



# Performance Standards

Family Focused Solution Based

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.

## **FAMILY FOCUSED SOLUTION BASED SERVICES**

### **PERFORMANCE STANDARDS**

Family Focused Solution Based Services (FFSBS) is designed for children, adolescents, and adults with a mental health diagnosis and involvement in the child welfare or juvenile justice systems. FFSBS are delivered within the home and community by a team consisting of a master's level clinician and a bachelor's level family support specialist. FFSBS are designed to integrate mental health treatment, family support services, and case management and are intended to reduce the need for out-of-home placements by enabling families to maintain their role as primary caregivers for their children and adolescents. These services have been developed on the 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/caregivers are the primary influences on their children and adolescents. FFSBS are provided to families in their natural setting. A primary goal of FFSBS is to facilitate the development of a positive milieu across community based settings that will be supportive and caring for family members after the services are completed.

FFSBS are an important service on the continuum of care that Community Care offers to our members involved in the child welfare or juvenile justice systems. There are components to the service design that distinguish this service from other community based services. All FFSBS staff participate in monthly clinical consultation and/or training with family systems theory, particularly structural family therapy, serving as the theoretical foundation of the training and including solution focused techniques. Clinical presentations by the FFSBS teams and a critiquing of their work are essential components of the training program.

FFSBS are a comprehensive program offering psychotherapeutic interventions, crisis intervention service (with availability 24 hours a day, seven days a week), family support, and case management to families. FFSBS are delivered by a team of two clinicians who provide 80% individual and 20% team delivered services. FFSBS are voluntary and an adult member of the family must want and commit to participation. The team and family work to identify and include all important people to the family that can be a source of support throughout the course of treatment, including CYF and JPO. As a result, FFSBS ensures that services are well coordinated and delivered in an integrated manner.

The referrals for this program come from CYF or JPO to enrolled providers. The providers assess the family and, if the criteria for admission into the FFSBS are met as determined by a psychiatrist or licensed psychologist, then the family is admitted to FFSBS.

The following 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 families. 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 member who receives FFSBS is to have a uniquely developed treatment plan, which identifies strengths and addresses needs.

FFSBS 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 Management Department.

### **Access Standards, Management of Referrals, and Engagement**

- FFSBS providers should continually educate referral sources about the service, program strengths, areas of specialization, and the appropriateness of referrals based on Medical Necessity Criteria (MNC). Referral sources are expected to provide sufficient information to the FFSBS provider in order for referrals to be managed appropriately.
- 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 FFSBS.
- Providers are expected to respond rapidly to referrals, consistent with agreements with CYF and JPO. 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 service planning team (ISPT) meeting with the referral source and family if there is difficulty engaging the family once services have begun.
- FFSBS providers must demonstrate reasonable efforts to engage 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.
- FFSBS providers are expected to reinforce with referral sources the importance of 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 strengths based treatment process.
- Upon initial contact with families, the FFSBS provider is expected to discuss confidentiality issues with the 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.
- FFSBS teams should talk to families about supportive people in their lives 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 FFSBS “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 FFSBS 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 contact with families to determine how to best match teams to families.
- In general, the following issues should be considered in order to effectively manage referrals:
  - FFSBS are appropriate for families 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 family from participation in the FFSBS program if a child is at risk of an out-of-home placement.
  - FFSBS are intended to be comprehensive and therefore, recipients must be willing to commit a considerable amount of time and effort to participate in the services. The model is most effective when caregivers believe that they share responsibility with other interagency team members in supporting their child to meet the goals that the family and team have worked together to develop.
  - While FFSBS may be an ideal service to support a family when a child is transitioning home after an episode of care in a residential treatment facility (RTF), it is crucial that the RTF provides a comprehensive summary of treatment progress and assists with the identification of transition goals. Ideally, the FFSBS team should initiate contact with the family 30 days prior to the discharge date from the RTF.

### **General Appropriateness for Services**

For a family to access services, a referral is made to the providers by the county CYF or JPO. The provider conducts an assessment to determine eligibility for FFSBS. A precertification form, completed and approved by the program’s psychiatrist, is faxed to Community Care for review and authorization. Families who receive FFSBS must meet the following eligibility criteria:

- Member has Medical Assistance eligibility
- Member has an Axis I diagnosis
- FFSBS is the least restrictive service that meets the needs of the family
- At least one parent or caregiver is involved and willing to participate in treatment
- A child or adolescent is a risk for abuse and/or neglect or a child or adolescent is determined to be a risk for out-of-home placement, or a child or adolescent is being reunited with the identified family.

