Louisiana Behavioral Health Service Definitions Manual for the Uninsured

DEPARTMENT OF HEALTH AND HOSPITALS
Behavioral Health

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TABLE OF CONTENTS

CHAPTER 1: CRISIS SERVICES 2
SECTION 1.1: SHORT TERM RESPITE CARE 3
SECTION 1.2: CRISIS STABILIZATION 6

CHAPTER 2: RECOMMENDED SUPPORTS AND SERVICES 8
SECTION 2.1: CASE CONFERENCE 9
SECTION 2.2: RECOMMENDED SUPPORTS AND SERVICES AND TREATMENT PLANNING COORDINATION 11

CHAPTER 3: PREVENTION AND WELLNESS 13
SECTION 3.1: PREVENTION SERVICES 14
SECTION 3.2: LOUISIANA PARTNERSHIP FOR SUCCESS 17
SECTION 3.3: PROBLEM GAMBLING PREVENTION AND TREATMENT SERVICES 19
SECTION 3.4: TOBACCO USE PREVENTION AND TREATMENT 20

CHAPTER 4: BEHAVIORAL HEALTH SERVICES 21
BEHAVIORAL HEALTH SERVICES PROVIDED BY LICENSED AND UNLICENSED INDIVIDUALS
SECTION 4.1: PSYCHOSOCIAL REHABILITATION (PSR) 22
SECTION 4.2: CRISIS INTERVENTION 24
SECTION 4.3: COMMUNITY PSYCHIATRIC SUPPORT & TREATMENT 26
SECTION 4.4: THERAPEUTIC GROUP HOME 28
SECTION 4.5: ADDICTION SERVICES 32
SECTION 4.6: LOUISIANA STATE ADOLESCENT TREATMENT ENHANCEMENT AND DISSEMINATION PROGRAM (LA SAT-ED) 57
SECTION 4.7: LOUISIANA STATE YOUTH TREATMENT- IMPLEMENTATION PROGRAM (LA SYT-I) 58

CHAPTER 5: OUTPATIENT & INPATIENT HOSPITAL & PRTF 59
OUTPATIENT & INPATIENT HOSPITAL AND PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY (PRTF) SERVICES
SECTION 5.1: OUTPATIENT AND INPATIENT HOSPITAL 60
SECTION 5.2: PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY (PRTF) 62

CHAPTER 6: OUTPATIENT THERAPY BY LICENSED PRACTITIONERS 70
OUTPATIENT THERAPY SERVICES BY LICENSED PRACTITIONERS
SECTION 6.1: OTHER LICENSED PRACTITIONER OUTPATIENT THERAPY 71
SECTION 6.2: MEDICAL, PHYSICIAN/PSYCHIATRIST OUTPATIENT MEDICAL SERVICES 74

CHAPTER 7: SERVICES FOR THE HOMELESS 75
SECTION 7.1: PROJECTS FOR ASSISTANCE IN TRANSITION FROM HOMELESSNESS (PATH) 76
SECTION 7.2: HOUSING ASSISTANCE: MENTAL HEALTH AMERICA OF LOUISIANA 78
SECTION 7.3 COOPERATIVE AGREEMENT TO BENEFIT HOMELESS INDIVIDUALS (CABHI) STATES GRANT AND CABHI SUPPLEMENT 80

ADDENDA: 85
ADDENDUM A: MEDICAL NECESSITY DEFINITION 86
ADDENDUM B: ADDITIONAL SERVICE CRITERIA FOR EBPS 87

Chapter 1:
Crisis Services

Section 1.1: Short Term Respite Care

Definition

Short term respite care provides temporary direct care and supervision for the individual in the home or a community setting that is not facility-based (i.e., not provided overnight in a provider-based facility). The primary purpose is relief to families/caregivers of an individual with a serious emotional disturbance (SED) or relief of the individual. The service is designed to help meet the needs of the primary caregiver, as well as the identified individual in need of respite. Respite services help to de-escalate stressful situations and provide a therapeutic outlet for the individual. Respite may be either planned or provided on an emergency basis. Normal activities of daily living are considered to be included in the content of the service when providing respite care. These include support in the home, after school or at night, transportation to and from school/work/medical appointments or other community-based activities and/or any combination of the above. Short term respite care can be provided in an individual's home or place of residence or provided in other community settings, such as at a relative's home or in a short visit to a community park or recreation center. The individual must be present when providing short-term respite care. Short term respite care may not be provided simultaneously with crisis stabilization services and does not duplicate any other service otherwise available to recipient at no cost.

Provider Qualifications	Eligibility Criteria
Direct support worker The following individual qualifications are required for the direct care staff person (direct support worker, direct service worker and direct care staff person are used interchangeably): • Be at least 18 years of age. • Have a high school diploma, general equivalency diploma or trade school diploma in the area of human services, or demonstrate competency or verifiable work experience in providing support to persons with disabilities. • Criminal and professional background checks. • Not be included on the Direct Service Worker Registry. • Possess a valid social security number. • Provide documentation of current cardiopulmonary resuscitation (CPR) and first aid certifications. • Completion of respite training according to the curriculum approved by the Office of Behavioral Health (OBH) prior to providing the service. **Respite care services agency** • Licensed as a HCBS provider/In Home Respite agency per Revised Statute 40:2120.1 et seq. and Louisiana Administrative Code (LAC) 48:I.Chapter 50. • Completion of State-approved training according to a curriculum approved by OBH prior to providing the service. **Personal care attendant (PCA) agency**	Children and adults in an LGE when the service has been determined medically necessary by the ASO.

• Licensed as a HCBS provider/PCA agency per Revised Statute 40:2120.1 et seq. and Louisiana Administrative Code (LAC) 28:I.Chapter 50. • Completion of State-approved training according to a curriculum approved by the OBH prior to providing the service. **Supervised Independent Living (SIL) agency** • Licensed as a HCBS provider/SIL agency per Revised Statute 40:2120.1 et seq. and Louisiana Administrative Code (LAC) 48:I.Chapter 50. • Completion of State-approved training according to a curriculum approved by the OBH prior to providing the service. **Crisis receiving center** • Licensed per Revised Statutes (RS) 28:2180.12 and Louisiana Administrative Code 48:I.Chapters 53 and 54. • Completion of State-approved training according to a curriculum approved by OBH prior to providing the service. **Center-based respite** • Licensed as a HCBS provider/Center-based Respite per Revised Statute 40:2120.1 et seq. and Louisiana Administrative Code (LAC) 48:I.Chapter 50. • Completion of State-approved training according to a curriculum approved by OBH prior to providing the service.	

Limitations/Exclusions	**Allowed Mode(s) of Delivery**
Short term respite care must be pre-approved by the ASO in collaboration with the LGE. 1. Services provided must include communication and coordination with the family and/or legal guardian. Coordination with other child-serving systems should occur, as needed, to achieve the treatment goals. All coordination must be documented in the individual's medical record. 2. Short term respite care will not duplicate any other services otherwise available to the recipient at no cost. 3. Respite care may be provided by a licensed respite care facility, with the availability of community outings. Community outings would be included on the Recommended Services and Supports (RSS) plan developed by the ASO and would include activities, such as school attendance or other activities the individual would receive if they were not receiving respite from a center-based respite facility. Such	Individual Off-site

community outings would allow the individual's routine not to be interrupted. Respite is not provided inside a provider facility. 4. The provider must be at least three years older than an individual under the age of 18.	

Additional Service Criteria
Services provided must include communication and coordination with the family and/or legal guardian (if applicable), including any agency legally responsible for the care or custody of the individual. Coordination with other child-serving systems should occur, as needed, to achieve the treatment goals. All coordination must be documented in the individual's medical record.

Section 1.2: Crisis Stabilization

Definition

Crisis stabilization is intended to provide short-term and intensive supportive resources. The intent of this service is to provide an out-of-home crisis stabilization option for the family in order to avoid psychiatric inpatient and institutional treatment of the individual by responding to potential crisis situations. The goal will be to support the individual and family in ways that will address current acute and/or chronic mental health needs and coordinate a successful return to the family setting at the earliest possible time. During the time the crisis stabilization is supporting the individual, there is regular contact with the family to prepare for their return and his/her ongoing needs as part of the family. It is expected that the individual, family, and crisis stabilization provider are integral members of the individual treatment team.

