieu under the direction of a physician. Within the medical context of an inpatient facility, clients can be safely evaluated, medications can be prescribed and monitored, and treatment interventions can be intensively implemented. Inpatient treatment services represent the most restrictive and intensive intervention available within the DPBHS continuum of services. A Psychiatric Hospital is a locked medical facility for youth who are dangerous to self or others because of behavioral health problems. Movement inside the facility and egress from the facility are strictly limited. External doors and some internal doors cannot be opened from the inside without a key. Education is provided on-site. Use of this facility is limited and is to protect the client and/or the community from his/her dangerous behaviors.

Inpatient Hospitalization, Involuntary:
The CONTRACTOR, through this contract and in accordance with 16 Del, C. sections 5001(2) and 5135, is hereby designated by the DEPARTMENT Secretary as an appropriate facility for the diagnosis, care and treatment of mentally ill minors who are involuntarily committed to the custody of the CONTRACTOR'S psychiatric hospital pursuant to 16 Del. C. section 5122 or section 5001 et. seq. It is the intent of this contract to purchase from the CONTRACTOR involuntary psychiatric hospital services for minors only insofar as said services are required by and in compliance with pertinent provisions of 16 Del. C. Chapters 50 and 51, herein incorporated by reference. The CONTRACTOR will be familiar with pertinent provisions of 16 Del C. Chapters 50 and 51 and associated legal and professional procedures governing involuntary hospitalization of juveniles. It is expected that the CONTRACTOR will seek clarification from the DEPARTMENT should questions or problems arise in the implementation of services under this contract.

Service Components

Inpatient treatment exists as one component of a continuum of care. Therefore, inpatient treatment is used primarily for short-term acute care to address symptoms which cannot be addressed at other less restrictive levels of care. Involuntary inpatient treatment should be used only in extraordinary circumstances where a minor meets the legal definition for involuntary admission, and a parent or legal guardian's signature for voluntary inpatient treatment is unavailable. When the acute crisis is resolved, the client can continue treatment in a less restrictive program. Inpatient treatment offers a therapeutic milieu with strong psychiatric medical support is central to effective inpatient treatment. Therapeutic interventions, activities, milieu and educational components must be carefully integrated to create a total ecological treatment regime. Individual characteristics of such an integrated treatment regime include:

- Thorough evaluation of medical, psychological, social, familial, behavioral and developmental dimensions of the client's situation within the context of the client's precipitating symptoms.
- Management of the environmental stimuli to which the child or adolescent is subject.
- Careful monitoring of psychotropic medications and their effects on the client's behavior.
- A high degree of structure, order, and predictability with regard to the routines of daily living, the management of behavior and the provision for basic needs.
- Careful monitoring and management of peer group interaction to promote social learning and minimize the negative effects of peer influence.
- Programmed activities for the amelioration of presenting problems, including skill building, with an emphasis upon interpersonal and problem solving skills; self-care/life skills; activity and recreational programming.

- Counseling and psychotherapy, including individual and group approaches and problem-specific approaches.
- Family therapy with focus upon reintegration into the community within the shortest clinically appropriate time frame.
- Therapeutic stabilization of youth in crisis, including physically aggressive minors, and minors who are a danger to self or others.
- Provisions for educational opportunities.
- A safe and secure environment for all minors who are involuntarily committed, including those who are violent and dangerous to themselves and/or others and those who have been adjudicated or are otherwise in the custody of the DYRS.

This is a site-based twenty-four hour, seven day per week program with three shifts of awake staff. The client receives multiple services which appear on a treatment/service plan and may include but are not limited to:

- education
- individual counseling
- family counseling
- supervised daily living
- supervised recreational activities
- medical/psychiatric services including nursing

Services are provided with a team approach. The team must be headed by a licensed mental health professional and includes, at minimum:

- One or more trained clinical staff, e.g. minimum of masters level in some human service discipline, RN, etc.
- Clinical staff available for consultation and some intervention, e.g. physicians including psychiatrists and psychologists.
- Trained, supervised staff may be added to the team. These individuals specialize in some aspect of behavior change, e.g. residential childcare workers or non-residential community interventionists.

Goals of Inpatient Hospitalization

- Stabilization of current problems and symptoms and adequate resolution to allow safe return of the child to the family and community.
- Design of aftercare treatment plans that can be effectively implemented upon return to the community.
- Reduction of recidivism of admission into acute psychiatric services by providing aftercare services and/or linkages with appropriate community services.
- Promote stability by decreasing frequency, intensity and duration of crisis episodes.
- Develop supports by promoting resiliency, promote age-appropriate functioning and understand the effects of the emotional disturbance or substance use.