- FFSBS also serves families who are unable to participate in traditional outpatient 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 FFSBS 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.
- Assessment of substance use and domestic violence for all family members must be done at the point of referral and during the course of FFSBS to determine if, in fact, this level of care is generally appropriate. The FFSBS team is expected to discuss such issues openly with family members, work to contract with families on conditions of participation in the FFSBS, 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 FFSBS team is expected to make a determination as to the appropriateness of the continuation of FFSBS and on the family's ability to fully participate.
- After the initiation of services, any determination by the FFSBS program that services are not appropriate for a family must be made in a timely manner, and communicated to the family and referral source. The basis of the determination must be documented and communicated to the consulting physician or psychologist.
- It is recognized that it may take a FFSBS team up to 30 days while rendering treatment services to a family to reach a final determination about the appropriateness of this level of care to best meet the needs of the family. Likewise, families may decide during this early phase of treatment that FFSBS are not appropriate and may choose to discontinue services. The FFSBS team is expected to share and openly discuss their assessments and recommendations regarding the continuation of services with families throughout the treatment process.

### **Interagency Service Planning Team (ISPT) Meeting Process**

- FFSBS providers should utilize ISPT meetings as a tool to ensure coordination of care for families. Providers must convene, at a minimum, an initial ISPT meeting within 30 days of the initiation of services and convene a discharge planning meeting prior to the close of service. ISPT 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:
  - CYF/JPO, as well as other agencies, systems, natural supports, and community resources that the family wishes to include in the meeting, are formally invited to participate and clearly notified in advance of the meeting date, location, and time. The FFSBS team should also make phone contact with those 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 FFSBS 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 FFSBS staff in the ISPT meeting should be clearly defined prior to the meeting. In preparation, the FFSBS team may role play with the family various conversations about sensitive issues that may occur during the ISPT meeting. 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, strengths, and needs of the family. The agenda should support the family to talk early in the process. 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 ensures 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 family in goal attainment.
- 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. 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.
- The FFSBS team should give families the opportunity to debrief after an ISPT meeting. The information from such a debriefing may be useful in planning for a subsequent ISPT meeting and creating a meeting environment that is supportive of families. Documentation of this discussion should occur in progress notes and member feedback should be reflected by how the subsequent ISPT meeting is facilitated.
- ISPT meeting participation is documented. FFSBS team should provide all attendees with documentation that summarizes the meeting, details what actions are to be taken, target dates for completion of assigned tasks, and identifies who is responsible for completing each assigned task. The FFSBS team is responsible for maintaining contact with members of the ISPT to ensure that all planned interventions are being acted upon.

## Crisis Planning

- FFSBS services must be available 24 hours a day, seven days a week to provide crisis intervention services. FFSBS 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 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 FFSBS team. Any process FFSBS programs develop to meet the expectation for 24 hours a day, seven days a week availability must result in a prompt response to a family's request for help. Consistent, prompt responses must be evident from review of the 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 receiving FFSBS is presenting for hospitalization, the inpatient provider will contact the FFSBS provider. Community Care will then also contact the FFSBS provider. The FFSBS provider is expected to fully communicate with the inpatient provider and work to divert the hospitalization, when clinically appropriate. Ideally, a representative from the FFSBS program should meet the family at the facility and support the family through the diversion. CYF/JPO will be notified of any safety factors to a child or adolescent, which may result in the need for placement. If CYF/JPO deems it necessary to place a child or adolescent, then Community Care is notified by the FFSBS service team.
- FFSBS teams are expected to develop individualized crisis/safety plans with families at the initiation of services. Families should be asked to define what constitutes crises to them 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 team to follow through with identified steps. Directions to the families' home should be available to the FFSBS program to be proactive 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 family.
- Crisis plans should be signed by the family and by the treating FFSBS team.
- Crisis plans should be available to any staff within the FFSBS program that 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 if an inpatient admission or out-of-home placement occurs.
- Crisis plans should be shared with systems and service providers who may be involved with families being served by the FFSBS 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, and specific alternatives to be tried prior to consideration of inpatient treatment (given that the situation can be safely managed in current level of care).

- A FFSBS team is expected to review the crisis plan with the family following crisis situations. The plan should be revised when clinically indicated.