Transportation is provided between the individual's place of residence and other services sites and places in the community.

Provider Qualifications	Eligibility Criteria
Respite care services agency • Licensed as a HCBS provider/In Home Respite agency per Revised Statute 40:2120.1 et seq. and Louisiana Administrative Code (LAC) 48:I. Chapter 50. • Completion of State-approved training according to a curriculum approved by OBH prior to providing the service. **Crisis receiving center** • Licensed per RS 28:2180.12 and Louisiana Administrative Code 48:I. Chapters 53 and 54. • Completion of State-approved training according to a curriculum approved by OBH prior to providing the service. **Center-based respite** • Licensed as a HCBS provider/Center-based Respite per Revised Statute 40:2120.1 et seq.and Louisiana Administrative Code (LAC) 48:I.Chapter 50. • Completion of State-approved training according to a curriculum approved by OBH prior to providing the service.	To qualify to receive crisis stabilization services, individuals must, as a result of a potential crisis situation, be in need of short-term and intensive supportive resources in order to avoid psychiatric inpatient and/or institutional treatment. The individual must require a service that includes direct monitoring by professional behavioral health staff that would not be able to be provided by a less restrictive service. These services are provided as part of a comprehensive specialized psychiatric program available to individuals with significant functional impairments resulting from an identified mental health or substance use diagnosis. The medical necessity for these services must be determined by and services recommended by a licensed mental health practitioner or physician who is acting within the scope of his/her professional licensed and applicable state law and furnished by or under the direction of a licensed practitioner, to promote the maximum reduction of symptoms and/or restoration of a individual to his/her best age-appropriate functional level. Services are subject to prior approval, must be medically necessary and must be recommended by a licensed mental health practitioner or physician. Medical necessity of the services is determined by a licensed mental health practitioner or physician.

Additional Service Criteria	Allowed Mode(s) of Delivery
1. Services provided must include communication and coordination with the family and/or legal guardian (if applicable), including any agency legally responsible for the care or custody of the child. Coordination with other child-serving systems should occur, as	Individual On-site

needed, to achieve the treatment goals. All coordination must be documented in the individual's medical record. 2. Crisis stabilization shall not be provided simultaneously with short-term respite care and does not duplicate any other service otherwise available to the recipient at no cost	

Chapter 2: Recommended Supports and Services

Section 2.1: Case Conference

Definition

A case conference is a scheduled face-to-face meeting between two or more individuals to discuss the beneficiary's treatment. The conference may include treatment staff, collateral contact or the consumer's other agency representatives, not including court appearances and/or testimony. Case conference includes communication between an LMHP, advanced practice registered nurse (APRN) or psychiatrist for a client consultation that is medically necessary for the medical management of psychiatric conditions. The member does not need to be present for the conference.

Provider Qualifications	Eligibility Criteria
LMHPs who are not physicians or APRNs. An LMHP is an individual who is licensed in the State of Louisiana to diagnose and treat mental illness or substance use, acting within the scope of all applicable State laws and their professional license. An LMHP includes individuals licensed to practice independently: • Medical psychologists • Licensed psychologists • Licensed clinical social workers • Licensed professional counselors (LPCs) • Licensed marriage and family therapists (LMFTs) • Licensed addiction counselors (LACs) • APRNs (must be a nurse practitioner (NP) specialist in adult psychiatric and mental health, and family psychiatric and mental health or a certified nurse specialist in psychosocial, gerontological psychiatric mental health, adult psychiatric and mental health, and child-adolescent mental health, and may practice to the extent that services are within the APRN's scope of practice)	Children and adults in an LGE when the service has been determined medically necessary by the ASO.

Limitations/Exclusions	Allowed Mode(s) of Delivery
Services must be prior authorized and are limited to the available funding. Telephone coordination is excluded. Individual, group, family therapy allowed; assessment is permitted as well, but all treatment is restricted to marriage and family therapy issues. LMFTs and LACs are not permitted to render diagnosis of mental, emotional or addictive disorders but may perform assessments within their scope of practice.	On-site Off-site

Commensurate with R.S. Title 37, Chapter 13, 37 and Act No 636 of the 2012 regular session of the LA legislature, LPCs may render or offer prevention, assessment, diagnosis and treatment, which includes psychotherapy of mental, emotional, behavioral and addiction disorders to individuals, groups and organizations, which is consistent with their professional training. In accordance with Act 636 of the regular legislative session of 2012, LPCs are not authorized to assess, diagnose or provide treatment to any individual suffering from the serious mental illnesses listed below when medication may be indicated, except when a licensed professional counselor, in accordance with industry best practices, consults and collaborates a practitioner who holds a license or permit with the Louisiana State Board of Medical Examiners or an advanced practice registered nurse licensed by the Louisiana State Board of Nursing who is certified as a psychiatric nurse practitioner and is authorized to prescribe medications in the management of psychiatric illness. "Serious mental illness" means any of the following diagnoses: a. Schizophrenia or schizoaffective disorder b. Bipolar disorder c. Panic disorder d. Obsessive-compulsive disorder e. Major depressive disorder-moderate to severe f. Anorexia/bulimia g. Intermittent explosive disorder h. Autism i. Psychosis NOS, when diagnosed in a child under seventeen years of age j. Rett's disorder k. Tourette's disorder l. Dementia LMFTs may practice and provide marriage and family therapy, including the application of psychotherapeutic and family systems theories and techniques in the assessment and treatment of individuals and families, while rendering professional marriage and family therapy services to individuals, couples and families, singly or in groups. APRN: Collaborative Practice Agreement required. APRNs have certified nurse specializations as specified in the authorities' documents.	
Additional Service Criteria	
1. Additional coordination with other medical professionals, to support the provision of the case conference, may be needed. Services provided to children and youth must include communication and coordination with the family and/or legal guardian, including any agency legally responsible for the care or custody of the child. Coordination with other child-serving systems should occur, as needed, to achieve the treatment goals. All coordination must be documented in the youth's medical record. 2. Case conference does not duplicate any other service otherwise available to recipient at no cost.	

Section 2.2: Recommended Supports and Services (RSS) and Treatment Planning Coordination

Definition

The ASO assesses special needs children and adults and develops a Recommended Supports and Services (RSS) plan that is used by the LGE and/or provider to develop an individualized, person-centered, strengths-based treatment plan. The LGEs and/or provider shall review and submit treatment plans quarterly to the ASO to determine the need for continued services.

The current populations eligible for RSS plan development and treatment planning through the ASO include uninsured adults and children.

The function of the RSS plan is to make recommendations to be used in the development of a community-based, individualized treatment plan. This includes working with the individual and/or family to identify who should be involved in the RSS and treatment planning process. The RSS guides the treatment plan development process and should guide subsequent treatment plan review and revision on a quarterly basis, at minimum, and more frequently when changes in the consumer's circumstances warrant changes in the treatment plan. Emphasis should be on building collaboration and ongoing coordination among the family, caretakers, service providers and other formal and informal community resources identified by the family and promote flexibility to ensure appropriate and effective service delivery to the child or adult and family/caregivers.

1. Screening

The ASO or LGE/provider will conduct an initial screening of the individual seeking services based on the individual's point of entry to access services (either through the LGE/provider or by calling the ASO directly). Once the initial screening is complete, the ASO shall determine if the individual meets medical necessity criteria for services and shall detail authorized services in the RSS plan.

2. Development of an individualized treatment plan

Using the information collected through an assessment, the treatment planner, together with the individual and others identified through the assessment, develops a person- and family-centered, individual treatment plan that specifies the goals and actions to address the medical, social, educational and other services needed by the eligible individual. The treatment planner works directly with the child/adult, the family (or the authorized health care decision maker) and others to identify the strengths, needs and goals of the child and the strengths, needs and goals of the family in meeting the individual's needs. The treatment plan meets the following requirements: It is developed by the individual's behavioral health treatment planner and in consultation with the PCP and any specialists' care for the individual who then receives a copy of the treatment plan. The treatment plan lists any specialists to whom the individual should be referred for individual's condition and identified needs.