Anticipated Length of Stay: Average length of stay is 3 to 10 days. Length of stay will vary based on the individual's needs.

MONITORING AND ASSESSMENT OF SERVICE DELIVERY

- On-site monitoring.
- Routine chart reviews.
- Compliance with DPBHS requirements are continually evaluated as part of the monitoring process.

Assessment types may include:

- Child and Adolescent Service Intensity Instrument (CASII)
- Utilization Review which includes detailed report of child's progress of lack of progress in achieving treatment goals, highlights barriers or perceived barriers to treatment and evaluation of whether the youth meets the continued stay criteria for this level of service.

PROGRAM DELIVERABLES

In addition to the specifications in the DPBHS Provider Manual and Involuntary Procedures Manual, the CONTRACTOR agrees to the following:

- The following must be delivered to DPBHS within 48 hours of admission:
  - Admission Summary - including psychiatric evaluation with DSM 5 diagnosis, initial treatment plan and signed by attending physician.
  - Provider Certificate of Need.

Monthly - The hospital will provide to the DPBHS Program Manager, at the close of every month a report which specifies how many minors were involuntarily admitted in the previous month, and for each patient, the level of care from which each patient was admitted, the level of care the patient was discharged to, the number of previous psychiatric hospitalizations, and whether the patient was involuntarily admitted or referred by an agent or employee of the hospital, or by a psychiatrist with admitting privileges at the hospital.

BILLING

Reimbursement for private psychiatric hospitals for inpatient psychiatric hospitalization services is paid at the current Delaware Medicaid rate for Inpatient Psychiatric Services.

The Centers for Medicare and Medicaid Services (CMS) revised their rates and made the inpatient psychiatric hospital rate all inclusive. Attachment 4.19-A.1, page 34 of the Delaware Medicaid State Plan states that "No supplemental payments are made for public or private inpatient psychiatric hospital services". Prior to this revision, DMMA had been paying providers of inpatient psychiatric services and partial hospital psychiatric services an "individually negotiated rate with each provider". CMS has disallowed this methodology and the Division has adopted a more uniform rate for private providers of these services using Medicare rates as a point of reference. "This change in rates for private psychiatric hospital services will bring Delaware into compliance with federal reimbursement principles, will pay rates that will be consistent across providers and that will enable Delaware to meet the federal upper payment limit tests for inpatient and outpatient hospital services".

Invoices will be submitted in compliance with the DPBHS Provider Manual.

PROVIDER QUALIFICATIONS:

- The facility must be accredited by the Joint Commission or another accrediting organization with comparable standards recognized by the State of Delaware.
- Providers must provide services in accordance with an individualized treatment plan. The activities included in the service must be intended to achieve identified treatment plan goals and objectives and be designed to achieve the beneficiary's discharge from Inpatient Hospital status at the earliest possible time.
- Services to be provided must be in accordance with the Code of Federal Regulations (CFR).
- Provider of Inpatient Hospital services will be an enrolled provider of the service with Delaware's Division of Medicaid and Medical Assistance (DMMA).

Inpatient Hospitalization, Voluntary

ADMISSION CRITERIA: *The youth must* ***meet 1, 2, 3 and at least ONE*** *from* ***4-7****:*

9. Youth is 17 years of age or younger and meets DPBHS eligibility criteria.
10. A prior authorization for the service is required.
11. Care cannot be provided safely or effectively in less restrictive level of care.

The youth meets any ***ONE*** *of the following criteria or a combination:*

12. Self harm: The client has made suicide attempts or credible threats of significant self-injury with a plan and means. Risk factors to be considered include, but are not limited to: suicide of significant other, disturbed sense of reality, depression, hopelessness, previous suicide attempts, substance use, and recent losses.
13. Life threatening risk: The client has exposed himself or herself to life threatening risk. Examples include life-threatening eating disorders, repeated drug overdoses requiring medical intervention, and extreme noncompliance with medical intervention for serious medical illnesses.
14. Danger to others: The client has a serious psychiatric disorder such as psychosis or major affective disorder and displays behavior related to the disorder that may result in serious physical assault, sexual assault, or fire setting or other major harm to others.
15. Severe Psychiatric disorder: The client exhibits a severe psychiatric disorder such as an acute psychotic state, or multiple disorders that require intensive or frequent psychiatric or general medical evaluation or intervention.