### **Treatment Planning Process and the Development of the Treatment Plan**

- FFSBS providers are expected to create a service delivery environment in which the family participates as a full partner of the treatment team in the development of the treatment plan.
- The service planning process is expected to identify initial priorities for services and establish a progressive course for treatment. The team should do an immediate safety risk assessment. An initial treatment plan, addressing the issues that put a child or adolescent at risk for out-of-home placement, should be developed at the initiation of services. This plan should include a crisis/safety plan for the 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 individual and family functioning.
- The treatment plan is to be developed in collaboration with the family and is expected to be completed within 30 days of the initiation of services. It should demonstrate an integrated, well-collaborated approach to services across all involved systems. The treatment plan document serves as a “contract” between all involved parties regarding their responsibilities for the services to be rendered to the family. The treatment plan is to be updated with the family at least every 30 days.
- With the family’s consent, all members of the ISPT should receive copies of those parts of the treatment plan relevant to their involvement with the family. 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 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, FFSBS teams should consider including the program supervisor in a discussion with the family while reviewing the treatment plan progress.
- 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 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 must be achievable and measurable goals must 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.
- The treatment plan should identify how services from several sources will be coordinated and integrated to best address the needs of the family. When multiple systems are involved, the FFSBS team should discuss with the family the need for regularly scheduled ISPT meetings. The FFSBS 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.
- Establishing the primary goals for services is often difficult given the complex needs of the family in 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. FFSBS teams should assist the family in focusing on a few meaningful, attainable goals for the episode of care. The identified goals should require services of the intensity of FFSBS. Having measurable goals to review also helps the family 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.
- Treatment plans should reflect building support systems and community linkages. FFSBS are always to be aimed at building family self-sufficiency and healthy interdependency.
- The crisis/safety plan should be considered as part of the treatment plan and should be developed at the initiation of services.
- The treatment planning process should prompt a discussion with the family to identify discharge goals and to prepare for the transitioning out of the FFSBS program. While it is often difficult to balance engaging the family in treatment and preparing for discharge, it is essential that FFSBS providers commit to discussing discharge planning on a regular basis with the family. “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 ongoing discussion.
- Progress notes should be connected to the treatment plan and FFSBS 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.

## **Service Delivery**

- FFSBS services are designed as a comprehensive service with the primary goal of enabling the family to care for children in the home and reduce the need for out-of-

home placement. Related goals include strengthening the family, improving coping skills, and serving as an advocate.

- Within the first five days of treatment, the FFSBS team works with the family to identify the preliminary service goals, making sure to address any safety issues first. During the first month of services, the FFSBS team conducts various assessment activities and works very closely with the family to develop a comprehensive treatment plan. Ongoing assessment activities to measure functioning improvements are essential during the course of service delivery.
- In addition to early assessment and treatment planning activities, a primary goal of early contacts with the family is to engage the family fully in treatment. FFSBS providers are expected to try multiple interventions that support the families to fully participate in services. Programs are expected to have a comprehensive orientation process for families to promote engagement.
- Family systems theory, structural family therapy, solution focused techniques, cognitive behavioral therapy, and ongoing training and supervision are central to the model of FFSBS. FFSBS programs are expected to utilize appropriate clinical and behavioral interventions from various schools of thought.
- FFSBS programs are expected to provide treatment services that include assessment, crisis planning and intervention, therapy, and case management support. Service linkage, coordination of care, and family support and advocacy are also key components of FFSBS. Given the multiple types of services delivered in this model and the complex needs of the family who is typically serviced, it is imperative that FFSBS providers attend to the balance of services delivered, ensuring that proper attention is given to treatment needs. FFSBS are also expected to introduce innovative therapeutic activities in response to input from the family.
- 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.
- 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 member 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 a component of the FFSBS program; therefore effective management of the program must include the ongoing assessment and monitoring of the use of team delivered services at a family level as well as at a program level. The supervisors are responsible for ensuring that 20% of each team’s time is spent rendering team delivered services. Clinical discussion in supervision and during all treatment planning activities should provide the basis as to how to most appropriately manage this aspect of the FFSBS program.
- The assessment of the family's needs and the treatment plan should be used as a guide in determining the intensity of service delivery. Given the variability in service

intensity, 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.