The treatment planner may also use multiple tools, including a strengths-based standardized assessment instrument approved by OBH, in conjunction with a comprehensive psychosocial assessment and other clinical information, to organize and guide the development of an individualized treatment plan. Assessment activities include, without limitation, the treatment planner 1) assisting the adult, child and family to identify appropriate collateral contacts; 2) identifying strengths and needs of the child or adult and strengths and needs of the family in meeting the child or adult's needs; and 3) collecting the needs of the child or adult for any medical, educational, social or other services. Further assessments will be provided as medically necessary.

3. Referral and related activities

The treatment planner 1) convenes, coordinates and communicates with the individual and identified collateral contacts to implement the individual treatment plan; 2) works directly with the child/adult and family to implement elements of the individual treatment plan; 3) prepares, monitors and modifies the individual treatment plan; 4) coordinates the delivery of available services including behavioral health, educational, social or other services; 5) develops, in concert with the individual and collateral contacts, a transition plan when the child/adult has achieved the goals of the treatment plan; and 6) collaborates with other service providers on the child/adult and family's behalf.

4. Monitoring and follow-up activities

Includes reviewing the individual treatment plan quarterly to update accordingly to reflect the changing needs of the child/adult. The treatment planner performs such reviews and includes: 1) whether services are being provided in accordance with the individual treatment plan; 2) whether the services in the individual treatment plan are adequate; and 3) whether there are changes in needs or status of the individual and, if so, recommended adjustments to the treatment plan as necessary. The quarterly review and revisions to the treatment plan shall be submitted to the ASO.

Provider Qualifications	**Eligibility Criteria**
• Have at least a BA/BS degree or be equivalently qualified by work experience or a combination of work experience in the human services field and education, with one year of experience substituting for one year of education. • Passing criminal and professional background checks and completion of a standardized basic training program approved by the OBH.	Uninsured children or adults who meet medical necessity.

Limitations/Exclusions	**Allowed Mode(s) of Delivery**
Treatment planning is an administrative activity provided by the LGE and/or service provider based on the RSS developed by the ASO.	Individual On-site Off-site

Additional Service Criteria

1. Services provided to children and youth must include communication and coordination with the family and/or legal guardian, including any agency legally responsible for the care or custody of the child. Coordination with other child-serving systems should occur, as needed, to achieve the treatment goals. All coordination must be documented in the youth's medical record.

2. Treatment planning is provided to address the unique needs of clients living in the community and does not duplicate any other service otherwise available to the recipient at no cost.

3. The treatment planner and RSS planner shall be an LMHP with experience regarding specialized mental health service and such, shall be available at all times to provide back up, support and/or consultation.

Chapter 3:
Prevention and Wellness

Section 3.1: Prevention Services

Definition

OBH Prevention Services provide evidence-based prevention programming in school- and community-based settings. The State utilizes the 20% set aside from the Substance Abuse Prevention and Treatment Block Grant to fund programs that meet the following criteria: 1) inclusion in a federal list or registry of evidence-based interventions; or 2) being reported (with positive effects) in a peer-reviewed journal.These evidence-based programs are designated as universal, indicated and/or selective programs. Universal prevention programs address the entire population with messages and programs aimed at preventing or delaying the use of alcohol, tobacco, and other drugs. Selective prevention programs target subsets of the total population that are deemed to be "at risk" for substance use by virtue of their membership in a particular population segment. Indicated prevention programs are designed to prevent the onset of substance use in individuals who do not meet criteria for a substance use disorder diagnosis, but who are showing early danger signs, such as falling grades and consumption of alcohol and other gateway drugs.

In addition, OBH provides population-based services/activies to the general population. These population-based services are intended to provide public awareness and include disseminating information, rallies, health fairs, billboard campaigns, television and radio interview, and public service announcements.

Components

The following is a list of Evidence-Based Programs currently being implemented:

- Life Skills Training
- Project Northland
- Positive Action
- Kids Don't Gamble…Wanna Bet?
- Project Alert
- Coping Skills
- Too Good for Drugs
- Al's Pals, Protecting You – Protecting Me
- Project Towards No Tobacco Use
- Guided Imagery Program
- Second Step
- Keep a Clear Mind
- Strengthening Families
- Leadership and Resiliency
- Insight Class Program

Population-based services are provided to the general population in an effort to raise awareness. These services are typically one-time events.

Provider Qualifications	**Eligibility Criteria**
There is a statewide licensing/certification program for the substance use prevention workforce. The Addictive Disorder Regulatory Authority is the state licensing and credentialing board for addiction counselors and prevention professionals. A prevention professional must first register as a Prevention Specialist in Training (PSIT). Based on	Universal prevention: activities targeted to the general public or a whole population group that has not been identified on the basis of individual risk.

education and experience, a prevention professional may become a Licenced Prevention Professional (LPP), a Certified Prevention Professional (CPP), and a Registered Prevention Professional (RPP). ELIGIBILITY REQUIREMENTS FOR LPP*:* • At least 21 years of age and holds a Master's or Doctoral degree from an accredited institution of higher education • A legal resident of the United States • In not in violation of any ethical standard subscribed to by the ADRA • Has not had a substance use disorder or compulsive gambling problem for at least two years prior to the date of the application. • Has not been convicted of a felony; however, the ADRA has the discretion to waive this requirement upon review of the circumstances. • Has successfully completed 100 total clock hours of education approved by the ADRA. 50 hours of the 100 hours must be specific to substance use training, with 6 hours in professional ethics, 30 hours from National Prevention Training with the remaining 14 hours being related. All hours are subject to approval by the ADRA. • Has successfully completed 2000 hours (1 full-time year) of supervised work experience engaged in providing prevention services. Of the 2000 hours, a 120 hour practicum in the 5 domains must be obtained with at least 10 hours in each domain. The experience must be supervised by a qualified professional. • Has completed and received approval for testing based on submission of the application prescribed by the ADRA to include a case study. • Demonstrates competence in addiction counseling by passing the written examination prescribed by the ADRA. ELIGIBILITY REQUIREMENTS FOR CPP: • At least 21 years of age and holds a Bachelor's degree from an accredited institution of higher education • A legal resident of the United States. • In not in violation of any ethical standard subscribed to by the ADRA. • Has not had a substance use disorder or compulsive gambling problem for at least two years prior to the date of the application. • Has not been convicted of a felony; however, the ADRA has the discretion to waive this requirement upon review of the circumstances. • Has successfully completed 100 total clock hours of education approved by the ADRA. 50 hours of the 100 hours must be specific to substance use training, with 6 hours in professional ethics, 30	Selective prevention: Activities targeted to individuals or a subgroup of the population whose risk of developing a disorder is significantly higher than average. Indicated prevention: Activities targeted to individuals in high-risk environments who are identified as having minimal but detectable signs or symptoms foreshadowing disorder, or having biological markers indicating predisposition for disorder but not yet meeting diagnostic levels.

hours from National Prevention Training with the remaining 14 hours being related. All hours are subject to approval by the ADRA. • Has successfully completed 4000 hours (2 full-time years) of supervised work experience engaged in providing prevention services. Of the 4000 hours, a 120 hour practicum in the 5 domains must be obtained with at least 10 hours in each domain. The experience must be supervised by a qualified professional. • Has completed and received approval for testing based on submission of the application prescribed by the ADRA to include a case study. • Demonstrates competence in addiction counseling by passing the written examination prescribed by the ADRA. ELIGIBILITY REQUIREMENTS FOR RPP: • At least 21 years of age and hold a High School Diploma or a high school diploma equivalent (GED). • A legal resident of the United States. • In not in violation of any ethical standard subscribed to by the ADRA. • Has not had a substance use disorder or compulsive gambling problem for at least two years prior to the date of the application. • Has not been convicted of a felony; however, the ADRA has the discretion to waive this requirement upon review of the circumstances. • Has successfully completed 100 total clock hours of education approved by the ADRA. 50 hours of the 100 hours must be specific to substance use training, with 6 hours in professional ethics, 30 hours from National Prevention Training with the remaining 14 hours being related. All hours are subject to approval by the ADRA. • Has successfully completed 6000 hours (3 full-time years) of supervised work experience engaged in providing prevention services. Of the 2000 hours, a 120 hour practicum in the 5 domains must be obtained with at least 10 hours in each domain. The experience must be supervised by a qualified professional. • Has completed and received approval for testing based on submission of the application prescribed by the ADRA to include a case study. • Demonstrates competence in addiction counseling by passing the written examination prescribed by the ADRA. In addition, each provider must be certified in the evidence-based curriuculum that he or she delivers.	
Allowed Mode(s) of Delivery	
School-Based Services Community-Based Services	

Section 3.2: Louisiana Partnership for Success

Definition

The Louisiana Partnerships for Success (LaPFS) is a SAMHSA-funded project whose aim is to address the following prevention priorities: 1) Underage Drinking among persons aged 12-20; and 2) Prescription Drug Misuse/Abuse among persons aged 12- 25. The LaPFS is a state/community collaborative which uses data-driven decision-making to develop, implement, and evaluate effective prevention strategies.

