



Performance Standards

Family Based Mental Health Services

Performance Standards are intended to provide a foundation and serve as a tool to promote continuous quality improvement and progression toward best practice performances, to increase the consistency of service delivery and to improve outcomes for members.

Disclaimer: These Performance Standards should not be interpreted as regulations. Entities providing services as part of the HealthChoices program must first be enrolled in the Pennsylvania Medical Assistance program as the appropriate provider type. Providers must then comply with all applicable Pennsylvania laws, including Title 55, General Provisions 1101, licensing program requirements and any contractual agreements made with Community Care Behavioral Health Organization in order to be eligible for payment for services.

PERFORMANCE STANDARDS FAMILY BASED MENTAL HEALTH SERVICES

Final April 2008

As defined by the Department of Public Welfare, 55 PA. Code, Chapter 5260, Family Based Mental Health Services (FBMHS) for Children and Adolescents are team delivered services rendered in the home and community which are designed to integrate mental health treatment, family support services and case management, so that families may continue to care for their children and adolescents with serious mental illnesses or emotional disturbances at home. Family Based Mental Health Services are intended to reduce the need for psychiatric hospitalizations and out-of-home placements by providing services that enable families to maintain their role as the primary caregiver for their children and adolescents. These services have been developed on principles and objectives developed by the Child and Adolescent Service System Program (CASSP) to recognize that children and adolescents are a part of the family unit and that parents are the primary caregivers for their children and adolescents. FBMHS are provided to the child, adolescent and family in their natural setting. Services at this level of care are intended to comprehensively address the intensive treatment needs of children and adolescents. A primary goal of Family Based Mental Health Services is to facilitate the development of a positive milieu across community based settings, which will be supportive and caring for the child or adolescent after the services are completed.

Family Based Mental Health Services are an important service on the continuum of care Community Care offers to its members. While there are other community based services like Behavioral Health Rehabilitation Services, core components to the service design of FBMHS distinguish this service from other community-based services. All FBMHS staff participates in an extensive, intensive three-year clinical training program with family systems theory serving as the theoretical foundation of the training. Clinical presentations by the FBMHS teams and a critiquing of their work are essential components of the training program. FBMHS are a comprehensive program offering intensive psychotherapeutic interventions, crisis intervention services with availability 24 hours a day and seven days a week, family support services, and case management to children, adolescents and their families. FBMHS are primarily a team delivered service, with two clinicians assigned to each family. FBMHS emphasize the importance of the interagency team meeting process. The teams and family work to identify and include all people important to the family that can be a source of support throughout the course of treatment. As a result, the Family Based team ensures that services are well coordinated and delivered in an integrated manner. FBMHS are voluntary. One parent or caregiver must want and commit to participating in order for FBMHS to be provided. The purpose of these performance standards is to build upon the strengths already inherent in the program design of FBMHS.

These performance standards are the result of a series of meetings facilitated by Community Care Behavioral Health, with representatives from network FBMHS providers, county representatives, and representatives from oversight entities. The goal of the meetings was to develop standards to expand upon the current regulations. Input

from other stakeholder groups, including family and member representatives was also sought prior to the finalization of this document. These standards are intended to clearly articulate Community Care's expectations of FBMHS providers and define the parameters of reasonable standards of practice for the provision of FBMHS. The standards are intended to provide a foundation and serve as a tool to promote continuous quality improvement and progression toward best practice performance, to increase the consistency of service delivery, and to improve outcomes for children, adolescents, and their families. In some instances, the standards set the bar higher than baseline performance standards. Overall, this is reflective of the current level of quality within the network and the commitment of all involved stakeholders to continually strive to improve the quality of FBMHS.

These standards should not be interpreted as regulations, nor will they be utilized as a means of requiring or prohibiting specific interventions for specific individuals. Each child or adolescent receiving FBMHS is to have a uniquely developed treatment plan, based on recovery and resiliency principles, which identifies strengths and addresses needs.

FBMHS providers are expected to monitor adherence to the standards and to take corrective actions where indicated to comply with the standards. Community Care will assess compliance to these performance standards during medical chart reviews conducted by our Quality Department and will include feedback in provider benchmarking efforts. As Community Care and its providers implement monitoring activities to assess compliance with the standards and establish baseline measures, Community Care may move to pilot less intense utilization review processes or alternative reimbursement methodologies with high quality FBMHS providers.