CONTINUED STAY CRITERIA: ***All*** *of the following criteria are necessary for continuing treatment at this level of service*:

2. The CASII and/or other relevant information indicate that the youth continues to require this level of care.
3. There is adequate documentation from the provider that the member is receiving the scope and intensity of services required to meet the program goals stated in this Service Description
4. Client is actively participating in treatment, or there are active efforts being made that can reasonably be expected to lead the child to engage in treatment.
5. The family/caregiver is involved in treatment as required by the treatment plan, or there are active efforts being made and documented to involve them.
6. Current/updated treatment plan to address progress or lack thereof warranting continued stay.
7. Current discharge criteria and discharge date and plan are provided.
8. If discharge date changes, an explanation as to rationale for change.

DISCHARGE CRITERIA: ***Any*** *of the following criteria is sufficient for discharge from this level of service:*

5. The client's parent/family requests discharge.
6. The goals of the individualized treatment plan have been substantially met and youth no longer meets the continued stay criteria.
7. Transfer to another service is warranted by the change in the youth's condition.
8. The youth has received maximum benefit or has failed to benefit from a reasonable course of inpatient hospitalization, and documentation supports that a suitable alternative placement is established that will meet the youth's needs, and the discharge plan includes input from the youth, caregiver/legal guardian, and is supported by DPBHS.

EXCLUSION CRITERIA: ***Any*** *of the following is sufficient for exclusion from this level of service:*

3. The youth does not meet DPBHS eligibility criteria.
4. The youth has a sole diagnosis of Autism Spectrum Disorder and there is no co-occurring ICD 10 / DSM 5 diagnosis or symptoms/behaviors consistent with a DSM 5 diagnosis.
5. The youth has a sole diagnosis of Intellectual Developmental Disorder and there is no co-occurring ICD 10/DSM 5 diagnosis or the symptoms/behaviors consistent with a DSM 5 diagnosis.
6. The ASAM/CASII and/or other relevant information indicate that the youth/family's treatment needs are not consistent with this level of service and it is expected the child will not benefit from this level of service.
7. The caregiver does not voluntarily consent to treatment.
8. The behavioral symptoms are the result of a medical condition that warrants a medical setting for treatment.

Inpatient Hospitalization, Involuntary

The CONTRACTOR agrees to comply with all legal and DPBHS requirements governing admission, continued stay and discharge.

ADMISSION CRITERIA: *The youth must meet* ***all*** *of the following:*

1. Accept All Admissions - The CONTRACTOR must accept for admission all minors who are presented to the hospital for involuntary admission in accordance with Delaware law.
2. Confirmation with the DEPARTMENT - The CONTRACTOR will inform the DEPARTMENT of the actual date and time of any involuntary admission as soon as possible, and no later than 2 hours following the actual admission of a youth to the facility; unless the involuntary admission occurs at a time when State offices are closed, in which case the CONTRACTOR will notify the DEPARTMENT within the first two (2) hours of the next working day. In the event that said notification is not received within the specified time frames, the DEPARTMENT reserves the right to deny payment for all or part of the minor's course of hospital treatment.
3. Due Process - In accord with 16 Del. C. Ch. 50 and 51 concerning involuntary and provisional admissions, the CONTRACTOR will ensure that all applicable legal safeguards and procedures governing involuntary provisional hospitalization are implemented promptly for all involuntarily admitted patients and their families.

CONTINUED STAY CRITERIA: ***All*** *of the following criteria are necessary for continuing treatment at this level of service*:

1. Treatment. The CONTRACTOR will provide treatment to the involuntary minor as is medically appropriate.
2. Involuntary Treatment Pursuant to Court Ordered Commitment. If a patient is committed for continued treatment to the CONTRACTOR'S hospital pursuant to a Court order, the hospital shall provide treatment to the involuntary patient in accordance with the order, applicable Delaware law, this Contract and generally recognized professional standards.
3. Emergency Procedure Authorization. In the event that an emergency procedure must be performed at the facility or elsewhere, DPBHS must be informed on the next working day, or payment for the procedure may not be authorized. DPBHS will only consider funding for medical procedures that are directly related to the diagnosis and/or treatment of a client's psychiatric condition.
4. Ancillary Procedures Authorization. Psychological or other specialized evaluations, treatment or diagnostic procedures not included in the comprehensive per diem will be funded only as authorized by DPBHS.