- FFSBS is characterized by the expectation and ability to address the strengths and needs of individual family members as well as the family as a unit. The team should explore collaboratively with the family unit, the strengths, needs, and possible service linkages for each family member.
- Individual work can be done with other family members as long as it is directly tied to the identified member’s treatment goals. While FFSBS 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. FFSBS 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 the FFSBS program and the case management component of the service, the team should function as the lead clinicians for the member. 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. FFSBS providers should also help to educate other systems about the role of the program to promote effective coordination of care.
- While the family may sometimes not feel comfortable including others involved in their care at an ISPT meeting, FFSBS providers are expected to explore this fear or concern with the family and facilitate the strengthening of the family’s relationships with other systems when possible.
- FFSBS 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 PCP
  - Education/vocational systems

- Child protective services
- Juvenile probation
- Other behavioral health providers such as Intensive Case Management, drug and alcohol services, psychiatric evaluation, and medication monitoring, etc. When psychiatric services are being provided, it is imperative that the FFSBS providers maintain communication with the treating psychiatrist. FFSBS teams are expected to assist the family in monitoring adherence to the medication regimen. FFSBS providers should encourage family members to seek psychiatric services when it appears as if a family member has a disorder amenable to psychotropic intervention or is in need of more intensive psychiatric services.
- In exceptional cases when FFSBS are delivered in combination with behavioral health rehabilitation services (BHRS), such as therapeutic staff support (TSS), or an in-home provider, the FFSBS treatment plan must clearly delineate the treatment goals of the BHRS and in-home provider. Attention must be given to not duplicating services unnecessarily and to ensuring that services are delivered in a well coordinated manner. FFSBS providers hold the responsibility for leading or providing clinical direction to the other providers when jointly serving families. Regular meetings or discussions must occur between the providers to ensure the coordination of care. Linkage agreements should be established to detail the nature of the working relationship between the entities, especially when a pattern of shared cases is established.
- FFSBS providers are expected to hold other involved service providers accountable by following up with those providers that are failing to provide interventions agreed to during the ISPT meeting and the development of the comprehensive treatment plan.
- FFSBS providers are expected to establish linkage agreements with other providers and child service system partners. Such linkage agreements are intended to be practical documents that clarify expectations of each other. Linkages should be reviewed at least annually.

## **Discharge Planning**

- Discussion 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.
- An episode of FFSBS is defined as three to six months. 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 professional advisor at Community Care will review any requests for an extension beyond the six month limit.
- FFSBS 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 FFSBS staff are often intense. FFSBS providers may also use “transition sessions” of less frequency to help families prepare for discharge. FFSBS are required to maintain at least weekly contact with the families during this transition time. FFSBS will utilize titration of services prior to discharge as a means for testing treatment gains and sustainability of gains once discharged from the program. “Graduation celebrations” or rituals are often useful to families and staff in preparing for discharge.

- There will be occasions when FFSBS are not meeting the needs of the family and services will be terminated by the provider or by the family. In such situations, the FFSBS provider is expected to frame the decision positively for the family and assist the family in exploring other service options.
- An ISPT 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 FFSBS.
- 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 six months must be based on clinical rationale as presented by the team and the team’s psychologist/ psychiatrist. In addition, Community Care may review all requests for an extension internally with a psychologist or physician (referred to as professional advisors) 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 FFSBS. 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). FFSBS providers should always consult with the current lead treatment provider, before initiating a “booster shot.”

## **Cultural Competency**

- FFSBS providers are expected to support the ongoing development of cultural competence within their programs. Supervisors should make cultural competence an on-going topic of discussion with their teams.
- Cultural Competency will be addressed in the FFSBS training curriculum.
- FFSBS programs take the philosophical approach of learning from the families serviced, identifying strengths and recognizing the uniqueness of each family. Providers should engage in open, respectful communication about culturally based values and belief systems before intervening.

- Providers are expected to maintain documentation of all initiatives to further develop the cultural competence and sensitivity of staff and programs. Some of the ways to assess the cultural competence of a program is through family satisfaction surveys and/or member complaints.

## **Outcomes**

- FFSBS providers are expected to have an outcomes measurement program, consistent with their agency-wide continuous quality improvement plan.
- FFSBS providers are expected, at a minimum, to gather family satisfaction data on at least an annual basis and demonstrate quality improvement initiatives in response to the survey results.
- Providers are expected to administer a standardized functional assessment (GAF scores, Columbia Impairment Scale, North Carolina Family Assessment Scale, CAFAS, or Los Angeles Family Assessment) to analyze the impact of services.
- Providers are expected to have outcomes related to child safety, permanency, and well-being.