Access Standards, Management of Referrals, and Engagement

FBMHS providers should continually educate referral sources about the service, program strengths, areas of specialization, and the appropriateness of referrals based on state guidelines and medical necessity criteria. Referral sources are expected to provide sufficient information to the FBMHS provider in order for providers to manage referrals appropriately and to not have to initiate services with a family only to find within the first several weeks of treatment, that FBMHS are not the most appropriate services for the identified child/adolescent and family.

- Providers always have the option of encouraging the referral sources to consider alternative levels of care if FBMHS do not appear to be the most appropriate level of care. Providers should educate prescribers and referral sources on the medical necessity criteria for FBMHS. Likewise, providers should also feel free to send any additional information that was not included in the initial precert packet and was obtained in the course of discussion with the family or other sources that helps to better clarify the clinical appropriateness of FBMHS.
- Providers are expected to provide adequate precert information to Community Care in order for a determination to be made on the appropriateness of FBMHS. This involves whatever is necessary and may include a review precert packet, a

conversation with the family, the referral source or prescriber or an Interagency Service Planning Team meeting.

- Providers should inform families and referral sources that there is a choice of providers and that the service is voluntary. The provider has an obligation to provide information to the family to insure that the family has the opportunity to make an informed choice about their provider of Family Based Mental Health Services.
- Providers should also clarify with referral sources and families if there are any other providers to whom the FBMHS referral has been made. As a courtesy to other providers, once a family is contacted and there is a verbal agreement to treatment, the other providers should be notified of the family's status so that they can be removed from the other providers' referral list. This prevents problems associated with inflated referral lists and misconceptions about FBMHS availability and accessibility.
- Providers are expected to respond rapidly to referrals, with the initiation of services within seven days of receipt of a complete referral with a prescription letter, for routine requests for service. Providers are to notify referral sources when in receipt of incomplete referrals to maintain clear communication regarding what additional information is needed.
- FBMHS are intended to be available as a diversion from inpatient services when a child or adolescent is experiencing a crisis but does not need services as restrictive as inpatient care. Therefore, providers are expected to have a process for triaging referrals in order to be able to accept urgent referrals within 24 hours.
- If a provider is unable to offer timely access to services, the provider is expected to inform the family and referral source when their services will be available and offer to assist the family in contacting another provider if the family would prefer. The provider should also inform the family that Community Care is available to assist them in obtaining Family Based Services. Providers are also expected to notify Community Care when unable to meet timely access standards.

If there is a wait for treatment at a particular provider and the family has been informed of this and wishes to wait for services from a particular provider, providers are expected to encourage families to remain connected and involved in their previous level of care until the provider can accept the new case. They should also provide information to the family on crisis options such as mobile crisis or walk in crisis, if available in their area.

- Providers are expected to maintain communication with referral sources regarding the status of the referral and the actions they have taken upon receipt of the referral. Providers are expected to contact the referral source if there is any difficulty contacting or engaging the family. Providers should consider coordinating an interagency team meeting with the referral source and family if there is difficulty engaging the family once services have begun.
- FBMHS providers must demonstrate reasonable efforts to engage children and families in the treatment process. Efforts should be documented and should include

multiple types of interventions such as telephone contact, letters, and as stated previously, contact with the referral source.

- FBMHS providers are expected to reinforce with referral sources the importance of the referral sources seeking authorizations from parents and caregivers to release and obtain relevant treatment history information, and to give written permission to the treatment team to consult with others that are essential to ensure a strength-based treatment process.
- Upon initial contact with families, the FBMHS provider is expected to discuss confidentiality issues with the member (when age appropriate) and family to obtain written permission to consult with others that will aid in the assessment, treatment plan development, and monitoring of the effectiveness of treatment interventions over the course of care.
- Family Based teams should talk to families about who they have in their lives that support them, or what resources within their community are important to them. Efforts must be made to engage significant others and natural supports in the treatment process. Such efforts can be very beneficial in helping to engage families in treatment and empowering families.
- Families should be given written meaningful and easily understood service descriptions that detail what Family Based Mental Health Services “can and can’t do.” During initial contacts, providers are expected to clearly discuss with families what families can expect from the services and what is expected of families as partners in the treatment team.
- All Family Based Programs are expected to have processes in place that meet the goal of obtaining sufficient information to determine the appropriateness of services in a timely manner. All programs are also expected to gather information from referral sources and from initial contacts with families to determine how to best match teams to families. One effective method toward achieving this goal is to have Project Directors or Program Supervisors make the initial contact with referred families by phone or in person.
- In general, the following issues should be considered in order to effectively manage referrals:
 - FBMHS are appropriate for children and adolescents who are involved in multiple systems. It is important to understand the goals and assessments of each involved system. It is also crucial to know what interventions are being provided by each involved system so as to develop one comprehensive treatment plan that clearly reflects the roles of each member of the interagency team. The lack of involvement in multiple systems does not preclude a child and family from participation in family based services if the child is at risk of an out-of-home placement.

