Vaya Health

Family Centered Treatment® Alternative or "in Lieu of" Service Definition

SERVICE NAME: Family Centered Treatment®
PROCEDURE CODE: H0036 HK U5

DESCRIPTION:

Family Centered Treatment® (FCT) is an evidence-based practice designed to prevent out-of-home placements for children and adolescents. It is delivered by clinical staff trained and certified in FCT and promotes direct intervention with both the child and the family. Coordination and intervention also target other systems, such as schools, child welfare departments, the legal system and primary care physicians. Family Centered Treatment® includes the provision of crisis services.

This is a time-limited, intensive intervention that is intended to accomplish the following:

- reduce presenting psychiatric or substance use disorder symptoms;
- provide first responder intervention to address crisis;
- ensure linkage to community services and resources;
- prevent out of home placement for the member;
- ensure successful transitions of care from residential services to home settings

FCT is a researched, viable alternative to residential placements, hospitalization, correctional facility placement and other community-based services. A distinctive aspect of FCT is that it has been developed because of frontline practitioners' effective practice. FCT is one of few home-based treatment models with extensive experience with youth with severe emotional and behavioral challenges, dependency needs and mental health diagnosis as well as histories of delinquent behavior, otherwise known as crossover youth. In addition, FCT is extremely cost-effective and stabilizes youth at risk and their families.

FCT is based on eco-structural therapy and emotionally focused therapy. It focuses on addressing the functions of behavior, including system functions that look deeper than behavioral compliance getting, thus creating sustainable change and decreasing the likelihoodof recidivism. Based on the understanding that families requiring such services may have experienced trauma, all phases incorporate **trauma-focused treatment**.

The FCT provider shall provide "first responder" crisis response, as indicated in the Person- Centered Plan (PCP), 24 hours a day, seven days a week, 365 days a year, to beneficiaries of thisservice. Appropriate back up staffing shall be available in the event of multiple crisis events.

The service is an alternative to Residential Level II and III treatment and may be used in lieu ofthese services. In situations where entry into Residential Level III treatment cannot be prevented, the addition of FCT will target reduction of the Level III to 90 days or less.

There are four phases to the service:

- Joining and Assessment - Identify family strengths, gain acceptance and trust, assessfor systematic changes and adjustments. (Family Centered Evaluation©)
- Restructuring - Enactments (experiential practice) are targeted as shifting therepetitive interaction patterns that make up the structure of the family.

- Valuing Change - Question and define reason for the change. Sustainable change ina family system occurs when the behavioral change made during restructuring are valued and seen as necessary by the family.
- Generalization - Skill adoption and family success. Family becomes able to usestrategies independently.

Specific treatment techniques are integrated from empirically supported behavioral and familytherapies including eco-structural and emotionally focused treatment. In addition to focusing on the youth, FCT also engages the family in treatment. FCT therapists strengthen the family's problem-solving skills and operant family functioning systems, including how they communicate, handle conflict, meet the needs for closeness and manage the tasks of daily living that are known to be related to poor outcomes for children/youth. The therapist, in conjunction with the youth, family and other stakeholders, develops an individualized treatment plan. Using established psychotherapeutic techniques and intensive family therapy, the therapist works with the entire family, or a subset, to implement focused interventions andbehavioral techniques designed to:

- Enhance problem-solving
- Improve limit-setting
- Develop risk management techniques and safety plans
- Enhance communication
- Build skills to strengthen the family
- Advance therapeutic goals
- Improve ineffective patterns of interaction
- Identify and utilize natural supports and community resources for the youth andparent/caregiver(s) in order to promote sustainability of treatment gains

FCT's personalized interventions are designed to strengthen the family's capacity to improvethe youth's functioning in the home and community with a goal of preventing the need for ayouth's admission to an inpatient hospital, psychiatric residential treatment facility, or othertreatment setting. FCT utilizes a highly thorough and frequent session schedule to promote change for families with intensive needs.

FCT therapists are expected to provide a minimum of two multiple-hour sessions per week and increase this as indicated by the youth and family's evolving needs. Frequent, intensive therapyin the context of the family/home setting facilitates sustainable change via immediate and on- site enactments or coaching to parents, offering support where and when suggestions are mostneeded. Phone contact and consultation are provided as part of the intervention. In addition, unlike other in-home models, the first and last month of FCT treatment—joining and discharge respectively—are not tied to the minimum standard due to the titration up and down of service provision. With FCT, a therapist is available 24 hours a day, seven days a week during each phase of FCT toprovide additional support and crisis services as indicated.

When/where applicable, best practice standards of in-home therapy are paramount. All FCTtherapists are expected to understand and abide by best practice standards for in home therapy including but not limited to safety of client/family/others & self, coordination of services including medical, on-call and crisis service, quick and timely responses to intake ofservices, and interventions that are timely, accessible, and not experimental in nature.