Goals of LaPFS

- To prevent the onset and reduce the progression of underage drinking and prescription drug misuse/abuse
- To reduce short-term and long-term consequences of underage drinking and prescription drug misuse/abuse
- To eliminate disparities in the prevention of underage drinking and prescription drug misuse/abuse
- To strengthen and sustain prevention capacity/infrastructure at the state and community levels
- To leverage, redirect, and align state-wide funding streams and resources for prevention

Identification of High Need Parishes/Communities

Ten (10) high need parishes/communities across the state were identified to receive LaPFS funding. The identification of High Need Communities/Parishes was done in collaboration with the State Epidemiology Workgroup and a diverse group of stakeholders who participated in the LaPFS proposal development.

High Need Communities/Parishes were identified using a comprehensive public health approach that focused on two components: (1) Highest Rates of Underage Drinking and Prescription Drug Abuse - data from various state and parish sources were used to determine the parishes with the highest rates of the two federal prevention priority areas; and (2) Highest Rates of Disadvantage/Challenge - key indicators regarding disadvantage and challenge were used to determine parishes that had relatively limited resources available to address underage drinking and prescription drug abuse. Therefore, High Need Communities are the parishes in Louisiana with the highest rates of underage drinking and prescription drug abuse and the lowest levels of social and economic factors that help communities promote health, wellness and safety.

Steps Used to Identify High Need Communities/Parishes

Step 1: Reviewed State Epidemiology Workgroup data to identify the prevention priorities to address in the proposal.
Step 2: Compiled more extensive data at the parish level about the prevention priorities to identify whether high need communities/parishes were clustered in a specific area of the state, or were distributed statewide.
Step 3: Used more extensive data about prevention priority indicators at the parish level to identify the highest need communities/parishes within each Local Governing Entity.
Step 4: Used data about resources to identify the highest need communities/parishes within each Local Governing Entity that not only had high burden of underage drinking and prescription drug misuse/abuse, as well as, shared risk factors related to depression, but also had fewer resources for addressing these burdens.

Provider Qualifications	Eligibility Criteria
Development of local coalitions who are committed to addressing the prevention priorities of 1) Underage Drinking among persons aged 12-20 and 2) Prescription Drug Misuse/Abuse among persons aged 12- 25. • LGEs to establish Memorandums of Understanding	N/A

(MOUs) with OBH for LaPFS project. • Develop coalitions to address high need areas and communities. • Develop and submit community-specific action plans (with related budgets) for approval.	

Section 3.3: Problem Gambling Prevention and Treatment Services

Definition

Gambling Disorders are characterized by increasing preoccupation with gambling, a need to bet more money more frequently, restlessness or irritability when attempting to stop, "chasing" losses, and loss of control manifested by continuation of the gambling behavior in spite of mounting, serious, negative consequences. There are a variety of options for the treatment and prevention of gambling disorder, including outpatient, intensive outpatient, and residential services.

Components

Treatment:

- Assessment using an evidence-based assessment tool, such as the South Oaks Gambling Screen (SOGS)
- Individual or group counseling in an outpatient or intensive outpatient setting for adults statewide.
- Residential treatment at Center for Recovery (CORE)
- Outpatient treatment for adolescents (ages 12-17)

Prevention:

"Kids Don't Gamble…Wanna Bet?" is a curriculum for students in grades 3-8 to discourage underage gambling and improve critical thinking and problem solving related to gambling. The curriculum includes age-appropriate lesson plans and activities in addition to a resource guide for parents.

Provider Qualifications	**Eligibility Criteria**
Licensed, certified or registered clinicians to conduct counseling.	All Louisiana residents are eligible for services *at no cost*, including family members of gamblers.

Allowed Mode(s) of Delivery

Individual, group, family

Section 3.4: Tobacco Use Prevention and Cessation Treatment

Definition
This program addresses the needs of persons that are seeking treatment for Tobacco/Nicotine Dependence. Services are provided on site or in collaboration with stakeholders within the Local Governing Entity. The Office of Public Health (OPH) also offers the Louisiana Tobacco Quitline (1-800-QUIT-NOW), which provides for brief coaching calls via phone and the ability to assist with nicotine replacement therapy.
Components
Treatment interventions include but are not limited to; screening, assessment, individual counseling, group therapy, nicotine replacement therapy etc. • Ask, Advise, Refer (AAR) model at clinics that do not provide services • Evidenced based screening and assessment • Individual and/or group counseling • Nicotine replacement therapy • Phone coaching calls

Provider Qualifications	**Eligibility Criteria**
The Louisiana Tobacco Quitline coaches are trained in tobacco cessation. LGE services are provided by licensed, certified or registered clinicians	Any current Louisiana resident who was a smoker prior to September 1, 1988, and wants to stop smoking cigarettes can apply for free services through the Smoking Cessation Trust The Louisiana Tobacco Quitline services are free for all Louisiana residents age 13 and older who are ready to quit within the next 30 days

Service Utilization	**Allowed Mode(s) of Delivery**
N/A	Individual, group, phone

Additional Service Criteria
Additional telephone counseling sessions from the Louisiana Tobacco Quitline available for pregnant women

Chapter 4:
Behavioral Health Services

Behavioral Health Services Provided by Licensed and Unlicensed Individuals

Section 4.1: Psychosocial Rehabilitation (PSR)

Definition

Psychosocial rehabilitation (PSR) services are designed to assist the individual with compensating for or eliminating functional deficits and interpersonal and/or environmental barriers associated with their mental illness. Activities included must be intended to achieve the identified goals or objectives as set forth in the individual's individualized treatment plan. The intent of PSR is to restore the fullest possible integration of the individual as an active and productive member of his or her family, community and/or culture with the least amount of ongoing professional intervention. PSR is a face-to-face intervention with the individual present. Services may be provided individually or in a group setting. A minimum of 51% of a PSR's contacts must occur in community locations where the person lives, works, attends school and/or socializes.

Components

A. Restoration, rehabilitation and support to develop social and interpersonal skills to increase community tenure, enhance personal relationships, establish support networks, increase community awareness, develop coping strategies and effective functioning in the individual's social environment, including home, work and school.

B. Restoration, rehabilitation and support to develop daily living skills to improve self-management of the negative effects of psychiatric or emotional symptoms that interfere with a person's daily living. Supporting the individual with development and implementation of daily living skills and daily routines necessary to remain in home, school, work and community.

C. Implementing learned skills so the person can remain in a natural community location and achieve developmentally appropriate functioning.

D. Assisting the individual with effectively responding to or avoiding identified precursors or triggers that result in functional impairments.

Provider Qualifications	**Eligibility Criteria**
• Must be at least 18 years old and have a high school diploma or equivalent. Additionally, the provider must be at least three years older than any individual they serve under the age of 18. This can include certified peer support specialists. • Passing criminal, professional background checks and completion of a State-approved, standardized basic training program. • The provider must operate under an agency license. PSR services may not be performed by an individual who is not under the authority of an agency license. The behavioral health service (BHSP) provider licensing rule and RS 40:2151, et.al. prohibit PSR from being performed by an unlicensed individual not operating under an agency license with the exception of providers meeting exemption requirements as per R.S. 40:2154.	Meets medical necessity criteria for rehabilitation services.

