



Performance Standards

Mobile Therapy

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

MOBILE THERAPY

FINAL

5/4/06

INTRODUCTION

On January 1, 1994, the Department of Public Welfare (DPW) added Mobile Therapy (MT) to the Medical Assistance (MA) fee schedule as a new outpatient psychiatric mental health service. MT is one of the several behavioral health rehabilitation services (BHRS) that MA recipients under the age of 21 may receive if they meet medical necessity as a result of a diagnosis of mental illness or serious emotional disturbance. MT, as well as the other BHR services, is available for children who present with social, emotional, or behavioral issues that result in impairment that substantially interferes with or limits the child's role or functioning in family, school, or community activities. BHRS, including MT, are services that will or are reasonably expected to improve or stabilize certain behavioral symptoms exhibited by children. BHR services are not intended to assist children and their families in dealing with the normal and expected behaviors related to the child's stage of growth and development.

MT services are part of the comprehensive mental health system of care for children, adolescents and their families approved by Congress in 1984 for the Child and Adolescent Service System Program (CASSP). This children's system of care is based on a well-defined set of principles for mental health services for children and adolescents with or at risk of developing severe emotional disorders and their families. These principles are summarized in six core statements also known as the CASSP Principles:

- **Child-centered:** Services meet the individual needs of the child, consider the child's family and community contexts, and are developmentally appropriate, strengths-based and child-specific.
- **Family-focused:** Services recognize that the family is the primary support system for the child and participates as a full partner in all stages of the decision-making and treatment planning process.
- **Community-based:** Whenever possible, services are delivered in the child's home community, drawing on formal and informal resources to promote the child's successful participation in the community.
- **Multi-system:** Services are planned in collaboration with all the child-serving systems involved in the child's life.
- **Culturally competent:** Services recognize and respect the behavior, ideas, attitudes, values, beliefs, customs, language, rituals, ceremonies and practices characteristic of the child's and family's ethnic group.

- Least restrictive/least intrusive: Services take place in settings that are the most appropriate and natural for the child and family and are the least restrictive and intrusive available to meet the needs of the child and family.

Mobile therapy is a face-to-face, child-centered, family-focused, individualized psychotherapy provided in a setting, other than a therapist's or provider's office identified in the treatment plan as the site where the child will benefit from therapy. The Mobile Therapy Performance Standards are the result of a series of meetings facilitated by Community Care Behavioral Health, with representatives from network BHRS providers, county representatives, consumers, parents/guardians of consumers and representatives from oversight entities. The goal of these 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 BHRS providers offering Mobile Therapy to MA consumers, and define the parameters of reasonable standards of practice for the provision of this service. 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 care for children and adolescents.

These standards should not be interpreted as regulations, but rather a progression towards a better standard of performance. These standards will not be utilized as a means of requiring or prohibiting specific interventions for specific individuals. Each child or adolescent receiving Mobile Therapy services will have a uniquely developed treatment plan, which identifies strengths and addresses needs.

BHRS providers are expected to monitor adherence to the standards and to take corrective actions where indicated to assure compliance 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 to high quality Mobile Therapy providers.

SERVICE DESCRIPTION

Core Services

Mobile Therapy (MT) is a voluntary mental health treatment service for children and their families. Mobile therapy includes face to face, child centered, family focused,

individualized and family psychotherapy, and behavioral management (only if the clinician is skilled in Applied Behavioral Analysis – ABA), utilizing a strengths-based approach, provided in a setting other than a therapist or provider’s office. The settings in which MT is to be provided is identified in the treatment plan by the treatment team at the Interagency Service Planning Team (ISPT) meeting. When other behavioral services are being provided simultaneously, the MT should serve as the Primary (Lead) Clinician. The lead clinician should have the primary responsibility of the clinical direction of the treatment for the child including development of the treatment plan, coordinating and attending ISPT meetings, collection of data, measurement of symptomatology, and reporting progress on identified goals. As defined in the treatment plan, the MT can provide specialized therapies providing the MT is certified in this specific type of treatment. Although MT may be utilized with children with autism spectrum disorders and/or children with mental retardation, the Behavior Specialist Consultant (BSC) is typically the primary or lead clinician for these children, and therefore, takes responsibility for the above tasks excluding psychotherapy.

BHRS, including MT is more restrictive and intrusive to the child and family than typical outpatient therapy, but less restrictive than treatment in Individualized Residential Treatment (IRT) or a Residential Treatment Facility (RTF). The clinical intensity of MT is individualized to meet the child’s behavioral health needs. MT may be an alternative for other levels of behavioral health care when:

- Children are in need of a step down from more restrictive levels of care including inpatient, RTF and IRT
- Children are in need of a step up in service from outpatient treatment
- Children are in need of further assessment by a master’s level clinician in the field
- Children are in need of therapy in a community setting to reduce symptoms in a specified community domain, i.e., home, school or other community setting

The ultimate goal of MT is to improve or stabilize certain behavioral health symptoms exhibited by children in the domains in which they are occurring; however, MT is not intended to assist children and their families in dealing with the normal and expected behaviors related to the child’s stage of growth and development.

Average Length of Stay

The average length in treatment with MT is between 4 – 8 months; however, length of stay can vary depending on the child and family’s needs.

Scope of Services

Mobile Therapy (MT) includes face-to-face, child-centered, family-focused, individualized psychotherapy provided in a setting, other than a therapist or provider’s office identified in the treatment plan as the site where the child will benefit from therapy. Settings include the child’s home, in particular. Other potential settings for the

mobile therapist's services include the school, member's place of worship, the community center, a neighbor's or extended family member's home, and other community settings.

Services provided by a mobile therapist vary according to the individualized needs of a child and family. Core services include the following:

1. Assessment of strengths and therapeutic needs of child and family.
2. Active listening, asking questions, and exchanging information with child and family. These are critical elements of assessment and treatment.
3. Inclusion of the child as a participant in his/her own treatment.
4. Inclusion of parents or other caretakers as members of the treatment team and as partners in treatment. Such inclusion requires that the family actively participate, in an ongoing manner, in the formulation, development, implementation, and monitoring of treatment efforts. Such participation presumes the family's broad knowledge about the child and the family's intention to contribute constructively to positive outcomes. Parental participation in the ISPT, Treatment Plan development/reviews, and Individual Education Plans (IEP's) is essential, and should be supported by the mobile therapist. However, family participation should occur throughout treatment, not just at the time of formal reviews.
5. Determination, with the family and the case manager, of any necessary family support services. Development, with the case manager and other involved professionals, of a plan to obtain these identified services.
6. Provision of child-centered, family-focused, individual and family psychotherapy, as agreed upon by therapist and family. It is expected that the mobile therapist, in addressing defined problems, will utilize a strengths-based approach. Specific formats for individual and family therapy will vary according to the individualized needs of the child and may include, in the home or community setting, sessions with:
 - the child individually,
 - the entire nuclear family,
 - the family and a community resource – minister, Scoutmaster, community leader, mentor, other;
 - the family and teacher, guidance counselor, or principal;
 - subsystems of any of the above, as clinically indicated and agreed upon.
6. Provision of collateral therapy to other members in the home. Collateral therapy is therapy, which is related to the primary consumer.
7. Determination, in conjunction with child and family and other involved professionals, of the clinical need for special evaluations and services, such as medication assessment by a psychiatrist, psychological testing, or other.
8. Collaboration with the child, family and other involved professionals to develop daily routines during times of crisis and transition and a 24-hour crisis plan.
9. Collaboration with other involved professionals and agencies in order to provide unified services and continuity of care to child and family.

10. If clinically experienced, the MT may bill for the following activities when a BSC is not authorized or when the MT is designated in the treatment plan as the lead clinician:
 - a. Consultation with parents, school officials, and other persons either in person or by phone concerning the behavioral health needs of the child.
 - b. Attendance at meetings involving the child's behavioral health issues. Please note; however, that if MT and BSC services are both authorized for a member, the MT and BSC cannot bill at the same time when attending the same meeting.
 - c. Phone calls to the child or family in times of crisis.
 - d. Development of the treatment plan, goals and objectives.
 - e. Collecting and analyzing data for the purpose of developing a behavior plan.
11. Any additional MT responsibilities as defined in the child's treatment plan and authorized by Community Care.