- FBMHS are intended to be comprehensive and intensive, and therefore, recipients must be willing to commit a considerable amount of time and effort to participate in the services. In particular, the provider should specify the time commitment emphasizing the expectation of at least once per week, but ideally 2-3 times a week and including both individual and family sessions. The model is most effective when caregivers believe that they share responsibility with other interagency team members for supporting their child to meet the goals the family and team have worked together to develop.
- While FBMHS may be an ideal service to support a child and family when a child is transitioning home after an episode of care in a residential treatment facility, it is crucial that the RTF provides a comprehensive summary of treatment progress and assists with the identification of transition goals. The Family Based team should initiate contact with the adolescent and family upon authorization and at least 30 days prior to the discharge date from the RTF. Family Based providers should notify Community Care in the event that a referral has not been received at least 30 days prior to RTF discharge in order for the precert authorization to be expedited.
- Special attention should be taken to assess the appropriateness of referrals and the commitment of the family to work with the team when the family is also considering residential treatment for their child. Since children are best treated in the context of their families every effort should be made to use FBMHS as diversionary services from the recommended RTF placement even in those cases that RTF is considered to be imminent.

General Appropriateness for Services

For a child to access FBMHS, a physician, psychiatrist, or licensed psychologist must prescribe the service as medically necessary prior to the initiation of services. The best-practice prescription letter format developed by Community Care is used by prescribers and must include a complete evaluation of the child/adolescent and family's strengths and needs, review of past treatment trials, and full consideration of the continuum of care available to children and adolescents. The prescription must be dated within 2 months of initiation of services

- Children and adolescents who receive FBMHS must meet the medical necessity criteria established by the Department of Public Welfare. In addition, children and adolescents who are appropriate for these services generally meet the following criteria:
 - The child or adolescent is under 21 years of age
 - The child or adolescent has a serious mental illness or emotional disturbance.
 - The child or adolescent is determined to be at high risk for out-of-home placement.

- The child/adolescent or family is involved with multiple systems.
- FBMHS are often appropriate for families experiencing the return home of a child/adolescent from an inpatient hospitalization or residential treatment facility or as a diversion from a more restrictive or higher level of care.
- FBMHS also seeks to serve families for which previous lower levels of care have been ineffective and continuation of these services is no longer clinically indicated.
- At least one adult member of the family must agree to actively participate in the service.
 - At least one parent must have the cognitive ability to learn new skills related to addressing the behavioral health needs of their child that has a serious emotional disturbance.
- FBMHS providers are expected to assess safety concerns at the point of a referral and during the initial contacts with a family and determine if it is necessary to reach an agreement with the family on issues related to safety for the continuation of services. Providers are expected to work closely with families and other involved systems to resolve safety issues that may be a barrier in service delivery or treatment progress. While there may be occasions in which safety concerns preclude a Family Based team from being able to provide services, the provider is expected to document all reasonable efforts to address this issue and the steps taken to assist the family in accessing appropriate services.
- Substance use or domestic violence within the family and the child/adolescent must be assessed at the point of referral and during the Family Based team's initial contacts with a family to determine if in fact this level of care is generally appropriate. The Family Based team is expected to discuss such issues openly with family members, work to contract with families on conditions of participation in the Family Based program, and offer to assist family members in accessing other needed services. Within the first several weeks of treatment and during the early engagement process, the Family Based team is expected to make a determination as to the appropriateness of the continuation of FBMHS based upon on the family's ability to fully participate. The Family Based team should monitor and continually assess for domestic violence and substance abuse as engagement with the family may make disclosure more likely as treatment progresses.

It is recognized that it may take a Family Based team up to 30 days while rendering treatment services to a child/family to reach a final determination about the appropriateness of this level of care to best meet the needs of the identified child/adolescent and family. Providers should document all efforts made to engage the family in treatment and the family's response. If a determination is made that services

are not appropriate then the FB provider should contact Community Care prior to closing the case and it is recommended that an ISPT be convened to explore treatment barriers and alternatives. Likewise, families may decide during this early phase of treatment that FBMHS are not appropriate and may choose to discontinue services. The Family Based team is expected to share and openly discuss their assessments and recommendations regarding the continuation of services with families. If the family maintains their decision to discontinue services then the provider is expected to notify the referral source, the prescriber and Community Care within 5 business days of case closure.