DISCHARGE CRITERIA: ***Any*** *of the following criteria is sufficient for discharge from this level of service:*

1. Emergency Apprehension. If a youth is admitted pursuant to 16 Del. C. section 5122, the youth will be discharged from involuntary status within 72 hours unless admitted or committed under some other provision of Delaware law. The CONTRACTOR must provide discharge recommendations in consultation with DPBHS.
2. Provisional Hospitalization. If a youth is admitted pursuant to 16 Del. C. section 5003, the youth must be discharged from involuntary status within two (2) working days unless judicial commitment proceedings are undertaken pursuant to 16 Del. C. section 5007 et. seq., in order to obtain legal authorization for continued hospitalization under a judicial commitment order. The CONTRACTOR must provide discharge recommendations in consultation with DPBHS.

Adjunctive Services

I. SERVICE OVERVIEW

A. Definitions

DPBHS	Division of Prevention and Behavioral Health Services
DSCYF	Department of Services for Children, Youth and Their Families
DYRS	Division of Youth Rehabilitative Services

B. Description

1. Supplemental Supervision - As an adjunct to the inpatient hospital and day/part day hospital programs operated under the contract, the CONTRACTOR, with authorization from DPBHS, may assign additional staff to provide one-to-one supervision for clients who are deemed to require that added service in order to make it possible to treat them safely and effectively at this level of care. When authorized, the additional staff member will be assigned solely and exclusively to the client, for whom the service was authorized, during agreed upon daily time periods, and for the duration of the authorization period.

2. Translation Service (subcontracted) - As an adjunct to the inpatient hospital and day hospital programs operated under the contract, the CONTRACTOR has the capacity to arrange for the provision of interpretation and translation services for clients who are not fluent in English or who are hearing impaired and require this service in order to participate in treatment.

II. TARGET POPULATION

Adjunctive services will be provided, when authorized and funded, to specific named clients who are DPBHS clients admitted to either the inpatient hospital program or the day hospital program within the CONTRACTOR'S system.

III. AUTHORIZATION AND FUNDING

A. Authorization. Adjunctive services must be specifically authorized for a named client by the DPBHS' Child and Family Care Coordination Team assigned to that client. The authorization will be for a designated and time limited period, subject to periodic renewal as client needs dictate.

B. Funding. The CONTRACTOR will bill separately for the cost of authorized adjunctive services at the rates specified in Attachment B-4.

Appendix 8 –Sample Format Client Progress Documentation

D.A.P. Progress Note Checklist

Data	**Check If addressed**
1. Subjective data about the client-what are the client's observations, thoughts, direct quotes?	
2. Objective data about the client-what does the counselor observe during the session (affect, mood, appearance)?	
3. What was the general content and process of the session?	
4. Was homework reviewed (if any)?	
Assessment	
5. What is the counselor's understanding about the problem?	
6. What are the counselors' working hypotheses?	
7. What are the results of any testing, screening, assessments?	
8. What is the client's current response to the treatment plan?	
Plan	
9. Based on client's response to the treatment plan, what needs revision?	
10. What goals, objectives were addressed this session?	
11. What is the counselor going to do next?	
12. When is the next session date?	
General Checklist:	
13. Does this note connect to the client's individualized treatment plan?	
14. Is this note dated, signed, and legible?	
15. Is the client name and identifier included on each page?	
16. Has referral information been documented?	
17. Are client strengths/limitations in achieving goals noted and considered?	
18. Are any abbreviations used standardized and consistent?	
19. Would someone not familiar with this case be able to read this note and understand exactly what has occurred in treatment?	
20. Are any non-routine calls, missed sessions, or professional consultations regarding this case documented?	

Treatment Planning M.A .T .R.S.: Utilizing the Addiction Severity Index (ASI): Making Required Data Collection Useful

S.O.A.P. NOTE

S = Subjective or summary statement by the client. Usually, this is a direct quote. The statement chosen should capture the theme of the session.

1. If adding your own explanatory information, place within brackets [ ] to make it clear that it is not a direct quote.
   - Example of session theme: "When he raises his voice, I just… What do I do?... Yes, I'll talk more in group."
2. If client refers to someone else's name, indicate that other person by initials. This makes it clear that the client is the focus, not the person the client is talking about. It also guards against any breeches in confidentiality. This is especially true when a client refers to another client.
   - Example of client using someone else's name: "She really made me mad… You think I should make an appointment to talk to her? I don't like dealing with this stuff" [case worker S.P.].
3. If the client didn't attend the session or doesn't speak at all, use a dash on the "S" line.
   - Example: S: ---

O = Objective data or information that matches the subjective statement. Descriptions may include body language and affect.

- Example: 20 minutes late to group session, slouched in chair, head down, later expressed interest in topic.