Noncovered Services

Payment will not be made for the following:

1. Service(s) provided to individuals 21 years of age or older.
2. Covered service(s) that have not been rendered.
3. Service(s) provided before Community Care has authorized the service.
4. Services rendered not in accordance with an approved service description.
5. Services provided before the completed psychiatric or psychological evaluation is signed by the prescribing physician or recommending licensed psychologist.
6. Services not identified on the child's treatment plan.
7. Clinical and administrative functions and activities other than direct provision of services, excluding time spent by either a Mobile Therapist or a BSC in:
 - a. gathering data for the development of a treatment plan;
 - b. attending ISPT meetings.
8. MT provided to parents, siblings, or others to address problems not directly related to the child's issues and not listed on the child's treatment plan.
9. MT and BSC services provided by the same person to the same child.
10. Services performed by a BSC serving as a primary clinician except for children with a diagnosis of Autism Spectrum Disorder.
11. TSS services provided to children who are not in active treatment with a primary clinician.
12. Services provided as a substitute for educational personnel such as but not limited to a teacher, a teacher's aide, or an academic tutor.
13. Habilitative services.
14. Services provided as a substitute for the parent or other adults responsible for providing care.
15. Respite care.
16. Transportation for the child and/or family.
17. Services provided by individuals who do not meet the staff qualifications for services on the MA Program Fee Schedule.

18. Services provided by individuals who do not meet the staff qualifications described in the approved service description for services not on the MA Program Fee Schedule.
19. Services for a child who is already receiving Psychiatric Partial Hospitalization, Family-Based Mental Health or Residential Treatment Facility (RTF) services, unless approved as medically necessary by a Community Care Physician Advisor.
20. Services provided during STAP hours of operation unless approved as medically necessary by a Community Care Physician Advisor.

Relationship of Mobile Therapy to the Continuum of Behavioral Health Care

Mobile Therapy is a behavioral health rehabilitation service (BHRS), which provides face-to-face, child-centered, family-focused, individualized psychotherapy in a setting other than a therapist or provider's office. BHRS, including MT, fits into the continuum of care between outpatient treatment and IRT or RTF treatment (see continuum of care chart in Appendix 1). On the continuum of behavioral health care, BHR services, including MT, are on the same level as Family-based Mental Health Services (FBMHS) because both are community based services. However, FBMHS have a different overall focus than BHRS. FBMHS should be considered when:

- the family unit is the focus of treatment;
- when 1 or more members of the family are in need of intensive community based services including, but not limited to, case management, individual and family therapy, crisis management, behavioral intervention, parent management training, community linkages (including advocacy, housing, finding community social and recreational resources, etc.); or
- when intensive family-based treatment can divert a more restrictive and intrusive level of care such as RTF or inpatient.

Unlike BHRS, FBMH services are delivered in a team format, limited to 32 weeks of intensive individual and family therapy, include case management and crisis services in addition to individual and family therapy; and the parent(s) or guardian(s) must participate in family treatment at a minimum of one time/week.

Exclusionary Criteria

MT would not be recommended if a child was exhibiting symptoms involving extreme dangerousness including; recurrent suicidal behavior, active psychosis, extreme homicidally; and active fire-setting behavior. In any of these instances a more restrictive level of behavioral health care would be more appropriate.

STAFFING REQUIREMENTS

MT Qualifications, Training and Supervision

Qualifications:

- A MT is a licensed mental health professional or an individual with a graduate level mental health degree (i.e., may include a degree in the field of education, juvenile justice, pastoral counseling, or human services).
- All MT's must have participated in a clinical practicum in the mental health field; or have at least 12 graduate credits in counseling; or at least 2 years paid experience providing clinical supervised treatment to children with mental illness or serious emotional disturbance.
- MT's with a clinical practicum or at least 12 graduate credits in counseling must have at least one year experience;
 - in a CASSP system (i.e., employed by or under contract to CYS/F, Juvenile Justice, Mental Health, Special Education, or D & A) working with children;
 - or employed by a licensed mental health services agency or subcontracted agency
- All MT's must have Act 33/34 clearances prior to the provision of services and annually thereafter.

Training

Prior to working alone with children, MT's must receive training on the following topics: professional ethics; conduct and legal issues including professional boundaries with children and families; child and general protective services and mandated reporting; confidentiality; CASSP principles and implementing and supporting those principles in clinical practice; the role of BHRS, including MT, in the home, school, and community settings; community resources; crisis intervention; and behavioral management and safety. In addition, each MT must receive at least 20 hours of training each year after the first year of full-time employment to acquire additional knowledge and skills related to the required job responsibilities and the population of children who he/she is treating. Suggested training after the first year of employment includes, but is not limited to: specific family therapy models including structural family therapy, social systems and models of family preservation; community based individual and family therapy; incorporating outcome measurements into the community based treatment model; and other various models of therapy including family therapy with developmental disabilities; grief/loss, divorce, abuse, sibling problems; fire-setting, substance abuse, sex offending, parent education about medications and diagnosis; normal child development; parenting skills, and behavioral therapy using an Applied Behavioral Analysis (ABA) model of intervention.

Supervision

There are two entities for the supervision of MT's; Administrative Oversight and Clinical Oversight.

Administrative Oversight involves monitoring by the enrolled provider to assure that all services provided either directly or through subcontractors are in compliance with all federal and state statutes and regulations, and the conditions and limitations established in these performance standards and MA bulletins and provider handbooks are being followed. Administrative Oversight entails the following activities; monitoring the professional qualifications; delivery of prescribed hours; accurate documentation and compliance with all state, managed care and agency documentation regulations; tracking the member's MA eligibility; tracking authorizations; knowledge of program policies and procedures; monitoring compliance with regulations, i.e. HIPAA, BHRS and DPW; developing and reviewing the MT job description; performance evaluations; monitoring training hours; ensuring availability of resources and clinical material; oversight of incident reports, grievances and complaints; maintaining consumer rights; oversight of billable hours; and oversight of time sheets.

Clinical Oversight involves monitoring by the enrolled provider in order to assure and improve the quality of rendered services, of the interventions and functioning of involved direct staff, which includes the following: professional conduct while carrying out assigned tasks and responsibilities; development of the treatment plan; fidelity to the treatment plan upon implementation; coordination of care with other involved staff; and consultation with the assigned Supervisor. Clinical Oversight also includes Clinical Supervision, which consists of professional development and monitoring of direct services in which the MT's performance and functioning is reviewed by a qualified clinical supervisor. Therefore, Clinical Oversight involves clinical supervision in reference to the children and families in which the MT is providing service. The requirements for clinical supervision include:

- the equivalent of 1 hour per week of supervision for MT's providing 20 or more hours per week of direct service OR the equivalent of 30 minutes per week of supervision for MT's providing less than 20 hours per week of direct service
- a review and discussion of the progress of each child on the MT's caseload at least once per month
- implementation of the treatment plan including specific interventions which are clinically appropriate for the child's diagnosis and realistic for the child and family
- an evaluation of the efficacy of the clinical interventions
- the development and utilization of a crisis plan for each client on the MT's caseload
- coordination with other professional and paraprofessional team members
- the MT's efforts to collaborate with the family, the treatment team members and apply CASSP principles
- the outcome of action steps planned in the preceding supervisory session
- the projected action steps to the next supervisory session
- incorporating natural and community supports into the treatment plan

- facilitating transition plans and incorporating discharge planning from the beginning of treatment
- the clinical application of specific regulations, i.e. mandated reporting and HIPAA or example

Qualifications of the MT Supervisor

Supervision of other staff is not a requirement of MT; however, some MT's may supervise other master's or bachelor's level staff if they meet the necessary qualifications as outlined in the DPW Bulletin. Qualifications of the clinical supervisor for MT staff include a master's degree in a mental health field; a clinical practicum; at least 2 years of post-graduate paid experience providing clinically supervised treatment to children with mental illness or serious emotional disturbance; and at least 1 year of experience supervising master's level staff who are treating children with mental illness or serious emotional disturbance. Clinical supervision may include individual or group sessions, but may not be exclusively group. Also, clinical supervision can be concurrent with administrative supervision provided the supervisor meets the qualifications of both.