Service Utilization	**Allowed Mode(s) of Delivery**

The PSR provider must receive regularly scheduled clinical supervision from a person meeting the qualifications of a LMHP with experience regarding this specialized mental health service. **Ratio:** • One FTE to 15 consumers is maximum group size for adults • One FTE to eight consumers is maximum group size for youth	Individual Group On-site Off-site

Additional Service Criteria

1. Services provided must include communication and coordination with the family and/or legal guardian (if applicable). Coordination with other child-serving systems should occur, as needed, to achieve the treatment goals. All coordination must be documented in the individual's medical record.

2. The PSR provider must receive regularly scheduled clinical supervision from a person meeting the qualifications of a LMHP with experience regarding this specialized mental health service.

Section 4.2: Crisis Intervention

Definition

Crisis intervention (CI) services are provided to a person who is experiencing a psychiatric crisis and are designed to interrupt and/or ameliorate a crisis experience, via a preliminary assessment, immediate crisis resolution and de-escalation and referral and linkage to appropriate community services to avoid more restrictive levels of treatment. The goals of CI are symptom reduction, stabilization and restoration to a previous level of functioning. All activities must occur within the context of a potential or actual psychiatric crisis. CI is a face-to-face intervention and can occur in a variety of locations, including an emergency room or clinic setting, in addition to other community locations where the person lives, works, attends school and/or socializes.

Components

A. A preliminary assessment of risk, mental status and medical stability and the need for further evaluation or other mental health services. Includes contact with the client, family members or other collateral sources (e.g., caregiver, school personnel) with pertinent information for the purpose of a preliminary assessment and/or referral to other alternative mental health services at an appropriate level.

B. Short-term CI, including crisis resolution and debriefing with the identified individual.

C. Follow up with the individual and, as necessary, with the individuals' caretaker and/or family members.

D. Consultation with a physician or with other qualified providers to assist with the individual's specific crisis.

Provider Qualifications	Eligibility Criteria
• Must be at least 20 years old and have an associate's degree in social work, counseling, psychology or a related human services field or two years of equivalent education and/or experience working in the human services field. Additionally, the provider must be at least three years older than an individual under the age of 18. Can include certified peer support specialists with the above qualifications. • Passing criminal, professional background checks and completion of a State-approved, standardized basic training program. • Employed by a licensed clinic. The BHSP rule and RS 40:2151, et.al. prohibit an unlicensed individual from providing crisis intervention without being under an agency license with the exception of providers meeting exemption requirements as per R.S. 40:2154. • The assessment of risk, mental status and medical stability must be completed by an LMHP with experience regarding this specialized mental health service, practicing within the scope of their professional license.	Meets medical necessity criteria (MNC) for rehabilitation services. All individuals who self-identify as experiencing a seriously acute psychological/emotional change, which results in a marked increase in personal distress and which exceeds the abilities and the resources of those involved to effectively resolve it, are eligible. .

Service Utilization	Allowed Mode(s) of Delivery
• An individual in crisis may be represented by a family member or other collateral contact that has knowledge of the individual's capabilities and functioning. Individuals in crisis who require this service may be using	Individual On-site Off-site

substances during the crisis, and this will not, in and of itself, disqualify them for eligibility for the service**.** • Substance use should be recognized and addressed in an integrated fashion, as it may add to the risk, increasing the need for engagement in care. • The crisis plan developed by the unlicensed professional from this assessment and all services delivered during a crisis must be provided under the supervision of a LMHP with experience regarding this specialized mental health service and must be available at all times to provide back up, support and/or consultation. • The CI provider must receive regularly scheduled clinical supervision from a person meeting the qualifications of a LMHP with experience regarding this specialized mental health service. • Employed by a licensed clinic. The BHSP rule and RS 40:2151, et.al. prohibit an unlicensed individual from providing crisis intervention without being under an agency license with the exception of providers meeting exemption requirements as per R.S. 40:2154 .	

Additional Service Criteria

- CI – Emergent is allowed an initial 24 hour period without the requirement of a prior authorization in order to address the emergent issues in a timely manner. Additional hours may be approved with prior authorization.

- An episode is defined as the initial face-to-face contact with the individual until the current crisis is resolved. The individual's chart must reflect resolution of the crisis which marks the end of the current episode. If the individual has another crisis within seven calendar days of a previous episode, it shall be considered part of the previous episode, and a new episode will not be allowed. The initial authorization can be exceeded when medically necessary through prior authorization or through the provision of other medically necessary ongoing services such as PSR, community psychiatric support and treatment (CPST), etc.

- The assessment of risk; mental status and medical stability must be completed by the licensed practitioner.

Section 4.3: Community Psychiatric Support and Treatment

Definition

Community Psychiatric Support and Treatment (CPST) are goal-directed supports and solution-focused interventions intended to achieve identified goals or objectives as set forth in the individual's individualized treatment plan. CPST is a face-to-face intervention with the individual present; however, family or other collaterals may also be involved. A minimum of 51% of CPST contacts must occur in community locations where the person lives, works, attends school and/or socializes.

Components

This service may include the following components:

Assist the individual and family members or other collaterals to identify strategies or treatment options associated with the individual's mental illness, with the goal of minimizing the negative effects of mental illness symptoms or emotional disturbances or associated environmental stressors which interfere with the individual's daily living, financial management, housing, academic and/or employment progress, personal recovery or resilience, family and/or interpersonal relationships and community integration.

Individual supportive counseling, solution-focused interventions, emotional and behavioral management and problem behavior analysis with the individual, with the goal of assisting the individual with developing and implementing social, interpersonal, self-care, daily living and independent living skills to restore stability, to support functional gains and to adapt to community living.

Participation in, and utilization of, strengths-based planning and treatments, which include assisting the individual and family members or other collaterals with identifying strengths and needs, resources, natural supports and developing goals and objectives to utilize personal strengths, resources and natural supports to address functional deficits associated with their mental illness.

Assist the individual with effectively responding to or avoiding identified precursors or triggers that would risk their remaining in a natural community location, including assisting the individual and family members or other collaterals with identifying a potential psychiatric or personal crisis, developing a crisis management plan and/or, as appropriate, seeking other supports to restore stability and functioning.

Restoration, rehabilitation and support to develop skills to locate, rent and keep a home, landlord/tenant negotiations, selecting a roommate and renter's rights and responsibilities.

Assisting the individual to develop daily living skills specific to managing their own home, including managing their money, medications and using community resources and other self care requirements.

Provider Qualifications	Eligibility Criteria
• Practitioners with a master's degree in social work, counseling, psychology or a related human services field may provide all aspects of CPST, including counseling. Other aspects of CPST, except for counseling, may otherwise be performed by an individual with a bachelor's degree in social work, counseling, psychology or a related human services field or four	Meets medical necessity criteria for rehabilitation services

years of equivalent education and/or experience working in the human services field. Can include certified peer support specialists who meet the qualifications above. • Passing criminal, professional background checks and completion of a State-approved, standardized basic training program. • Employed by a licensed clinic. The BHSP rule and RS 40:2151, et.al. prohibit an unlicensed individual from providing crisis intervention without being under an agency license with the exception of providers meeting exemption requirements as per R.S. 40:2154.	
Service Utilization	**Allowed Mode(s) of Delivery**
Ratio: Caseload size must be based on the needs of the clients/families, with an emphasis on successful outcomes and individual satisfaction and must meet the needs identified in the individual treatment plan. The CPST provider must receive regularly scheduled clinical supervision from a person meeting the qualifications of a LMHP with experience regarding this specialized mental health service. All analysis of problem behaviors must be performed under the supervision of a licensed psychologist/medical psychologist. Certified school psychologists must be supervised consistent with RS 17:7.1. The following general ratio should serve as a guide: • One FTE to 15 youth consumers • One FTE to 25 adult consumers No other limitations apply.	Individual On-site Off-site In residential setting
Additional Service Criteria	
1. Services provided to children and youth must include communication and coordination with the family and/or legal guardian. Coordination with other child-serving systems should occur, as needed, to achieve the treatment goals. All coordination must be documented in the youth's medical record. 2. Face-to-face for CPST includes a therapist in a different room/location from the client/family**,** but in the same building, with real-time visual and audio transmission from the therapy room and two-way audio transmission between client and/or family member and therapist. If the therapist is working with a single client/family, then family or individual therapy requirements and reimbursement would apply. If the therapist is working with more than one client/family, group therapy requirements and reimbursement would apply. Must be provided by licensed or qualified MA-level staff. MA-level staff must have appropriate oversight when providing treatment through real-time visual and audio transmission. The practice must be in accord with documented EBPs or promising practices approved by OBH (or the ASO). If not in the same building, then telemedicine requirements and reimbursement would apply.	