A = Assessment of the situation, the session, and the client, regardless of how obvious it might be based on the subjective and/or objective statements.

- Example: Needs support in dealing with scheduled appointments and taking responsibility for being on time to group.
- Example: Needs referral to mental health specialist for mental health assessment.
- Example: Beginning to own responsibility for consequences related to drug use.

P = Plan for future clinical work. Should reflect interventions specified in treatment plan including homework assignments. Reflect follow-up needed or completed.

- Example: Begin to wear a watch and increase awareness of daily schedule.
- Example: Complete Tx Plan Goal #1, Objective 1.
- Example: Consider mental health evaluation referral.
- Example: Contact divorce support group and discuss schedule with counselor at next session.

Adapted from work by Larry T. Mark and presented by Donna Wapner, Diablo Valley College. Handout included in materials produced by the Pacific Southwest Addiction Technology Transfer Center, 1999.

Appendix 9 – What can providers do to AVOID and CORRECT errors

Implement Internal Processes - Preventing improper billing starts with the provider. Implementing effective internal controls ensures the provider documents beneficiary services properly and bills them appropriately. Here are just a few suggestions:

- Be aware of and seek professional, State, and Federal training, seminars, technical opportunities, etc., offered to providers and staff that deal directly and specifically with proper billing practices, procedures, and policies to enhance billing competencies and improve billing practices;
- Make sure the assessments, reassessments, individual plans of care, and physician orders are reviewed as required, and that they are current and signed;
- Perform internal monitoring and auditing of documentation to ensure that documentation is complete, current, and sufficient to support the services billed, and supports the plan of care;
- Implement other internal processes to ensure State and Federal requirements are met; and
- Make sure to back up electronic health records (EHRs) daily.

Establish Compliance Programs - Providers can play a significant role in the fight against fraud, waste, and abuse by implementing preventive strategies, including a compliance program. The HHS Office of Inspector General (HHS-OIG) issued voluntary compliance program guidance that includes seven components to help providers and suppliers develop an effective compliance program. The components include a compliance officer, effective communication, written policies, procedures, and standards of conduct, appropriate staff education and training, enforcement of disciplinary standards, internal monitoring, and a prompt response to detected offenses through appropriate corrective action. While implementation of a compliance program is voluntary for various providers and suppliers, the Affordable Care Act requires the Secretary of HHS to establish, as a condition of enrollment in Medicare and Medicaid, a compliance program containing core elements for providers or suppliers within a particular industry or category.

Train and Educate Staff - Providers should train staff members and make sure they understand antifraud efforts. They should also provide proper training to increase awareness of Medicaid billing requirements, specifically as they relate to behavioral health services in their State. Many SMAs provide training for providers and their staff on Medicaid compliance, requirements, and proper billing practices. Additionally, providers and their staff should receive training on and be knowledgeable about the False Claims Acts (FCAs). The civil FCA is a Federal law under which substantial damages and civil penalties may be imposed on a person or entity who knowingly presents or causes to be presented a false claim for payment or uses or makes a false record or statement material to get a false claim paid by the government. There is also a criminal FCA that makes it a crime for any person or organization to knowingly make a false record or file a false claim regarding any Federal health care program. Many States have adopted their own civil and criminal FCA laws; providers should be aware of their State's FCA. Providers receiving at least $5 million annually from Medicaid are required to provide FCA education to their staff. Providers and their staff should receive training on Federal debarment and exclusions requirements. Under Federal law, Medicaid cannot make payments for services furnished by an excluded provider or entity.

Identity Excluded Individuals and Entities - CMS recommends that all providers conduct employee exclusion searches on a regular basis to determine whether the provider's employees and contractors have been excluded. Providers can search by name for the exclusion status of their employees through the HHS-OIG's List of Excluded Individuals and Entities (LEIE) at http://oig.hhs.gov/exclusions/exclusions_list.asp on the HHS-OIG website. The General Services Administration also maintains the System for Award Management (SAM) to record and report the eligibility of individuals and entities to receive government reimbursement for services like Medicaid. Visit https://www.sam.gov/portal/SAM/#1 on the Internet for access to this database.

Implementing measures such as verifying documentation accuracy, establishing a compliance program, educating staff, and checking for excluded providers will help maintain program integrity. Always consult the SMA for details on covered services, eligibility, and billing requirements. Please visit the following link on the CMS website for and electronic booklet, "Billing Behavioral Health" toolkit and other Medicaid Program Integrity Education material:

- https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/edmic-landing.html