Provider Policy and Documentation Requirements for MT Supervision

BHRS providers must develop and maintain a written policy for clinical supervision of MT's, and maintain or have access to documentation of the clinical supervision provided. The provider must maintain or have access to the record of supervision. The record must contain documentation that includes: the date and time of the supervision session, the location of the supervision session, the exact clock hours spent in the supervision session, a narrative descriptive summary of the points discussed during the session and identification of specific children discussed, and the dated signatures of both the supervisor and the supervised Mobile Therapist.

REFERRAL PROCESS

Access Standards

Upon receipt and acceptance of a referral for an initial evaluation, evaluators or facilities providing evaluation services are expected to schedule an appointment with a child and family within seven days of the referral date. In HealthChoices, access to routine care is expected to be provided within seven days. According to MA Bulletin 01-01-05, 29-01-03, 33-01-03, 41-01-02, 48-01-02, 49-01-04, 50-01-03 the Department expects each authorized BHR service to begin no later than sixty days after the initial request for services, unless the evaluation prescribes different timeframes. An initial request for service may be made by telephone, in person, or in writing. In order to meet this timely access to services standard, it is necessary for evaluators to complete evaluations in a timely manner.

If an evaluator offers an appointment within seven days, but this date and time is not agreeable with the family, and all agree to a date outside of the access standard, the evaluator is expected to document that an appointment within the access standard was offered to the family and the reasons for the date chosen.

When an evaluator is unable to offer an appointment for an initial evaluation within seven days, the family is to be given information about available options. The evaluator may offer the family appointment options outside of the access standard. The evaluator is also expected to inform the family that other evaluators may be available to offer an earlier appointment date. If the family chooses to accept an appointment outside of the access standard, the evaluator documents this choice. If the family would like to seek a referral to another evaluation, Community Care is to be contacted. Community Care will facilitate a referral to an evaluator that is able to meet the access standard.

Intake/Admission Procedures

Best Practice/Life Domain Evaluation

Prior to receiving any combination of BHR service, including MT, BSC and/or TSS, each child must receive an initial Best Practice/Life Domain evaluation conducted by a licensed psychiatrist or psychologist recommending MT as the least restrictive, least intrusive treatment necessary to meet the behavioral health needs of the child. Best Practice/Life Domain re-evaluations must be conducted every 4 months for children with a non-autistic disorder, or up to 12 months for children diagnosed with an Autism Spectrum Disorder (ASD), to continue treatment MT services. The initial Best Practice/Life Domain evaluation expires after 60 days and re-evaluations after 45 days, i.e., the BHRS packet requesting MT must be received by Community Care w/in 60 (initial request) or 45 (continued stay request) days from the day of the BP evaluation. The outline for the Best Practice/Life Domain evaluation must follow the Life Domain Format for Psychiatric/Psychological Evaluations, 2nd edition, as defined by Dr. Hodas in the Guidelines for Best Practice in Child and Adolescent Mental Health Services, Copyright 2001, can be seen in Appendix II. All Best Practice/Life Domain evaluations must also include a MISA screen; a screen for domestic violence and abuse and a global standardized measure.

BHRS Brief Treatment

The Office of Mental Health and Substance Abuse Services (OMHSAS) approved Community Care's request to allow providers in our network to implement a brief treatment model of BHRS. BHRS Brief Treatment became available to our providers in Allegheny County on January 1, 2004 and in York, Berks and Adams Counties on February 1, 2005. Providers may use the BHRS Brief Treatment Model for requests for Mobile Therapy (MT) *or* Behavioral Specialist Consultation (BSC) *only*, when requests are between the hours of 1 - 6/week. The following guidelines must be followed when requesting MT via BHRS Brief Treatment:

- An assessment by a master's level behavioral health clinician *and* a letter of recommendation *or* Prescriber Collaboration Form for BHRS Brief Treatment by a psychiatrist or licensed psychologist may be used to establish Medical Necessity for this service.

- Medical necessity determination will be based upon DPW's Appendix T BHRM Medical Necessity Criteria.
- Treatment is limited to MT *or* BSC *only*. A member will receive either MT *or* BSC, but not both services at the same time. TSS services will not be provided during BHRM Brief Treatment.
- Treatment will be limited to a maximum of thirty-six (36) weeks, with a maximum limit of two consecutive episodes of Brief Treatment per child.
- Treatment will be limited to a minimum of 1 hour per week and a maximum of six hours per week.
- Treatment delivery will begin with a specific number of hours/week (1 – 6 hrs/week) as recommended by the licensed psychologist or psychiatrist, but may fluctuate (between 1 – 6 hours per week) pending the child/family's need, concurrent review, and agreement of the ISPT, including the licensed psychologist or psychiatrist, with the plan for service.
- Three, non-consecutive two-week booster sessions will be permitted as needed for stabilization of the child/family within one year after the BHRM Brief Treatment service has ended. Booster sessions are limited to a maximum of MT *or* BSC for 6 hour/week. If more than two weeks of booster treatment is needed to stabilize the child, an additional booster session or a referral for traditional BHRM or an appropriate level of care will be made.
- The evaluation or assessment by Master's level or higher level clinician must include at minimum; a 5 axis diagnosis; referral concerns; a MISA Screen for children 12 years of age and older; a screen for domestic violence and abuse; a recommendation that outpatient behavioral health treatment is inappropriate or insufficient to meet the needs of the child; and the evaluation/assessment must be performed within 60 days of the date on the letter of recommendation *or* prescriber collaboration form.

MISA Screen

In 1999, the report of the MISA Consortium emphasized the fact that early identification of the existence of co-occurring disorders is crucial to ensuring that individuals receive appropriate behavioral health services. The report of the MISA Consortium recommended an initial screening process and identified essential components of a MISA assessment, to be conducted at the point of entry into either the mental health or the drug and alcohol service delivery system.

Community Care is committed to furthering the implementation of the recommendations outlined in the MISA Consortium Report. Therefore, it is the expectation of Community Care that all members 12 years of age and older be screened for the presence of symptoms of mental health issues and issues related to alcohol and other drug usage. For BHRM evaluations and BHRM Brief Treatment assessments, providers are expected to screen for the presence of mental health and substance abuse issues. The purpose of the screening process is to assess the member's immediate needs and whether emergency services are warranted. It is also our goal to ensure that all members are screened and then referred for an assessment for co-occurring disorders

when indicated. Consistent with the 1999 MISA Consortium Report, the MISA screening process is to be conducted by appropriately trained individuals and is to identify:

- 1) Alcohol and other drug issues
 - a) Substances used and intensity of use
 - b) Likelihood and severity of withdrawal
 - c) Medical and behavioral risk secondary to intoxication
- 2) Mental health issues
 - a) Suicidal, homicidal ideation/intentions/plans/history
 - b) Impairment of function and/or judgment
- 3) Medical issues
 - a) Pregnancy
 - b) Conditions posing an immediate risk of harm to self or others
 - c) Current medications and recent ingestions of any non-prescribed drugs or alcohol
- 4) Special needs
 - a) Barriers to access
 - b) Environmental risks

When contacting Community Care to request an initial authorization for services for a member, the Care Manager will ask if a MISA screening has been conducted for the member in question. All providers are expected to screen for the need for mental health services **and** drug and alcohol services for each individual that approaches them for treatment and to assist the member in accessing necessary services. Providers are also expected to re-assess for the existence of co-occurring disorders at each re-evaluation for BHR services. When conducting routine medical chart audits, Community Care will determine provider compliance with this expectation for all levels of care. In addition, at site visits by our Credentialing Department, Community Care will ask for verification that providers have a policy and procedure in place that demonstrates the provider's commitment to assess all of the individuals they serve for mental health and substance abuse issues.