Section 4.4: Therapeutic Group Home

Definition

Therapeutic Group Homes (TGHs) provide a community-based residential service in a home-like setting of no greater than eight beds, under the supervision and program oversight of a psychiatrist or psychologist. The treatment should be targeted to support the development of adaptive and functional behaviors that will enable the child or adolescent to remain successfully in his/her home and community and to regularly attend and participate in work, school or training. TGHs deliver an array of clinical and related services within the home, including psychiatric supports, integration with community resources and skill-building taught within the context of the home-like setting. TGH treatment must target reducing the severity of the behavioral health issue that was identified as the reason for admission. Most often, targeted behaviors will relate directly to the child's or adolescent's ability to function successfully in the home and school environment (e.g., compliance with reasonable behavioral expectations, safe behavior and appropriate responses to social cues and conflicts). Treatment must:

- Focus on reducing the behavior and symptoms of the psychiatric disorder that necessitated the removal of the child or adolescent from his/her usual living situation.
- Decrease problem behavior and increase developmentally appropriate, normative and pro-social behavior in children and adolescents who are in need of out-of-home placement.
- Transition child or adolescent from TGH to home- or community-based living, with outpatient treatment (e.g., individual and family therapy).

The ASO or its designee must have determined that less intensive levels of treatment are unsafe, unsuccessful or unavailable. The child must require active treatment that would not be able to be provided at a less restrictive level of care being provided on a 24-hour basis with direct supervision/oversight by professional behavioral health staff. The setting must be geographically situated to allow ongoing participation of the child's family. The child or adolescent must attend a school in the community (e.g., a school integrated with children not from the group home and not on the group home's campus). In this setting, the child or adolescent remains involved in community-based activities and may attend a community educational, vocational program or other treatment setting.

TGHs provide a 24 hours/day, seven days/week, structured and supportive living environment. Care coordination is provided to plan and arrange access to a range of educational and therapeutic services. Psychotropic medications should be used with specific target symptoms identification, with medical monitoring and 24-hour medical availability when appropriate and relevant. Screening and assessment is required upon admission, and every 14 days thereafter, to track progress and revise the treatment plan to address any lack of progress and to monitor for current medical problems and concomitant substance use issues. The individualized, strengths-based services and supports:

- Are identified in partnership with the child or adolescent and the family and support system, to the extent possible, and if developmentally appropriate.
- Are based on both clinical and functional assessments.
- Are clinically monitored and coordinated, with 24-hour availability.
- Are implemented with oversight from a licensed mental health professional.
- Assist with the development of skills for daily living, and support success in community settings, including home and school.

The TGH is required to coordinate with the child's or adolescent's community resources, including schools, with the goal of transitioning the youth out of the program to a less restrictive care setting for continued, sometimes intensive, services as soon as possible and appropriate. Discharge planning begins upon admission, with concrete plans for the child to transition back into the community beginning within the first week of admission, with clear action steps and target dates outlined in the treatment plan. The treatment plan must include behaviorally measurable discharge goals.

Limitations/Exclusions	Allowed Mode(s) of Delivery
Limitations: The psychiatrist or psychologist/medical psychologist must provide twenty-four (24) hour, on-call coverage seven (7) days a week. The psychologist/medical psychologist or psychiatrist must see the client at least once, prescribe the type of care provided and, if the services are not time-limited by the prescription, review the need for continued care every 14 days. Although the psychologist/medical psychologist or psychiatrist does not have to be on the premises when his/her client is receiving covered services, the supervising practitioner must assume professional responsibility for the services provided and ensure that the services are medically appropriate. Therapy (individual, group and family, whenever possible) and ongoing psychiatric assessment and intervention, as needed, (by a psychiatrist) are required of TGH, but provided separately by licensed practitioners. TGHs are located in residential communities in order to facilitate community integration through public education, recreation and maintenance of family connections. The facility is expected to provide recreational activities for all enrolled children.	On-site

Components

For treatment planning, the program must use a standardized assessment and treatment planning tool. The assessment protocol must differentiate across life domains, as well as risk and protective factors sufficiently, so that a treatment plan can be tailored to the areas related to the presenting problems of each youth and their family in order to ensure targeted treatment. The tool should also allow tracking of progress over time. The specific tools and approaches used by each program must be specified in the program description and are subject to approval by the State. In addition, the program must ensure that requirements for pretreatment assessment are met prior to treatment commencing. Annually, facilities must submit documentation demonstrating compliance with fidelity monitoring for at least two EBPs and/or one level of the American Society of Addiction Medicine (ASAM) criteria. The State must approve the auditing body providing the EBP/ASAM fidelity monitoring. TGH facilities may specialize and provide care for sexually deviant behaviors, substance use or dually diagnosed individuals, subject to state approval, if treatment for these populations is provided. If a program provides care to any of these categories of youth, the program must submit documentation regarding the appropriateness of the research-based, trauma-informed programming and training, as well as compliance with the ASAM level of care being provided (if applicable).

For service delivery, the program must incorporate at least two research-based approaches pertinent to the sub-populations of TGH clients to be served by the specific program. The specific research-based models to be used should be incorporated into the program description and submitted to the State for approval. All research-based programming in TGH settings must be approved by the State. For milieu management, all programs should also incorporate some form of research-based, trauma-informed programming and training, if the primary research-based treatment model used by the program does not (e.g., LAMod).

Staffing for the facility must be consistent with State licensure regulations on an FTE basis. For example, if State licensure requires a staff to client ratio of 1:25 and the facility has 16 child residents, then the facility must have at least .64 FTE for the 16 children. If the facility has 8 beds, then the facility must have at least .32

FTE for the 8 children.

Provider Qualifications	Eligibility Criteria
Provider qualifications: A TGH must be licensed by the Louisiana DHH and may not exceed eight beds. TGH staff must be supervised by a licensed mental health professional (supervising practitioner) with experience in evidence-based treatments. Staff includes paraprofessional, master's and bachelor's level staff (including certified peer support specialists) with degrees in social work, counseling, psychology or a related human services field, with oversight by a psychologist or psychiatrist. At least 21 hours of active treatment per week for each child is required to be provided by qualified staff (e.g., having a certification in the EBPs selected by the facility and/or licensed practitioners operating under their scope of practice in Louisiana), consistent with each child's treatment plan and meeting assessed needs. • A minimum of two (2) staff on duty per shift in each living unit, with the ability to call in as many staff as necessary to maintain safety and control in the facility, depending upon the needs of the current population at any given time. • A ratio of not less than one (1) staff to four (4) youth is maintained at all times; however, two (2) staff must be on duty at all times. • At least one (1) staff member per shift is required to have a current CPR and first aid certification. • Staffing schedules shall reflect overlap in shift hours to accommodate information exchange for continuity of youth treatment, adequate numbers of staff reflective of the tone of the unit, appropriate staff gender mix and the consistent presence and availability of professional staff. In addition, staffing schedules should ensure the presence and availability of professional staff on nights and weekends, when parents are available to participate in family therapy and to provide input on the treatment of their child. • Individual, group and family therapists are master level staff, available at least three (3) hours per week (individual and group) or two (2) hours per month (family). • A licensed registered nurse (RN) is on staff to establish the system of operation for administering or supervising residents' medications and medical needs or requirements; monitoring the residents'	For children only, less intensive levels of treatment must have been determined to be unsafe, unsuccessful or unavailable. The child must require active treatment provided on a 24-hour basis with direct supervision/oversight by professional behavioral health staff that would not be able to be provided at a less restrictive level of care.

response to medications; tracking and attending to dental and medical needs and training staff to administer medications and proper protocols. ○	