POPULATION TO BE SERVED:

Population	Age Range	Projected Numbers	Characteristics
Children with behavioral and/or emotional needs	3-21		There is a MH/SU diagnosis (may haveco-occurring IDD); **and** has participated in a course of residential treatment within the past 12 months and remains at risk of out of home placement in treatment setting Residential Level II or III; **or** Member has participated in inpatient treatment for symptoms of MHSU diagnosis(es) within the past three months AND the inpatient provider has recommended consideration of Residential Treatment Level II or III at discharge; **or** Member is currently in residential treatment where discharge has been delayed due to identified need for family systems treatment AND has participated in enhanced services prior to residential treatment admission.

TREATMENT PROGRAM PHILOSOPHY, GOALS AND OBJECTIVES:

The evidence-based model Family Centered Treatment® (FCT) is founded in the belief that families seemingly stuck in a downward spiral can make positive, lasting changes. Resilience theory holds that children and families have the capacity to function well in the face of significant life challenges. Because of this belief, all aspects of treatment value the youth and family's voice in the process and employ strength-based approaches that focus on hope ratherthan on deficits, challenges, and barriers. The intention is to promote permanency goals whilepreserving the dignity of youth and families within their culture and community.

FCT's origins derive from practitioners' efforts to find practical, commonsense solutions for families faced with forced removal of their children from the home or dissolution of the family,due to both external and internal stressors and circumstances. FCT is an alternative model grounded in the use of sound and research-based treatment. Personalized techniques are integrated from empirically supported behavioral and family therapies and services are provided frequently, with FCT therapists available 24/7 to support the youth and family when needed. Addressing needs while observing strengths and patterns of interaction as they are happening allows skilled practitioners to help families create change in the core components offamily functioning.

Another guiding principle of FCT is that it is family centered. While the referred client is integralto the treatment process, FCT is a family system model of home-based treatment and treatment can and does occur with other members when their behaviors or roles are critical to the progress of the referred family member (client). All phases of FCT involve the family intensively in treatment. During the assessment phase, the family defines their "family constellation," and those members are invited to participate in the structural family assessmentand subsequent treatment activities as directed. Other individuals who may have key roles in the youth's wellbeing (e.g., caregivers, stakeholders, psychiatrists, etc.) are also viewed as critical to the success of FCT and are, at minimum, informed of treatment progress. They can bemore integrally involved based on the family's need.

FCT places emphasis on the value of support systems—both during and after treatment. FCTdevelops a system of community resources and natural supports based on the youth and family's needs and preferences to enhance the individualized treatment plan by providing opportunities for further skill development. Building a network of support will also promote sustainable outcomes by providing the youth and family with resources to utilize after discharge.

Objectives and goals of the service include, but are not limited to, the following:

- Enhance family stability to a degree that allows for preservation of long-term child placement in the home, and provides sufficient structure for a child to return to thehome if short-term removal is deemed necessary;

- Identify the critical areas of family functioning that contribute to the risk of familydissolution;
- Reduce hurtful and harmful behaviors affecting family functioning;
- Enable changes that include family system involvement so that these are notdependent upon the therapist; and
- Enable discovery and effective use of the intrinsic strengths necessary for sustainingthe changes made and enabling stability.

FCT services are delivered to children and adolescents, primarily in their living environments, with a family focus, and include, but are not limited to, the following interventions as clinically indicated:

- Individual and family therapy;
- Substance use disorder treatment interventions;
- Developing and implementing a home-based behavioral support plan with the memberand the member's caregivers;
- Psychoeducation imparts information about the member's diagnosis, condition, andtreatment to the member, family, caregivers, or other individuals involved with the member's care;
- Intensive case management includes the following:
    - Assessment
    - Planning
    - Linkage and referral to paid and natural supports
    - Monitoring and follow up
- Arrangements for psychological and psychiatric evaluations
- Crisis management

EXPECTED OUTCOMES:

Members participating in FCT® will not have any further episodes requiring hospitalization,Residential Level II or III or PRTF within one-year post discharge. FCT outcomes compare favorably with the best in the field, especially on such key dimensions such as:

- Success in preventing out of home placement
- Reunification
- Engagement rates
- Customer satisfaction
- Recidivism

STAFFING QUALIFICATIONS, CREDENTIALING PROCESS AND LEVELS OF SUPERVISION ADMINISTRATIVE ANDCLINICAL) REQUIRED:

Staff must meet all the following requirements:

- A minimum of a master's degree in a human services field
- Active full or provisional licensure status in NC as one of the following: LMFT, LPA,LPC, LCSW or Licensed Psychologist
- Shall have at least two years of post-master's degree experience with thepopulation served

Required training and supervision:

- Completion of the FCT comprehensive training course, which includes staff certification (90 hours of training). This training includes both a guided self-studyprocess using the Wheels of Change© course and field-based certification.
- Supervisors are required to complete the basic certification courses, as well as theFCT Supervision Curriculum.

FCT teams meet no less than two hours weekly for clinical case supervision and oversight,but clinical supervision must be available daily as needed.

UNIT OF SERVICE:

The service is provided and billed on a per month basis, with a monthly unit consisting of aminimum of 10 documented treatment hours.

Prior Authorization for FCT is required. A complete Service Authorization Request (SAR), PCP, comprehensive clinical assessment and crisis plan should be submitted with initial requests.Continued authorization requests must include an updated PCP.