Family Choice

After an evaluation or assessment is completed recommending MT services the child and family must choose a BHRS provider to deliver this service. According to the Bulletin, "all MA recipients have the freedom to select the providers from whom they receive their behavioral health services without undue influences. Providers **must** comply with all federal and state regulations regarding an MA recipient's freedom of choice and should in no way attempt to alter or to influence the recipient's decision and choices."

Once a provider has been chosen the provider will schedule an Interagency Service Planning Team (ISPT) meeting within 7 – 14 days of the evaluation or assessment recommending MT.

Interagency Service Planning Team Meeting (ISPT)

Within 7 to 14 days after the Best Practice/Life Domain evaluation or assessment for BHRS Brief Treatment has been completed, an Interagency Service Planning Team Meeting (ISPT) is held. The main goal of the ISPT is to gather input from all entities involved with the child including: the child, his/her legal guardian, community affiliates as defined by the child/family, a school representative (required if services are to occur at school), all behavioral health service providers involved with the child, the Community Care Behavioral Health Care Manager and the County MH/MR representative, to develop a comprehensive treatment plan. The ISPT provides a forum in which the child's unique needs can be addressed and the family and child's voice heard. By drawing on the contributions of individuals with multiple perspectives who best know the child, the ISPT can enable a unified approach, with a single plan and offer a structure for the potential attainment of unity among all involved stakeholders.

Once the ISPT members agree on BHRS, specifically MT, as the least restrictive/intrusive level of care that can meet the child/family's needs, the treatment goals are defined. The treatment plan is then written by the primary clinician i.e., typically the MT, and approved by the family. An effective treatment plan should be both informative and practical. A person reading a treatment plan should be able to grasp the major concerns and how they are being addressed. As a "work plan," the initial treatment plan identifies the work to be done. Subsequent ISPT's are held to further develop the treatment plan and identify what is currently being done, what has recently been achieved and work and services planned for the future. By defining goals and objectives, which are measurable and can be monitored, the treatment plan becomes an instrument of accountability. The team can actively track identified goals, objectives and outcomes, and modifications in treatment made as needed.

ADMISSION PROCESS

Targeted Member/Client Population

Children and adolescents under the age of 21 with an Axis I or Axis II diagnosis (Axis II cannot stand alone) are eligible for MT. Members targeted for this level of care are in need of services in the community (including home, school, and/or community) because it has been determined that clinic-based treatment is not sufficient and the child is in need of individual or family psychotherapy and/or behavioral management in the community setting. For these individuals it has been determined that a less intensive level of care will not offer the expectation of improvement or perception of deterioration, and that on-site intervention will be more effective than clinic-based treatment. The child's risk of safety to self and others must be manageable in the community for this level of care. Members receiving MT may also have significant psychosocial stressors or a medical condition that increases the risk of declining functioning. A member who is being discharged from a higher level of care may need community-based treatment to sustain gains made, thus making MT an appropriate disposition plan. Short-term MT may be utilized with members with a diagnosis of an Autism Spectrum Disorder (ASD) or Mental Retardation (MR) in instances in which; individual and/or family therapy/psychoeducation is needed to address a new diagnosis of ASD and/or MR; a

family crisis or stressor has resulted in a decrease in the child's functioning and treatment progress has arrested due to this crisis or stressor; or to address a destructive behavioral patterns in the family that impeded the child's progress. In all instances in which MT is recommended, the parent and child must be involved in the treatment planning process and agree to participate in this level of service.

Medical Necessity Criteria

Medical necessity criteria for BHRS, including MT can be reviewed in Appendix T, Part B on the DPW Website:

<http://www.dpw.state.pa.us/omap/rfp/hlthchcrfp/HlthChBHAppdxTPartB.asp>

TREATMENT PLANNING PROCESS

Interagency Service Planning Team Meetings (ISPT's)

The interagency team, through its formal meetings and its follow-up activities, is expected to play a key role in planning, implementing, and monitoring the child's treatment. The ISPT has more than regulatory relevance, however. It embodies CASSP Principles in action. For example, the ISPT provides a forum in which the child's unique needs can be addressed and the family and child's voice heard (CASSP Principles #1 and 2: child-center and family-focused). By drawing on the contributions of individuals with multiple perspectives who know the child, the ISPT can enable different mandates and interests to be reconciled and a unified approach, with a single plan, developed (CASSP Principles #4: multi-system). In addition, the team draws upon natural supports and community resource persons (CASSP Principles #3 and 5: community-based and cultural competence). The clinical focus of the team plan is to help the child remain at home and in the community whenever possible, and to promote self-sufficiency as part of treatment (CASSP Principles #6: least-restrictive/least intrusive).

An effective ISPT has two principal goals that set into motion an ongoing process to address the unique needs of the child and family. These goals are: a) to create a context for restoring hope to the child and family and b): to promote constructive, collaborative treatment planning to benefit the child and family.

In Pennsylvania, the ISPT occurs after a Best Practice/Life Domain (BP) evaluation (or assessment by a master's level clinician for Brief Treatment MT) has already occurred, basic information has been gathered, and MT has been recommended as the least restrictive level of behavioral health treatment necessary to adequately meet the child and family's mental health needs. The initial ISPT meeting takes place prior to the initiation of MT services. At minimum, the following individuals should be present at this meeting: the child if 14 or older, the child's legal guardian, a representative from the child's school, the child's current behavioral health service provider, the Care Manager from the MCO, and the County MH/MR representative. An exception may involve the participation of school representatives if the parents/guardians object and the child is not expected to receive mental health services in the school. Another possibility is that the family desires limited participation by a particular system representative. This

situation may arise when the family wants the school to participate but prefers that school staff not have extensive information about home events. In this situation, it may be appropriate, through a prior-arranged process, to invite the school representative(s) to “visit” with the rest of the team to provide information about the child in the school setting sometime at the beginning of the meeting and then leave. In addition, every effort should be made to obtain the participation of the prescriber at this meeting. Ideally, this occurs face-to-face, however, if this is not feasible, then telephone participation is preferable to none at all. If the ISPT agrees that MT is the most appropriate treatment option, the provider, typically the MT him/herself develops the initial treatment plan. The ISPT also develops a safety plan, and if necessary, an interim plan so that active treatment is occurring on some level while the child is waiting for MT services to commence. This is completed to support the child and maintain him in the community setting that will secure his safety and reduce the possibilities of behavior deterioration. If the ISPT determines that MT services do not appear appropriate for the child and family, the case manager makes a referral to another level of care and/or supportive service deemed more appropriate.

Additional ISPT’s take place during specific time increments to further develop the treatment plan at different stages in treatment. The initial ISPT functions to develop the initial treatment plan. Subsequent ISPT’s are held every 4 – 12 months as determined by the interagency team to update the treatment plan for the each consecutive authorization period. However, with respect to children with autism spectrum disorders, in accordance with bulletins 01-01-05, 29-01-03, 33-01-03, 41-01-02, 48-01-02, 49-01-04, 50-01-03, an ISPT meeting will be required before BHR services are initiated and annually thereafter unless:

- a. any member of the team, including the parent or responsible caregiver, requests that the team convene sooner, based on the needs of the child or adolescent (please note that the Care Manager is a member of the treatment team); or
- b. the child is receiving (or expected to receive) services from three or more service delivery systems (e.g., mental health, mental retardation, children and youth, juvenile justice, drug and alcohol, education). In this instance an ISPT and treatment plan update is required at least every 4 months or more frequently if requested so by any member of the treatment team.

A discharge ISPT is conducted with the treatment team, discharge provider(s), discharge caregivers, and other discharge resources to review the child and family’s progress, disposition plan, status of referrals, and to identify treatment and service start dates as well as the dates that community resources have or will initiate.