Interagency Service Planning Team (ISPT) Meeting Process

- FBMHS providers should utilize interagency service planning team meetings as a tool to ensure coordination of care for children, adolescents and families. Providers must convene, at a minimum, an initial interagency service planning team meeting ideally within 30 and no more than 45 days of the initiation of services and convene a discharge planning meeting within 60 days of the anticipated date of discharge. Interagency service planning team meetings should be used more frequently if clinically indicated. Providers should plan for additional supportive resources when needed to enable families to fully participate in the ISPT meeting process (such as childcare for young children).
- Providers are responsible for ensuring that the core components of the ISPT meeting process are addressed including:
 - All involved agencies, systems, natural supports, and community resources that the family wishes to include in the meeting are notified in advance of the meeting of location, time and purpose. The Family Based team should also make phone contact with those to be invited to the meeting to begin to establish working relationships with members of the interagency team. Meetings are scheduled at the family's convenience both in terms of time and location, with consideration given to promoting attendance by key members of the interagency team.
 - The Family Based team should discuss the ISPT meeting process with the family prior to the meeting, defining goals and ground rules for the meeting, as well as determining with the family who will facilitate the meeting and how the team can be most supportive of the family during the meeting. The roles of each of the participating Family Based staff in the ISPT meeting should be clearly defined prior to the meeting. The Family Based team may role-play various conversations about sensitive issues that may occur during the ISPT meeting with the family in preparation. The family has the right to identify issues that are off limits for discussion in the ISPT meeting. The ISPT meeting process can be used to support families in the development of self-advocacy skills.

- The ISPT meeting should follow a standardized agenda that addresses referral concerns, and strengths and needs of the child or adolescent and family. The agenda should support the family to talk early in the process and to outline their hopes for their child. The development of treatment goals and/or progress on goals should be addressed. The goal of preventing the need for inpatient care or other types of out-of-home services should be discussed at the ISPT meeting. Modifications to the standardized agenda should be made to accommodate the unique needs or characteristics of families.
- The ISPT meeting is used as an opportunity for all involved systems and the family to develop and/or discuss treatment goals across systems and ensure that goals defined by various involved systems are as integrated as possible and do not conflict. The meeting also establishes accountability of all those involved in assisting the child to meet his or her goals.
- During the development of goals, parents or primary caregivers should be given the opportunity to identify a goal that helps them to take care of themselves, in order to be better able to support their family and child.. This goal is to be integrated into the overall treatment plan.
- ISPT meetings should include a discussion of both formal and informal supports. Linkages to supports in a variety of settings including home, school, mental health, social/recreational, and other systems should be explored for all family members. There should be significant exploration of natural and informal supports as well. The ISPT meeting presents an opportunity for the team to identify any obstacles to obtaining resources for the family.
- Family Based teams should give families the opportunity to debrief after an ISPT meeting. Information from such debriefing may be useful in planning for a subsequent ISPT meeting and creating a meeting environment that is supportive to families. This discussion should be documented in the progress notes and the family's feedback should be considered in determining how future meetings are facilitated.
- Meeting participation is documented with a sign in sheet. Providers should provide all attendees with a ISPT summary of the meeting which details what actions are to be taken and who is responsible for completing each assigned task as was determined at the ISPT meeting. Target dates for completion of assigned tasks are to be included in the ISPT meeting summary. The Family Based team is responsible for maintaining contact with members of the ISPT to ensure that all planned interventions are being acted upon.

Crisis Planning

- Family Based services must be available 24 hours/day, 7 days/week to provide crisis intervention services. FBMHS providers are expected to have policies in place

regarding processes for triaging family emergency calls and determining the most effective and therapeutic way to respond. All staff members are to be trained on such policies. Program supervisors are expected to monitor and review emergency responses by teams and continually work to improve the effectiveness of this service.