ENTRANCE CRITERIA:

FCT is provided to members ages 3 to 21 who meet the following criteria:

- Have an MH/SU diagnosis (may have co-occurring IDD) *and* one of the following:
  - Member has participated in a course of residential treatment within the past 12 months and remains at risk of out of home placement in treatment settingResidential Level II or III; *or*
  - Member has participated in inpatient treatment for symptoms of MHSU diagnosis(es) within the past three months AND the inpatient provider hasrecommended consideration of Residential Treatment Level II or III at discharge; *or*
- Member is currently in residential treatment where discharge has been delayed due to identified need for family systems treatment *and* has participated in enhanced servicesprior to residential treatment admission

CONTINUED STAY CRITERIA:

The member is eligible to continue this service if the desired outcome or level of functioninghas not been restored, improved, or sustained over the time frame outlined in the Person- Centered Plan (PCP) or the member continues to be at risk for out-of-home placement *and* one of the following applies:

- The member has achieved current PCP goals and additional goals are indicated as evidenced by documented symptoms
- The member is making satisfactory progress toward meeting goals and there is documentation that supports that continuation of this service will be effective inaddressing the goals outlined in the PCP
- The member is making some progress, but the specific interventions in the PCP need to be modified so that greater gains, which are consistent with the member's premorbid level of functioning, are possible *or*
- The member fails to make progress or demonstrates regression in meeting goals through the interventions outlined in the PCP. The member's diagnosis should be reassessed to identify any unrecognized co-occurring disorders, and interventions ortreatment recommendations shall be revised based on the findings. This includes consideration of alternative or additional services.

DISCHARGE CRITERIA:

The member meets the criteria for discharge if any one of the following applies:

- The member has achieved goals and is no longer in need of FCT® services
- The member's level of functioning has improved with respect to the goals outlined inthe PCP, inclusive of a transition plan to step down to a lower level of care
- The member is not making sufficient progress or is regressing, and all reasonable strategies and interventions have been exhausted, indicating a need for more intensive services *or*
- The member or legally responsible person no longer wishes to receive FCT services

EPSDT SPECIAL PROVISION:

Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age

42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products or proceduresfor Medicaid beneficiary under 21 years of age if the service is medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition

[health problem] identified through a screening examination (includes any evaluation by a physician or other licensed practitioner). This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for ahealth problem, prevent it from worsening or prevent the development of additional health problems.

Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary's physician, therapist or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary's rightto a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product orprocedure:

- That is unsafe, ineffective, or experimental or investigational
- That is not medical in nature or not generally recognized as an accepted method ofmedical practice or treatment

EPSDT and Prior Approval Requirements:
If the service, product or procedure requires prior approval, the fact that the beneficiary isunder 21 years of age does NOT eliminate the requirement for prior approval.

Important additional information about EPSDT and prior approval is found in the NCTracksProvider Claims and Billing Assistance Guide and on the EPSDT provider page.

Service limitations on scope, amount, duration, frequency, location of service and other specificcriteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product or procedure meets all EPSDT criteria,including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening or prevent the development of additional health problem.

ANTICIPATED UNITS OF SERVICE PER PERSON:

Initial authorization for services may not exceed 60 days. After initial authorization period,reauthorizations may be requested for additional 60-day periods.

TARGETED LENGTH OF SERVICE:

National target standards are six months, with the national average at 6.4 months (n=>2,000 families)

It is important to note that in scenarios where reunification or 'unknown' reunification is the objective, the national benchmarks for six months of service differs. When permanency or reunification is in question additional time to work with the family/caregivers/child is often warranted, extending the treatment time to nine to 11 months. The rationale for this is severalfolds:

- Additional time is often needed to assess safety and permanency needs in the earlymonths
- Frequently systems (courts) exceed six months to make a ruling surroundingpermanency
- The underlying complex dynamics of the systems involved: extreme distrust of the agencies and resistance to intervention and treatment require much longer treatmenttimes for developing trust necessary for effective engagement and adjustments that often occur to the permanency plan

RATIONALE FOR SERVICE:

FCT has been a structured, manualized model since 2004, and the model achieved evidence- based status in 2010. FCT is an alternative model to IIH that is grounded in the use of treatmentcomponents that are sound and research-based. FCT is comprehensive and designed to addressthe causes of family system breakdown. The model not only focuses on

changing negative behaviors—it also emphasizes the value of positive change so that families are more likely to sustain improvements in family functioning after treatment. FCT therapists are available to families 24/7. Attending to strengths, needs and patterns of interaction while they are happening allows skilled practitioners to help families create change in the core components offamily functioning.

PROCESS FOR REPORTING ENCOUNTER DATA:

Data will be uploaded to the state by the LME/MCO. Monthly payment, outcome payments andencounter data are kept for all services.

MONITORING ACTIVITIES:

FTC Foundation oversees and consistently performs program evaluation through data analysis (data is given to FCT Foundation on a quarterly basis for evaluation). Vaya will receive copies ofexternal fidelity reviews. Vaya will conduct post-payment reviews to ensure eligibility for outcome payments.