Service Utilization	Allowed Mode(s) of Delivery
The psychiatrist or psychologist must provide twenty-four (24) hour, on-call coverage seven (7) days a week. The psychologist or psychiatrist must see the client at least once, prescribe the type of care provided, and, if the services are not time-limited by the prescription, review the need for continued care every 14 days. Although the psychologist or psychiatrist does not have to be on the premises when his/her client is receiving covered services, the supervising practitioner must assume professional responsibility for the services provided and ensure that the services are medically appropriate. Therapy (individual, group and family, whenever possible) and ongoing psychiatric assessment and intervention, as needed, (by a psychiatrist) are required of TGH but provided separately by licensed practitioners. TGHs are located in residential communities in order to facilitate community integration through public education, recreation and maintenance of family connections. The facility is expected to provide recreational activities for all enrolled children.	On-site

Additional Service Criteria

TGHs may not be Institutions for Mental Disease (IMD). Each organization owning TGHs must ensure that in no instance, does the operation of multiple TGH facilities constitute operation of an IMD. All new construction, newly acquired property or facilities or new provider organizations must comply with facility bed limitations not to exceed eight beds. Existing facilities may not add beds if the bed total would exceed eight beds in the facility. Any physical plant alterations of existing facilities must be completed in a manner to comply with the eight bed per facility limit (i.e., renovations of existing facilities exceeding eight beds must include a reduction in the bed capacity to eight beds).

Average length of stay ranges from 14 days to six months. TGH programs focusing on transition or short-term crisis are typically in the 14 to 30 day range. Discharge may be determined based on the child no longer making adequate improvement in this facility (and another facility being recommended) or the child no longer having medical necessity at this level of care. Continued TGH stay should be based on a clinical expectation that continued treatment in the TGH can reasonably be expected to achieve treatment goals and improve or stabilize the child's or adolescent's behavior, such that this level of care will no longer be needed and the child or adolescent can return to the community. Transition should occur to a more appropriate level of care (either more or less restrictive) if the child or adolescent is not making progress toward treatment goals, and there is no reasonable expectation of progress at this level of care (e.g., child's or adolescent's behavior and/or safety needs require a more restrictive level of care or, alternatively, child's or adolescent's behavior is linked to family functioning and can be better addressed through a family-/home-based treatment).

Section 4.5: Addiction Services

Definition

Addiction services include an array of individual-centered outpatient, intensive outpatient and residential services consistent with the individual's assessed treatment needs, with a rehabilitation and recovery focus designed to promote skills for coping with and managing substance use symptoms and behaviors. Services for adolescents must be separate from adult services, be developmentally appropriate, involve the family or caregiver and coordinate with other systems (such as child welfare, juvenile justice and the schools). These services are designed to help individuals achieve changes in their substance use behaviors. Services should address an individual's major lifestyle, attitudinal and behavioral problems that have the potential to be barriers to the goals of treatment. Outpatient services may be indicated as an initial modality of service for an individual whose severity of illness warrants this level of treatment or when an individual's progress warrants a less intensive modality of service than they are currently receiving. Intensive outpatient treatment is provided any time during the day or week and provides essential skill restoration and counseling services for individuals needing more intensive treatment. Outpatient, intensive outpatient and residential services are delivered on an individual or group basis in a wide variety of settings, including treatment in residential settings of 16 beds or less, designed to help individuals achieve changes in their substance use behaviors.

Provider Qualifications	Eligibility Criteria
• Services are provided by licensed and unlicensed professional staff at least 18 years of age, with a high school or equivalent diploma according to their areas of competence as determined by degree, required levels of experience as defined by State law and regulations and departmentally approved guidelines and certifications. Can include certified peer support specialists who meet all other qualifications. • The provider must be at least three years older than an individual under the age of 18. • Anyone who is unlicensed providing addiction services must be registered with the Addictive Disorders Regulatory Authority and demonstrate competency as defined by the Department of Health and Hospitals, state law (RS 37:3386 et seq.) and regulations. State regulations require supervision of unlicensed professionals by a Qualified Professional Supervisor (QPS). A QPS includes the following professionals who are currently registered with their respective Louisiana board: licensed psychologist; licensed clinical social worker; licensed professional counselor; licensed addiction counselor; licensed physician and advanced practice registered nurse. The following professionals may obtain Qualified Professional Supervisor credentials; master-prepared individual who is registered with the appropriate State Board and under the supervision of a licensed psychologist, licensed professional counselor (LPC), or licensed clinical social	Any eligible person needing medically necessary substance use services.

worker (LCSW). The QPS can provide clinical/administrative oversight and supervision of staff. ▪	

Limitations/Exclusions	Allowed Mode(s) of Delivery
• These rehabilitation services are provided as part of a comprehensive specialized psychiatric program available to all eligible individuals with significant functional impairments resulting from an identified addiction diagnosis. Services are subject to prior approval, must be medically necessary and must be recommended by a LMHP or physician who is acting within the scope of his/her professional licensed and applicable State law to promote the maximum reduction of symptoms and/or restoration of an individual to his/her best age-appropriate functional level according to an individualized treatment plan. • The activities included in the service must be intended to achieve identified treatment plan goals or objectives. The treatment plan should be developed in a person-centered manner, with the active participation of the individual, family and providers and be based on the individual's condition and the standards of practice for the provision of rehabilitative services. The treatment plan should identify the medical or remedial services intended to reduce the identified condition, as well as the anticipated outcomes of the individual. The treatment plan must specify the frequency, amount and duration of services. The treatment plan must be signed by the LMHP or physician responsible for developing the plan. The plan will specify a timeline for re-evaluation of the plan that is, at least, an annual redetermination. The re-evaluation should involve the individual, family and providers and include a re-evaluation of plan to determine whether services have contributed to meeting the stated goals. A new treatment plan should be developed if there is no measureable reduction of disability or restoration of functional level. The new plan should identify different rehabilitation strategy with revised goals and services. • Providers must maintain medical records that include a copy of the treatment plan, the name of the individual, dates of services provided, nature, content and units of rehabilitation services provided and progress made toward functional improvement and goals in the treatment plan. • Services provided to children and youth must include communication and coordination with the family and/or legal guardian. Coordination with other child-serving systems should occur, as needed, to achieve the treatment goals. All coordination must be documented in the youth's medical record. • Services provided at a work site must not be job tasks-oriented and must be directly related to treatment of an individual's mental health needs. Any services or components of services, the basic nature of which are to supplant housekeeping, homemaking or basic services for the convenience of a person receiving covered services (including housekeeping, shopping, child care and laundry services) are non-covered. • All substance use involving adolescents should emphasize the family component within adolescent substance use programs and include family involvement, parent education and family therapy. • Services cannot be provided in an IMD.	Individual Group, as noted Off-site On-site

- ASAM levels of care require prior approval and reviews on an ongoing basis, as determined necessary by DHH to document compliance with the national standards.

Additional Service Criteria

A unit of service is defined according to the Health Care Financing Industry common procedure coding system (HCPCS) approved code set, unless otherwise specified. One session = one visit

1. Staffing for the facility must be consistent with State licensure regulations on an FTE basis. For example, if State licensure requires a staff-to-client ratio of 1:25 and the facility has 16 child residents, then the facility must have at least .64 FTE for the 16 children. If the facility has eight beds, then the facility must have at least .32 FTE for the eight children.

2. Adolescent facilities with greater than 16 beds must be a psychiatric residential treatment facility (PRTF) providing an inpatient level of care. Only facilities providing ASAM Level III.7 will be permitted to become PRTFs.

3. "Motivational enhancement program" refers to the systematic approach for encouraging change in clients by using principles/techniques like those found in Motivational Interviewing (client-centered, works with intrinsic motivation, focuses on resolving ambivalence about change, emphasis on clinician empathy, utilizes Prochaska/DiClemente's stages of change model, etc.). Motivation phase: The goals of this phase include creating a positive motivational context, minimizing hopelessness and low self-efficacy and changing the meaning of family relationships to emphasize possible hopeful experience. Required phase skills consist of relationship and interpersonal skills, a nonjudgmental approach, plus acceptance and sensitivity to diversity. Therapist focus is on the relationship process, separating blaming from responsibility while remaining strength-based. Activities include the interruption of highly negative interaction patterns and blaming (e.g., divert and interrupt), changing meaning through a strength-based relational focus, pointing process, sequencing and reframing of the themes by validating negative impact of behavior, while introducing possible benign/noble (but misguided) motives for behavior. Finally, the introduction of themes and sequences that imply a positive future are important activities of this phase.