In order to avoid being “just one more meeting” that exacerbates feelings of futility, the ISPT should not begin with another recitation of “what’s wrong” with the child or family or a litany of the most pressing problems. Similarly, the meeting need not elaborate on every past service failure. It is also important to be realistic about time expectations. In most instances, an ISPT cannot be completed in a single hour. It is also appropriate to guarantee that the appropriate stakeholders are present at the ISPT meeting

because informed and meaningful decisions cannot be made until the right people are at the table. The child's parents/guardians should be encouraged to invite anyone to the ISPT that will provide support to the family and child. Professionals should take into consideration that families would not automatically understand that they could invite community support persons to an ISPT unless they are informed of this option and encouraged to do so before hand.

To be effective, an ISPT needs to be guided by established ground rules and stages. Such structure helps set a constructive tone to the process, ensure that key issues are addressed, and promote effective use of time. Since there is more than one effective meeting protocol, the primary issues are a) that there be a protocol and b) that an individual familiar with it be designated as the meeting facilitator. When this occurs, the meeting is likely to flow smoothly. The meeting facilitator may be the same individual who invites and recruits participants, or a different individual. The identification of this individual is best made prior to the start of the actual meeting. The meeting facilitator may be the case manager, a therapist or other mental health professional, a wraparound coordinator, a school counselor, or a family member. It is the responsibility of the meeting facilitator to start the meeting, explain the protocol, initiate introductions, and make other initial comments, as indicates.

Most ISPT protocols share eight elements:

A. Early discussion of strengths

Following the initial team building stage of the ISPT, substantive discussion of the child and family should begin with strengths, not with problems, concerns, limitations, or failures. A meeting that begins with a focus on pathology is likely to activate feelings of pessimism.

B. Concern with child in multiple life domains

Regardless of the child's specific presenting concern, the interagency team is interested in the whole child, understood in multiple life contexts (also known as life domains) and also within a developmental framework. Therefore, a treatment plan that only addresses specific problematic behaviors of the child without also promoting the child's attainment of age-appropriate functioning is not consistent with a wraparound approach. Life domains may include: Spiritual, Family, Community, Friends/Social, Health, Emotional, Legal, Work, Educational, Safety, Cultural, and Others.

The key point is that an appropriate group of life domains be addressed, to ensure that each child is considered comprehensively, not just in terms of behaviors, symptoms, and disorders. When a child is considered comprehensively, information comes directly from the child and family through the psychiatric or psychological interview and the ISPT, not solely through written information and the judgment of professionals.

C. Avoidance of premature discussion of services

Service decisions, when appropriately determined, are made near the end of the meeting, not at the outset. It is only after identifying strengths, goals, barriers, and available resources at hand that a team is ready to consider professional services. Premature discussions of service, even if well intentioned, bypass the important information gathering and team building processes.

D. Active participation by family

An effective ISPT is one in which family members offer their points of view early in the process. Active and early family participation is important not only because of the family's valuable perspectives offered but also as a way to signal to the child and family that this meeting is for them and that they are equal participants in the process. If the parents/guardians and child do not offer their ideas spontaneously, it is the responsibility of the meeting facilitator to enlist their participation in a non-threatening manner.

E. Inclusion of a group envisioning process

The reason for the formation of the interagency team and the convening of the ISPT is the presence of a child, functioning unsuccessfully in the current setting, who is at risk of endangerment and/or more restrictive placement and more intrusive treatment. For an ISPT to be effective and for wraparound to be successful, there needs to be a collective capacity of team members to move beyond the present in an imaginative manner, in order to envision desired outcomes.

F. There is delineation of tasks and responsibilities prior to the end of the meeting

Since the goal of the ISPT is to identify a plan to help the child and the family, it is essential that there be clarity about the tasks and responsibilities of various team members including the child and parent/guardian themselves.

G. Other interagency tasks prior to ending the meeting include identifying the following:

1. Identify the individual responsible for completing the treatment plan with the child and family.
2. Identify the individual responsible for completing the necessary paper work and submitting the formal request.
3. Identify the individual responsible for completing the meeting notes and distributing them to all team members.
4. Identify the individual responsible to contacting team members absent from the meeting, to keep them in the loop.
5. Identify the individual(s) responsible for contacting community agencies and natural supports identified during the meeting.
6. Identify the individuals responsible during a crisis, and the nature of their specific roles.
7. Identify the individuals who will follow through with other identified tasks and interfaces.

8. Determine the mechanism for communication between meetings, and clarity as to the next meeting.

Linkages to Natural and Community Supports

Natural supports are those resources being used, or potentially available for use, by the child and family within the community, which do not involve formal behavioral health services, and which are consistent with the cultural beliefs and practices of the child and family. Natural supports may involve activities, community institutions, key resource individuals outside the immediate family, community beliefs, and a variety of informal supports found in the neighborhood or larger community. Natural resources are external to the child and family and, once accessed through active affiliation, become part of the child and family's strengths.

Natural supports help to normalize the child's life. As the child's life becomes more normalized and more "typical" of that of others, the child becomes less isolated and lonely. Participation in appropriately-chosen activities, such as a summer reading program, Scouts, a YMCA/YWCA program, enables the child to expand interest and experience competence and spontaneity.

Natural supports can also help the child's parents/guardians. Self-help groups for parents/guardians can be invaluable in sharing information and offering support. Neighbors and extended kin can help during times of crisis, and also offer the parents/guardians some time alone, by staying with the child in question or all of the children.

Finally, it should be appreciated that natural supports are important not just for children with mental health issues, but also for all children. It is through use of natural supports that the child develops friendships, community ties, and competence in the real world.

Although the use of natural resources is often limited during a time of crisis, or when services are initiated, consideration of available or potentially available community supports should occur so that the treatment offered is holistic. Over time as symptoms and behaviors stabilize there is additional opportunity to explore those individualized natural supports suitable to the child and family. The balance between professional services and natural supports shifts over time, as the child and family symptoms get better. This shift in balance enables services to be tapered and eventually discontinued. When there is total or primary reliance on behavioral health services, it may never seem like the right time to discontinue services, and the transition, when it does occur, may be difficult.

The first authority on community resources is always the family itself. In addition, it takes professionals who are knowledgeable about communities in general and the child's community in particular to assist in the identification process. The case manager can play an indispensable role here. In general, the training of many mental

health professionals tends to overlook the need to identify and incorporate community resources into the treatment process.

To begin the process of identifying areas of potential interest, an interest inventory should be conducted with the child during the intake process. An initial assessment of the home and community resources is recommended to occur within the first 30 days of treatment. The treatment team then assists the child and family to develop goals to incorporate natural and community resources into the treatment plan.

Standards for Initial and Continued Stay Treatment Plans

The BHRS Treatment Plan for MT services must follow the Life Domain format which is comprised of the following components:

1. *Child and Family Strengths*: including interests, abilities, activities, competencies, and past progress in treatment.
2. *Needs, Concerns and Problems*: including a specific description of symptoms and behaviors as described in the Best Practice/Life Domain evaluation or assessment (if Brief Treatment) and ISPT. Both symptoms and behaviors must be operationally defined, i.e., what does the symptom/behavior look like or consist of for the specific child, including current rates, i.e., frequency, intensity, and domain in which the symptom or behavior is occurring. Problems identified in the treatment plan should also be prioritized making it easy for the child, family, and all other ISPT members to identify the problems being targeted during the current treatment period vs. those that will be targeted at a later date.
3. *Statement of Goals and Measurable Objectives*: A goal is a global statement that reflects a positive resolution to the identified need or problem and indicates the specific area of functioning to be addressed, including an expected outcome. The objective is directly related to a specified goal, but is highly specific and identifies measurable steps toward achievement of the goal. Each problem targeted in the current treatment period must have a corresponding goal with measurable objectives, or steps leading to the attainment of the goal.
4. *Methods/Interventions*: answering who, what, where, how, and how often, i.e.,
 - Who is responsible for implementing each objective, i.e., the Host Home parent, child, parent, babysitter, teacher, or Boy Scout leader?
 - What is each person responsible for?