- Families should be provided with written material on how to access crisis intervention services at the initial contact with the Family Based team. Any process a Family Based program develops to meet the expectation for 24 hours/day, 7 days/ week availability must result in a prompt response to a family's request for help. Consistent, prompt responses must be evident from a review of the medical charts of the program.
- A primary goal of crisis planning is the prevention of the need for inpatient care or other out-of-home services or placements. When Community Care is notified by an inpatient provider that an individual currently getting services from a FBMHS Program is presenting for hospitalization, the inpatient provider will be advised that they must contact the FBMHS provider. The FBMHS provider is expected to fully communicate with the inpatient provider and work to divert the hospitalization when clinically appropriate. Ideally, a representative from the Family Based program should be present at the emergency room to assess the need for inpatient hospitalization and provide needed active therapeutic intervention to support a diversion.
- Family Based teams are expected to develop individualized crisis/safety plans with families within the first five days of treatment. Families should be asked to define what constitutes crises to individual family members to ensure that the developed crisis plan is individualized. How families have previously responded to crises should be considered in the development of the crisis plan. Crisis plans should include sufficient detail to enable families and teams to follow through with identified steps. Directions to the families' homes should be available to the Family Based program to proactively be prepared in the event that another program staff member needs to respond to a crisis. Crisis plans should include the identification of possible respite and transportation options to the families' homes.
- Crisis plans should be signed by the family and by the treating Family Based team.
- Crisis plans should be available to any staff within the Family Based Program who might be called upon to respond to a crisis situation with the family.
- Crisis plans should be attached to overall treatment plans and should be reviewed regularly (at a minimum of once a month), as are treatment plans. Crisis plans should always be reviewed and updated if the identified child or adolescent experiences an inpatient admission.
- Crisis plans should be shared in the context of ISPT meetings with systems and other service providers who may be involved with families being served by the Family

Based Program. Crisis/safety plans should identify all possible resources available to the family in the event of a crisis. Resources may include natural, family, and informal supports.

- Crisis plans should address at a minimum, identification of prior precipitants to crises, delineation of interventions to address precipitants, a means of assessing the outcome of the interventions, specific alternatives to be tried prior to consideration of inpatient treatment (given that the situation can be safely managed in current level of care).

Following a crisis, the Family Based team is expected to discuss the crisis situation with the family and make any needed revisions to the crisis plan when clinically appropriate.

Treatment Planning Process and the Development of the Treatment Plan

- Family Based providers are expected to create a service delivery environment in which children/adolescents and their families participate as full partners of the treatment team in the development of treatment plans.
- The service planning process is expected to identify initial priorities for services and establish a progressive course for treatment. The team should make an immediate safety risk assessment. An initial treatment plan addressing the issues that put the child at risk for out of home placement should be developed within five days of the initiation of services. This plan should include a crisis/safety plan for the child and family.
- The treatment plan should function as a living, usable document. It should be used as a working map for what the team and family plan to achieve and how to accomplish those goals. **The plan should include family system information and present a comprehensive perspective of child/family functioning.**
- The treatment plan is to be developed in collaboration with the family and updated with the family at least every 30 days. A comprehensive treatment plan that demonstrates an integrated, well-collaborated approach to services across all involved systems is expected to be completed within 30 days of the initiation of services. The treatment plan document serves as a “contract” between all involved parties regarding their responsibilities for the services to be rendered to the identified child or adolescent and their family.
- With the member and/or family’s consent, all members of the interagency service planning team should receive copies of those parts of the treatment plan relevant to their involvement with the member. With the permission of the family/guardian, the plan should be shared with the school team, when appropriate, to ensure that behavioral interventions are consistent across all environments. The member and or/family should sign the treatment plan and receive a copy of the document.

- Documentation of monthly treatment plan reviews must be maintained. Treatment progress should be reviewed weekly with the family. Such a review provides the opportunity to test that the treatment plan continues to be meaningful to the family and that the goals are realistic and achievable. Rating progress weekly can also be very useful in reviewing the effectiveness of current interventions and making modifications when clinically necessary. When progress is minimal, Family Based teams should consider including the program supervisor in a discussion with the family reviewing the treatment plan progress or conduct an ISPT meeting with all service systems involved.
- The service planning process and the resulting treatment plan should address the strengths and needs of each family member and clearly define goals, objectives and interventions. The objectives need to identify the specific steps that are to be taken (by the team, caregiver and child/adolescent) to achieve the stated goals. Target dates for the completion of goals need to be realistic and projected for each goal. Establishing target dates is an effective way of anticipating the length of stay at this level of care.
- **Goals should reflect both a recovery and resiliency orientation and must be achievable and measurable; they must also have realistic, practical meaning for families. Treatment plans are expected to be written in words that are understandable to families, avoiding behavioral health professional jargon.**
- Establishing the primary goals for services is often difficult given the complex needs of children and adolescents in need of this level of care. A deliberate discussion of overall goals and the narrowing to priority goals is an important step in the treatment planning process. Family Based teams should assist families in helping to focus on a few meaningful, attainable goals for this episode of care. The identified goals should require services of the intensity of FBMHS. Having measurable goals to review with families also helps families to recognize their progress and therefore their readiness for discharge. Goals that can be achieved at a less intense level of care can be identified through the discharge planning process.
- The treatment plan should identify how services from several sources will be coordinated and integrated to best address the needs of the child/adolescent and family. When multiple systems are involved, the Family Based team should discuss with the family the need for regularly scheduled interagency service planning meetings. The Family Based team is responsible for convening such meetings as frequently as necessary to ensure well-coordinated service delivery.
- Treatment plans must be individualized and comprehensive in nature. The plan should be inclusive of therapy goals, crisis planning goals, case management goals, and family support / advocacy goals. Case management and advocacy goals must be balanced with treatment goals.