- Where, or in what setting or circumstance is this to occur?
 - How – what is the specific method of intervention to address the concern (the behavior plan, the skill being taught).
 - How often – identify the expected rate of intervention.
5. *Target Date*: identify the date each objective is expected to be complete/attained.
 6. *Completion Date*: identify the date each objective was actually completed/attained.
 7. *Signatures*: Each participant should sign the treatment plan to indicate that they agree with the treatment goals, interventions and their role in the treatment process. In addition, each participant should be clearly identified by name and role within the treatment plan as well as in the signature section. At minimum, the signatures of the parent, child and provider are required on all treatment plans.
 8. *Comments Section (Update on Progress or Lack of Progress)*: This section includes the following information:
 - A description of the actual rates of target behaviors
 - A description of the skills acquired by child and family
 - A description of the child and family's response to treatment
 - An outline of any obstacles to treatment
 - A description of any special circumstances

In addition to the components defined via the Life Domain format, the following *Domains* (as applicable) are addressed in the BHRHS Treatment Plan:

1. *Family Legal Guardians* includes goals related to the family and the identified patient as part of the family unit and building natural (family) supports. The family domain identifies goals for both the host home and the biological family. Therapeutic leaves are documented in this section. Family strengths, needs and goals are identified as well as any progress that is made. The reintegration progress is specifically defined in the treatment plan, i.e., discharge resources/caretakers are discussed in this section as well.
2. *Educational/Vocational* includes goals related to the child's school or job. The school domain addresses the child's home school as well as the school the child is attending in the host home. Both school districts have input into the school goals in this domain.
3. *Peer* includes all goals related to peers in school and in the community, i.e., social skills development, development or maintenance of positive peer relationships.

4. *Physical/Environment/Structure* includes safety concerns in the child's living environment, i.e., elopement when it is a safety risk, unsafe neighborhood, when the child's basic needs are not being met.
5. *Leisure/Recreation* includes leisure/recreation needs of the child i.e., building community resources, identifying hobbies, special interests. The leisure/recreation domain includes community resources in the child's host home neighborhood as well as in his/her natural community.
6. *Psychiatric/Psychological* identifies behavioral health needs of the child up and above BHR services, i.e., medication evaluation/management, specialized therapeutic needs, groups, crisis services. Medications and medication visits are updated monthly in the psychiatric/psychological domain.
7. *Referral/Consultation* identifies any referrals that need to be made in any service system, i.e., referral for a psychiatric evaluation, ICM, Social skills group, evaluation for special education, physical exam, neurology consult, sex abuse counseling.
8. *Special Considerations* identifies any other need to make treatment successful that is not outlined in any other domain, i.e., transportation needs, need for interpreters, need for use of adaptive equipment for communication, CYS/juvenile justice involvement, D & A needs, ...
9. *A crisis plan* individualized for the child/family is developed and included in each child's treatment plan.
10. *Individualized behavioral plans* are developed as needed and attached to the child's treatment plan.
11. *Progress is reviewed* for all domains on a monthly basis and written into the existing plan at least every 4 months.

Coordination of Care with Other Behavioral Health Service Providers and Other Service Systems

Treatment plans should identify the coordination efforts with all other behavioral health programs and service systems involved with the child. Other service systems include education, Children, Youth and Families (CYF), juvenile justice, mental retardation, primary care physician, drug and alcohol, and other behavioral health programs. Releases of information must be completed between all agencies/services sharing information about the child.

One of the primary ways to ensure effective service coordination is by inviting the appropriate individuals to the ISPT. The ISPT recommends and identifies necessary referrals for the child in all appropriate domains. The behavioral health worker, parent or other service system provider as assigned at the ISPT, then generates the referral(s). The ISPT functions as a way to communicate treatment progress to all team members. It also assures that a duplication of services is not occurring. The behavioral health treatment team can include the prescriber, psychiatrist, primary clinician, MT, BSC, Therapeutic Staff Support (TSS), supervisor of the primary clinician or BHRS team members, the case manager, the MCO Care Manager, and any other behavioral health service provider involved with the child. The team communicates progress on treatment objectives, the appropriateness of the current prescription, the child, family, and caregiver's response to treatment, recommendations for the next BHRS prescription, a summary of standardized measures, follow-up on the prescriber's previous recommendations, a plan for reduction in services and plan for discharge, an update on the implementation or discharge of other behavioral health services, and an update on the initiation or discharge of other service systems.

Provider communication with Community Care is also important. The provider should:

- Invite the Care Manager to the ISPT/concurrent reviews
- Submit BHRS treatment packets according to the BHRS schedule
- Inform the Care Manager and Community Care about the start date of service and the amount of services delivered versus the amount authorized via the BHRS report
- Inform the Care Manager of hospitalizations, Partial Hospitalization Program admissions, or incarcerations
- Inform the Care Manager about concerns regarding services provisions, changes in placement/living arrangements, incident reports, requests for emergent services, special circumstances related to service provisions
- Submit documentation to the Care Manager about the treatment team's consensus to change the amount or type of service authorized
- Notify the Care Manager of the transfer of a case to another provider, any discharge plan, disposition plan, complaints, grievances
- Notify the Care Manager and/or MCO if the service commencement does not occur within 50 days from the evaluation, there is a significant break in service delivery (more than 2 weeks), and/or the need for an extension of a plan

Assuring Cultural Competency

According to CASSP principles, mental health professionals are required to address the cultural strengths and needs of each child and the child's family and recognize the impact of these strengths and needs on service delivery. Cultural competence has a direct impact on service delivery, and requires planning that incorporates the family as equal partners in the process. Culture has an impact on how the family defines itself, on who should be included in the assessment process, the language to be used in providing services, and the appropriateness of particular service modalities.

The fifth CASSP principle requires that multiple cultural factors be included in the formulation of services and treatment plans. Since few professionals are trained to address these factors, initial and ongoing training is required to assure that multiple dimensions of culture are being explored and appropriately documented for each child and family.

Within a “wraparound perspective”, the concept of relevant information includes; the child's strengths and interests, the family's religious and cultural beliefs, community resources, and the child and family’s ideas about treatment. The assumption by wraparound staff is that each family and each constellation of family resources are unique and must be discovered. As the child and family are asked about and given the opportunity to discuss strengths, accomplishments, cultural needs and goals, the stigma associated with receiving help often decreases and the process becomes safer and more productive. In taking cultural competency into consideration during any level of behavioral health treatment, goals should be set by considering the functioning of a typical student from the same cultural background as the child in treatment who is doing well (Hodas, 1996).

DISCHARGE PLANNING PROCESS

Disposition Planning

Discharge planning begins at the initial ISPT and should continue throughout treatment. Discharge from BHRS/MT is recommended when:

- The child/family has achieved an expected level of stability and goal attainment to no longer require BHRS; or
- Services should be discontinued because it ceases to be effective requiring reassessment of services and alternative planning; or
- Services provided create a service dependency interfering with the development of the child's progress toward his/her highest functional level, requiring reassessment of services and alternative planning; or
- The parent/guardian or an adolescent age 14 or older requests the termination of services; however, if a child age 14 refuses/requests the termination of services, services may begin/continue at the parents' request for an identified period of time in order to attempt to engage the adolescent in the treatment process.

In order for the child/family to be successful in treatment and be successfully discharged from this level of care, the MT should define achievable, measurable discharge objectives with the child/family and other members of the treatment team. The MT should also define the specific skills needed to stabilize the child/family, so that discharge is possible, as well as the level of natural and community supports and other services necessary to maintain the achieved level of stability.

Although discharge planning begins at the first ISPT, the ISPT for the final treatment period should put the disposition plan into action. A discharge ISPT is scheduled at the conclusion of this meeting and assignments are given to team members to assure that the disposition activities are scheduled and implemented.