- Treatment plans should reflect building support systems and community linkages. FBMHS are always to be aimed at building family self-sufficiency and healthy interdependency.
- The treatment planning process should prompt a discussion with the family to identify discharge goals and to prepare for the transitioning out of the Family Based program. While it is often difficult to balance engaging families in treatment and preparing for discharge, it is essential that Family Based providers commit to discussing discharge planning on a regular basis with families. How will we know when we are done? What will things look like? We are “done” when things look like this. This should be part of an on-going discussion.
- Progress notes should be connected to the treatment plan and Family Based activities must be related to the goals of treatment.
- The treatment plan has value as a tool in supervision. Teams are expected to review the implementation of the treatment plan on a case-by-case level in supervision, evaluating the effectiveness of interventions and discussing implementation of interventions in the context of supervision.
- The treatment plan is to guide service delivery. Services rendered are to support attainment of the identified goals. Documentation of service provision must clearly demonstrate the interventions provided, the response to the interventions, the relatedness to the treatment plan, and progress toward goal attainment. A narrative description of the “session” is not adequate.

Service Delivery

- FBMHS programs are expected to provide treatment services that include assessment, crisis planning and crisis intervention, therapy, and case management support. Service linkage, coordination of care, family support and advocacy are also key components of Family Based Mental Health Services. Given the multiple types of services delivered in this model and the complex needs of the children and adolescents typically served, it is imperative that Family Based providers attend to the balance of services delivered, ensuring that proper attention is given to treatment needs. FBMHS are not intended to be only case management or crisis intervention services. FBMHS are also expected to introduce innovative therapeutic activities in response to input from consumers.
- Family systems theory, structural family therapy, and ongoing training and supervision are central to the model of FBMHS. FBMHS programs are expected to utilize appropriate clinical and behavioral interventions from various schools of thought.
- In addition to early assessment and treatment planning activities, a primary goal of early contacts with the families is to engage families fully in treatment. FBMHS providers are expected to try multiple interventions that support families to fully

participate in services given the voluntary nature of this service. Programs are expected to have a comprehensive orientation process for families to promote engagement.

- Documentation of therapy services provided should note the modality of treatment, the participants, the primary focus of the session, and identification of key interventions delivered in a detailed manner (such as working with subsystems of the family, use of reframing, circular questioning, behavioral management interventions, etc.).
- The role of each of the team members working with any given family should be clearly identified within the team, with the family, and reflected on the treatment plan.
- Team-delivered services are at the foundation of the Family Based model. The team may consist of 2 master's level clinicians, 1 master's level and 1 bachelor's level clinician, or 1 bachelor's level clinician with FB certification and either a master's level or bachelor's level clinician.
- Effective management of FBMHS programs must include the ongoing assessment and monitoring of the use of team-delivered services at a member level as well as at a program level. The Project Director is responsible for ensuring that 60% of each team's time is spent rendering team-delivered services. Clinical discussions in supervision and during all treatment planning activities should provide the basis as to how to most appropriately manage this aspect of Family Based service delivery.
- The assessment of the child/adolescent and family's needs and the treatment plan should be used as a guide in determining the intensity of service delivery. Given the possible intensity of services, it is crucial that teams continually evaluate the appropriateness of their involvement and ensure that a focus on the primary goals is maintained. Given the "permeable boundaries" of working in community settings, it is important that the overall appropriateness of the team's involvement be evaluated in supervision on a regular basis.
- Family Based is characterized by the expectation and ability to address the strengths and needs of not only the identified member, but also other individual family members and the family as a unit. The team should explore collaboratively with the family strengths, needs, and possible service linkages for other family members.
- **Individual work can be done with other family members as long as it is directly tied to the identified member's treatment goals.** If family members require more individualized treatment, then a referral should be made to the appropriate service. While FBMHS are child-centered services, service delivery and treatment planning are always family-driven.