Discharge Process and Transition of Services

A Discharge IPST is held within 45 days prior to discharge from BHRS/MT services for all children/families actively involved in treatment. The treatment team, discharge provider(s), discharge caregivers, and other discharge resources are invited to the discharge ISPT to review the child and family's progress, disposition plan, status of referrals, and to identify treatment and service start dates as well as the dates that community resources have or will initiate. The BHRS provider/MT is responsible for all referrals for behavioral health services and to other service systems for continued care, even though such referrals are often assigned to a case manager or the family at the final ISPT. As per access standards, if follow-up behavioral health service are recommended after discharge from BHRS/MT services, the first appointment must occur within 7 days of discharge from BHR services.

Please note that not all children/families discharged from BHRS/MT services will require continued behavioral health treatment. In this instance natural and community resources should be initiated prior to discharge from services.

In addition, some children and families may discontinue services before the treatment team has established a discharge plan. In this instance the provider will send a letter to the child/family, case manager, prescriber, Care Manager and any other treatment team members notifying the team that the child/family is discharged from BHRS/MT services due to no contact.

At the time of discharge from BHRS/MT services the provider is required to call the Care Manager on or before day of discharge to report the actual discharge date and, if applicable, initial appointment for follow-up behavioral health care. The initial follow-up appointment must be offered or occur within 7 days of discharge from MT services. Please note that Community Care is willing to overlap services if needed for follow-up behavioral health care. A discharge summary is due to Community Care within 2 weeks of the child's discharge from BHRS.

After the child is discharged from BHRS, Community Care will follow up with the family to assure that appointments have been attended. If not Community Care will assist the child/family in making a follow up behavioral health appointment.

OUTCOMES

Measuring Member Outcome to Level of Care, Service, or Treatment

To obtain baseline measurements for all new BHRS clients, it is recommended that the provider utilize a preferred standardized measurement to gather baseline data. The baseline rates of behaviors and the baseline skill level are to be included in the Best Practice/Life Domain Evaluation and continued via the initial treatment plan. A risk assessment is helpful for determining the priority of problems/objectives. A signed document indicating that the parent/child agree with and understand the treatment goals, objectives, and methods is to be included as well.

Throughout the treatment process, it is recommended that a preferred standardized measurement be administered at least every 4 months to gather continuous data on the child's/family's progress. The treatment plan should be used as a qualitative and quantitative measure of outcome/progress by reviewing it on a monthly basis with the child/family and updating it on at least a quarterly basis.

It is essential that the continuity of care/treatment is maintained in the treatment process for as long as the child/family is receiving BHRS, i.e. through assessments, treatment planning, therapy, outcomes, and making sure the treatment team is following the plan. The following have been identified as ways to maintain continuity of care:

- Utilize the treatment plan as a guiding document
- Review the treatment plan during supervision at least one time per month

- Review the treatment plan with the child/family at least one time per month and develop an outline or plan indicating the treatment goals being addressed during the month
- Conduct internal treatment team meetings or supervision to review the treatment plan with the MT, prescriber, and other team members employed by the provider at least one time per month
- An ISPT is recommended to occur every 4 months at the discretion of the treatment team if the child is involved in less than three service systems

QUALITY IMPROVEMENT

Documentation Standards for Treatment Plans, Progress Notes, Discharge Summaries, and Additional Documentation

Treatment Plan

The treatment plan identifies the child's strengths, including family and community strengths. It includes measurable objectives for treatment and conveys this to the child/family in a way in which they will understand. The treatment plan should identify realistic goals and set the pace by identifying the timeline for working on the treatment goals. Specific interventions to use with the child/family are identified with the consideration of the cultural perspective in treatment. The roles and responsibilities of each team member are identified in reference to the goals and objectives in the plan. Discharge criteria and a plan for a reduction of service are included as well as a crisis/safety plan.

Progress Notes

All progress notes are to include the date, start/end time of each session, and the domain in which the service is occurring. It should also identify the participants of the session, the goals/measurable objective for which the session pertains, the interventions used, and the client's response to the intervention. Other information that is to be included in the progress notes include the method of coordinating services with other team members, any specific occurrence that influenced the session, the plan and date for the next session, and the MT's signature with credentials. Documentation is to be commensurate with time spent in the session.

Additional Documentation

The client's chart should include the following additional documentation:

- Information regarding internal treatment team or supervision meetings
- Communication with the prescriber
- Communication with other treatment team members
- Correspondence with the family
- Treatment consent
- The child/family's bill of rights
- Releases of information
- Provider choice form

- Parent education documents
- Incident reports
- Childline reports
- Encounter forms
- Parent's signature on all treatment plans
- Parent signature on other BHRS documents (if indicated by the agency's policy and procedure manual)
- BHRS notification forms for BHRS reporting (prior to July 2004)
- Standardized scales
- Coordination of services with the child's Primary Care Physician (PCP)

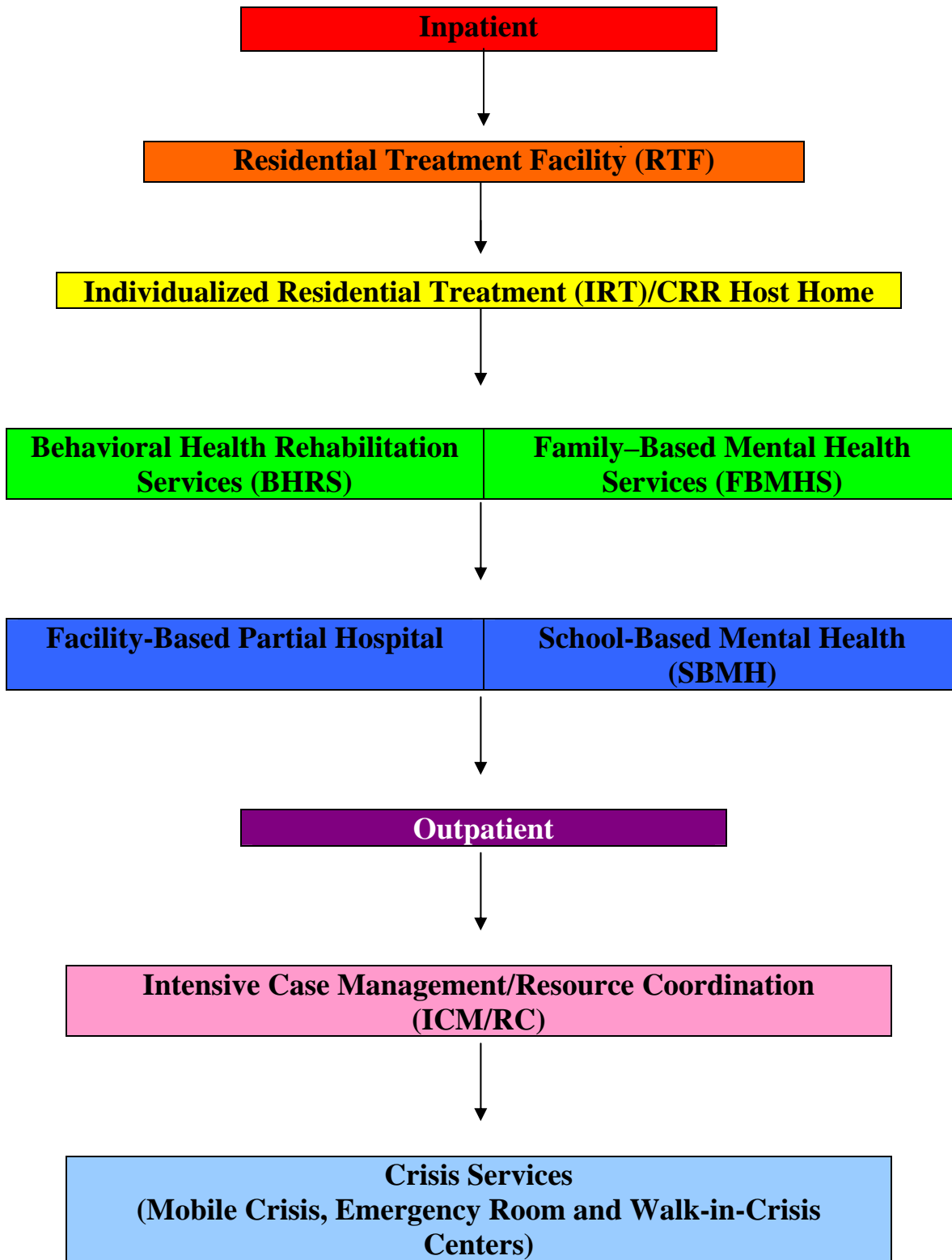
Discharge Documentation

The following documentation must be completed for each child upon discharge from BHRS/MT services;

1. A discharge summary is prepared by the MT and sent to the Care Manager within 2 weeks of discharge. The summary must include the disposition plan and discharge appointments. The provider should also obtain the appropriate releases such that the MCO, county, parent, new service provider, and others as needed, receive the discharge summary.
2. The BHRS provider/MT is responsible for all referrals for behavioral health services and to other service systems for continued care, even though such referrals are often assigned to a case manager or the family at the final ISPT.
3. As per access standards, if a follow-up behavioral health service is recommended after discharge from BHRS/MT services, the first appointment must occur within 7 days of discharge from BHR services.
4. After the child is discharged from BHRS, Community Care will follow up with the family to assure that appointments have been attended. If not Community Care will assist the child/family in making a follow up behavioral health appointment.

APPENDICES

APPENDIX I: CONTINUUM OF CHILD AND ADOLESCENT BEHAVIORAL HEALTH CARE FROM MOST INTRUSIVE/RESTRICTIVE TO LEAST INTRUSIVE/RESTRICTIVE



APPENDIX II
LIFE DOMAIN FORMAT FOR
PSYCHIATRIC/PSYCHOLOGICAL EVALUATIONS:
INITIAL AND CONTINUED CARE

2nd Edition

Note: This format is applicable to both initial and continued care evaluations. However, when writing an evaluation for continued care, it is recommended that Section III, Relevant Information, begin with an additional subheading called Brief Update that identifies and briefly summarizes the key events and changes during the most recent service period. The remainder of Relevant Information then follows the usual format (e.g., Strengths, Concerns, Etc).

I. Identifying Information:

- A. Places the child in individual, family, cultural, residential, and educational/vocational contexts (e.g., age, date of birth, gender, race, ethnicity, cultural/religious beliefs, name and grade in school, type of class setting).
- B. Identifies family and household members, including each biological parent, stepparents, siblings/half-siblings. Identifies marital status of parents, and nature of child's contact with a non-custodial parent. Identifies employment status of current parental caregivers.
- C. Identifies custody of the child, and child's legal status (e.g., adjudicated or not). Identifies other team members, including involved professional agencies/systems (e.g., MH/MR, C&Y, juvenile justice, case management, child psychiatrist, special education, etc.) and community supports.

II. Reason for Referral:

- A. Determine medical necessity for initial care or continued care service request.
- B. Identify additional purposes, as relevant (e.g., monitor medication, respond to crisis).

III. Relevant Information (begin with *Brief Update*, if a continued care request):

A. Strengths:

- Child/adolescent strengths, in multiple domains.
- Special attention to motivation and ability to form relationships and use support.
- Areas of greatest competence and independence.
- Family and community strengths.

B. Concerns:

- Clinical basis for current service request and recommended treatment.
- Nature, frequency, severity, and history of the child's behaviors/symptoms/ serious emotional disturbance (SED) of concern.

- Identification of both externalized behaviors and internalized symptoms, comparing present to past.
- Other identified needs and concerns.

C. *Family:*

- Family composition (including relevant extended family), family relationships, strengths/concerns.
- For child in substitute care, foster family and natural family included.
- Family cultural and spiritual beliefs and practices, as relevant.
- Family history of psychiatric disorder, as relevant.

D. *School/Vocational:*

- The child's academic, social, and behavioral adaptations, including relationships with school peers and with teachers and/or level of functioning in vocational programming.
- Efforts to date of school to address current problems. Characteristics of current class setting.
- Current or past use of school-based services, if relevant.
- Current or past educational testing, CER, and IEF. • Prior school placements.

E. *Community:*

- Place of residence-family home or apartment, group home, RTF, etc.
- Community activities and attachments.
- Use of leisure time.
- Community employment, current and in past.
- Degree of religious or spiritual involvement.
- Nature of neighborhood, in terms of resources and culture, safety, specific conditions.
- Specific stressors, as relevant.

F. *Peer Relationships:*

- Patterns of peer relationships in the neighborhood and in school, including similarities and differences between the two settings.
- Predominant age of peers-same-aged, older, or younger-and gender of relationships.
- Predominant activities with peers, formal and informal. Nature of peer culture.

G. *Drug and Alcohol:*

- Child's current use/abuse of drugs and alcohol-type, frequency, severity.
- Child's past history of use.
- Child's past drug and alcohol treatment, response to treatment, involvement in self- help groups.
- Family substance abuse history, where relevant, including nature of use, type and effectiveness of treatment.

H. *Medical/Developmental:*

- Medical illness, acute or chronic infection, physical limitation, brain or other injury, past surgery.
- Lead or other toxicity.
- Medication allergies as relevant.
- Developmental history: pregnancy, delivery, neonatal period, developmental milestones.
- Mental retardation, atypical development, autism/PDD.
- Trauma history: neglect, physical abuse, or sexual abuse.
- Gender preference, when relevant and with consent of the child, and other issues of sexuality. Past pregnancy, when relevant.

I. *Legal:*

- Custody.
- Adjudication as delinquent or dependent.
- Other delinquent status indicators: probation, placement in juvenile facility, incarceration.
- Outstanding legal issues: pending charges, community service requirement, other.

J. *Services:*

Service History:

- Services used in past, reason, level of participation, and effectiveness. Include all levels of care, psychotropic medication, out-of-home placements (mental health and other), and services from other systems.

Service Update.

- Current services-including hours and sites-with summary of recent service history.
- Impact of services:
 - Role of service providers and of family.
 - Progress/degree of attainment of treatment goals and objectives. Identify effective and ineffective interventions.
 - Receptivity of the child and family to services, and level of participation.
- Nature of planned modifications of goals and services.
- Specific indications for, and use of, psychotropic medication. Include names and dosages and, where applicable, blood levels. Indicate medication adherence and effectiveness of medication, when in use.
- Nature of regular clinical updates to prescriber by involved mental health staff, during most recent service period.

K. *Other:*

- Other domains as relevant, or added to earlier information.

IV. Interview:

- A. Identification of participants.
- B. The child/adolescent's appearance, hygiene, self-care.
- C. The child/adolescent's manner of relating to the interviewer and other identified adults present. Emphasis on level of engagement, cooperation, openness to input.
- D. The child/adolescent's formal mental status. Include verbalized goals, needs, requests, response and commitment to treatment, degree of understanding and insight, other individualized ideas of the child/adolescent, and ability to contract for safety, when relevant. Compare with previous contacts, if applicable.
- E. Key issues/themes addressed, and areas of agreement/consensus.

V. Discussion:

- A. Overview/summary.
- B. Hypothesis/formulation.
- C. Diagnostic considerations.
- D. Rationale for recommended services.
- E. Nature of consensus and agreements with the child/adolescent, family if present, and others.
- F. Prognosis.

VI. Diagnosis: 5-Axis diagnosis.

VII. Recommendations:

- A. Identification of each specific behavioral health service recommended, listing the amount, duration, and scope of each.
- B. Other treatment recommendations, both global and specific (e.g., other needed services and interventions for the team to consider; psychotropic medication referral or recommendation; additional recommended assessment(s); community referral(s) and natural supports; education and/or vocational recommendations; consultation with primary care physician; other)
- C. For continued care requests, criteria for service tapering or modification of level of care, and recommendations to increase natural supports.