- The importance of supervision and its impact on the service delivery process cannot be understated for this level of care. The inherent challenges in delivering services as a team should be an ongoing topic in supervision. Teams must be supported to mature in their ability to build upon each other's strengths, establish their individual roles with the families they serve, and maximize the therapeutic impact of working as a team. FBMHS programs should allow for one supervisor for every four teams in the program. Supervision with each team is expected to occur weekly at a minimum. Documentation of all supervision sessions, including detailed information about the supervisor's interventions with the team, is to be maintained by supervisors and reviewed regularly by Project Directors. Maintaining a separate document of each case review conducted during supervision is ideal. **Supervisors are expected to routinely go out into the field with teams to directly observe their work with families, provide feedback to the team, and support the team to continually develop their clinical skills.**

Coordination of Care

- Due to the comprehensive nature of Family Based Mental Health Services and the case management component of the service, the team should function as the lead clinicians for the child/adolescent. Providers should obtain as much information about what systems and providers are involved with all family members and help ensure that all roles and boundaries are clarified. As stated earlier, the ISPT meeting process can be a useful tool in addressing any coordination of care issues. FBMHS providers should also help to educate other systems about the role of Family Based Services to promote effective coordination of care.
- While families may sometimes not feel comfortable including others involved in their care at an interagency service planning team meeting, FBMHS providers are expected to explore this fear or concern with families and facilitate the strengthening of the family's relationships with other systems when possible.
- FBMHS providers must ensure that care is coordinated and service linkage on a case by case basis is provided with other involved systems including, but not limited to:
 - Physical health, including contact with the primary care physician and ensuring documentation of a physical within past 12 months
 - Education / vocational systems
 - Child Protective Services
 - Juvenile Probation
 - Other behavioral health providers such as Specialized Outpatient, Drug and Alcohol treatment, Intensive Case Management, CTT, psychiatric evaluation and medication monitoring, etc.

When psychiatric services are being rendered outside of the FBMHS agency, it is imperative that the FBMHS provider maintains communication with the treating psychiatrist. FBMHS providers should seek psychiatric evaluations for children and adolescents diagnosed with disorders amenable to psychotropic interventions and when

the diagnostic picture for an individual is unclear, or treatment progress is stalemated. The FBMHS team should assist the family with scheduling psychiatric evaluations within the first month of services in such cases, when the individual has not been evaluated within the month prior to the initiation of Family Based Services. All identified consumers of FBMHS are expected to obtain a psychiatric evaluation ideally within 30 days of admission to the program, but no later than six months from admission to the program if not evaluated in the six months prior to admission. FBMHS teams are expected to assist the family in monitoring adherence to the medication regime.

- Special attention must be given to service delivery in school settings. Family Based teams are expected to meet with school staff, with the family present when possible, prior to the delivery of any services in the school setting. The purpose of the service delivery in the school setting must be clearly defined and must be directly related to the treatment of the identified child's and possibly siblings behavioral health needs. At a minimum, weekly to biweekly contact with school personnel is often crucial in the overall service delivery process when the identified child experiences any behavioral difficulties in the school setting. FBMHS may also have contact with the school for a sibling of the identified child.
- In exceptional cases when FBMHS are delivered in combination with PHP or SBPHP services, teams should meet routinely with the program, but should not meet individually with the member during their treatment time at the PHP as this is considered a duplication of services.
- In exceptional cases when FBMHS are delivered in combination with BHR services, such as TSS, the FBMHS treatment plan must clearly delineate the treatment goals of the BHR services. Attention must be given to not duplicating services unnecessarily and to ensuring that services are delivered in a well-coordinated manner. FBMHS providers hold the responsibility for leading or providing clinical direction to the BHR services providers when jointly serving families. Regular meetings or discussions must occur between the two providers to ensure the coordination of care. Linkage agreements should be established to detail the nature of the working relationship between the two entities, especially when a pattern of shared cases is established. BHRs and FBMHS are expected to share the responsibility for development of a treatment plan for the BHRs staff to implement with the family. Supervision of the BHRs staff is the responsibility of the BHRs provider agency.
- Family Based providers are expected to hold other involved service providers accountable by following up with other providers that are failing to provide interventions agreed to during the interagency team meeting process and the development of the comprehensive treatment plan.
- FBMHS providers are expected to establish linkage agreements with other providers and child serving system partners. Such linkage agreements are intended to be practical documents that clarify expectations of each other. Linkages should be reviewed on a regular basis.

Discharge Planning

- Discussions about discharge planning and aftercare should begin as early as the first day of treatment and discharge criteria are to be included in the development of the initial 30-day treatment plan. Discharge planning should be revisited each time the treatment plan is reviewed and a target discharge date must be identified. Target dates are useful in helping to establish expectations regarding length of stay in the program.
- While by regulation, an episode of FBMHS is defined as up to 32 weeks, Community Care expects providers to be diligent about managing utilization in terms of intensity and length of stay at a case-by-case level. Utilization management should be discussed as a routine part of supervision. A psychologist or physician advisor at Community Care will review any requests for an extension beyond the 32-week limit.
- FBMHS providers are expected to help families to understand the process of preparation for discharge in a number of ways. Providers should educate families about the likelihood of their experiencing a “crisis” as the planned discharge date approaches. Providers should discuss with families the emotions associated with the “letting go” process, recognizing that due to the fact that services are intense and are delivered in the families’ homes, the working relationships between families and the Family Based staff are often intense. FBMHS providers may also use “transition sessions” of less frequency to help families prepare for discharge. FBMHS are required to maintain at least weekly contact with the family during this transition time. FBMHS will utilize titration of services prior to discharge as a means for testing treatment gains and sustainability of gains once discharged from FBMHS. “Graduation celebrations” or rituals are often useful to families and staff in preparing for discharge.
- There will be occasions when FBMHS are not meeting the needs of the child/adolescent and/or family and services will be terminated by the provider or by the family. In such situations, the FBMHS provider is expected to frame the decision positively for the family and assist the family in exploring other service options.
- An interagency service planning team meeting must be held prior to discharge. The referral source and/or the appropriate administrative case management program are to be notified of the closing of FBMHS.
- Providers are expected to link families with aftercare providers and assist in the successful transition to those services. Providers are expected to facilitate the transition to other levels of care to ensure continuity of care and follow-up.
- Requests for extensions beyond 32 weeks must be based on clinical rationale and prescribed by the physician or psychologist as medically necessary. Proactive discharge planning reduces the need for service extensions. The Family Based Project Director should first review any request for an extension. In addition,

Community Care will review all requests for an extension with a Psychologist or Physician Advisor internally before rendering a service determination decision.

- Community Care will consider requests for “booster shots” or the short-term resumption (generally up to two weeks) of services to a family discharged within the past year from FBMHS. This approach is appropriate when attempting to prevent an inpatient episode of care. It can also be very helpful in strengthening the implementation of the aftercare plan or modifying the aftercare plan to better meet the needs of the family. Community Care is amenable to recommendations from the provider as to the needed intensity of duration of “booster shots.” Providers may also include planned “booster shots” in the discharge planning process to assist families during transition times (such as the anniversary of a loss). FBMHS providers should always consult with the current lead treatment provider, with member or family authorization, before initiating a “booster shot.”

Cultural Competency

All FBMHS providers are expected to support the ongoing development of cultural competence within their programs. Cultural competency is currently addressed in the FBMHS training program. Assimilation of training is expected. Supervisors should make cultural competence an on-going topic of discussion with their teams.

- In the service delivery process, providers are expected to assess for the family’s needs and plan accordingly.
- As a program, Family Based takes the philosophical approach of commitment to learning from the individuals serviced and to identifying strengths and recognizing the uniqueness of each child and family. Providers should engage in open, respectful communication with children, families and caregivers about culturally based values and belief systems that need to be considered when intervening with a child.
- Providers are expected to maintain documentation of all initiatives to further develop the cultural competence and sensitivity of staff and programs
 - One means of assessing the cultural competence of a program is through member and family satisfaction surveys.
 - Another means of assessing the cultural competence of a program is through member complaints.

Outcomes

- All Family Based providers are expected to have an outcomes measurement program, consistent with their agency-wide continuous quality improvement plan.
- At a minimum, providers are expected to gather member and family satisfaction data on at least an annual basis and demonstrate quality improvement initiatives in response to satisfaction survey results. Providers are also expected to administer a standardized functional assessment, analyzed in aggregate to assess the impact of

services (GAF scores, Columbia Impairment Scale, North Carolina Family Assessment Scale or the CAFAS are some commonly used assessment tools).

- FBMHS providers are also expected to implement a plan for follow-up contact with families to gather additional information regarding the consumer's status (such as community tenure, inpatient utilization, follow-up with aftercare plan) and to develop quality improvement initiatives in response to identified issues.