Alcohol and drug assessment and referral

Alcohol and drug assessment and referral programs provide ongoing assessment and referral services for individuals presenting a current or past use pattern of alcohol or other drug use. The assessment is designed to gather and analyze information regarding a client's current substance use behavior and social, medical and treatment history. The purpose of the assessment is to provide sufficient information for problem identification and, if appropriate, substance use-related treatment or referral. A licensee shall develop, implement and comply with policies and procedures that establish processes for referrals for a client. A licensee may conduct an initial screen of an individual's presenting substance use problem before conducting an assessment of the individual. A licensee shall comply with licensing standards in regard to assessment practices. Once an individual receives an assessment, a staff member shall provide the individual with a recommendation for further assessment or treatment and an explanation of that recommendation.

ASAM Level I: Outpatient

Outpatient level 1 services are professionally directed assessment, diagnosis, treatment and recovery services provided in an organized non-residential treatment setting. Outpatient services are organized activities which may be delivered in any appropriate community setting that meets State licensure.

These services include, but are not limited to, individual, group, family counseling and psycho-education on recovery and wellness. These programs offer comprehensive, coordinated and defined services that may vary in level of intensity but are fewer than nine contact hours or less per week.

Admission guidelines for ASAM Level I

1. Acute intoxication and/or withdrawal potential – No signs or symptoms of withdrawal, or individual's withdrawal can be safely managed in an outpatient setting.

2. Biomedical conditions and complications – None, or sufficiently stable to permit participation in outpatient treatment.

3. Emotional, behavioral or cognitive conditions and complications – None or minimal. If present, symptoms are mild, stable and do not interfere with the patient's ability to participate in treatment.

4. Readiness to change – Participant should be open to recovery but require monitoring and motivating strategies to engage in treatment and to progress through the stages of change but not be in need of a structured milieu program.

5. Relapse, continued use or continued problem potential – Participant is able to achieve abstinence and related recovery goals, with support and scheduled therapeutic contact to assist with issues that include, but not limited to, ambivalence about preoccupation of alcohol use or other drug use, cravings, peer pressure and lifestyle and attitude changes.

6. Recovery environment – Environment is sufficiently supportive that outpatient treatment is feasible, or the individual does not have an adequate, primary or social support system but has demonstrated motivation and willingness to obtain such a support system.

Additional admission guidelines for outpatient treatment:

1. Initial point of entry/reentry. Activities related to assessment, evaluation, diagnosis and assignment of level of care are provided, including transfer between facilities and/or treatment levels, relapse assessment and assignment to level of care.

2. Early intervention for those who have been identified as individuals suffering from addictive disorders and referred for education, activities or support services designed to prevent progression of disease.

3. Continuing care for those who require a step-down, following a more intensive level of care and require minimal support to avoid relapse.

4. Any combination of the above.

Assessment/treatment plan review

1. Comprehensive bio-psychosocial assessment completed within 72 hours of admission which substantiates appropriate patient placement. The assessment must be reviewed and signed by a qualified professional.

2. An individualized, interdisciplinary treatment plan, which includes problem formulation and articulation of short-term, measurable treatment goals and activities designed to achieve those goals. This plan should be developed in collaboration with the client.

3. The treatment plan is reviewed/updated in collaboration with the client, as needed, or at a minimum of every 90 days.

4. Discharge/transfer planning must begin at admission.

5. Referral arrangements made, as needed.

Staffing
Facility license is not required for individual or group practice of licensed counselors/therapists providing the above services under the auspices of their individual license(s).

- MD(s) on site or on call as needed for management of psychiatric/medical needs.
- Psychologist – NA
- Nursing – There is at least one nurse (LPN,RN, APRN) on site when nursing services are being provided, with appropriate supervision as required by their respective licensing boards.
- Licensed or certified clinician or counselor with direct supervision – One FTE per 50 clients
- Clerical Support Staff – One to Three FTE day shift
- Care Coordinator - one FTE per 50 clients, and/or duties may be assumed by clinical staff

1. Qualified professional: must be available (defined as on site or available by phone) at all times for CI and on site when clinical services are being provided.

2. Outreach worker/peer mentor – Strongly recommended .

3. Caseload size is based on needs of the active individuals to ensure effective, individualized treatment and rehabilitation. Approval by the Health Standards Section (HSS) is required in writing when caseload exceeds 50 active individuals. For this standard, *active* is defined as being treated at least every 90 days.

4. Counseling groups should not exceed 12 individuals – educational group size is not restricted.

Level II.1 Intensive Outpatient Treatment
Intensive outpatient treatment is professionally directed assessment, diagnosis, treatment and recovery services provided in an organized non-residential treatment setting. Intensive outpatient services are organized activities which may be delivered in any appropriate community setting that meets State licensure.

These services include, but are not limited to, individual, group, family counseling and psycho-education on recovery, as well as monitoring of drug use, medication management, medical and psychiatric examinations, CI coverage and orientation to community-based support groups. Intensive outpatient program services should include evidence-informed practices, such as cognitive behavioral therapy (CBT), motivational interviewing and multidimensional family therapy. These programs offer comprehensive, coordinated and defined services that may vary in level of intensity but must be a minimum of nine contact hours per week for adults, age 21 years and older, (six hours per week for adolescents, age 0-21 years) at a minimum of three (3) days per week. This level consists of a scheduled series of face-to-face sessions appropriate to the individual's POC. This level provides:

Admission guidelines ASAM Level II.1
1. Acute intoxication and/or withdrawal potential – No signs or symptoms of withdrawal, or individual's withdrawal can be safely managed in an intensive outpatient setting.

2. Biomedical conditions and complications – None, or sufficiently stable to permit participation in outpatient treatment.

3. Emotional, behavioral or cognitive conditions and complications – None to moderate. If present, client must be admitted to either a co-occurring disorder capable or co-occurring disorder enhanced program, depending on the client's level of function, stability and degree of impairment.

4. Readiness to change – Participant requires structured therapy and a programmatic milieu to promote treatment progress and recovery. The participant's perspective inhibits their ability to make behavioral changes without repeated, structured and clinically directed motivational interventions.

5. Relapse, continued use or continued problem potential – Participant is experiencing an intensification of symptoms related to substance use, and their level of functioning is deteriorating despite modification of the treatment plan.

6. Recovery environment – Insufficiently supportive environment and participant lacks the resources or skills necessary to maintain an adequate level of functioning without services in intensive outpatient treatment.

Additional admission guidelines for intensive outpatient treatment:

1. Initial point of entry/re-entry – Activities related to assessment, evaluation, diagnosis and assignment of level of care are provided, including transfer between facilities and/or treatment modalities, relapse assessment and assignment to level of care.

2. May be provided for persons at risk of being admitted to more intensive levels of care, such as residential, inpatient or detoxification.

3. Continuing care for those who require a step-down following a more intensive level of care and require support to avoid relapse.

4. Any combination of the above.

Assessment/treatment plan review:

1. Comprehensive bio-psychosocial assessment completed within 72 hours of admission which substantiates appropriate patient placement. The assessment must be reviewed and signed by a qualified professional.

2. An individualized, interdisciplinary treatment plan, which includes problem formulation and articulation of short-term, measurable treatment goals and activities designed to achieve those goals. This plan should be developed in collaboration with the client.

3. The treatment plan is reviewed/updated in collaboration with the client, as needed, or at minimum of every 30 days.

4. Discharge/transfer planning must begin at admission.

5. Referral arrangements, made as needed.

Staffing

- MD(s) on site or on call as needed for management of psychiatric/ medical needs.
- Psychologist – NA
- Nursing – There is at least one nurse (LPN, RN, APRN) on site when nursing services are being provided, with appropriate supervision as required by their respective licensing boards.
- Licensed or certified clinician or counselor with direct supervision – One FTE per 25 clients
- Clerical Support Staff – One to Three FTE day shift
- Care Coordinator - one FTE per 50 clients, and/or duties may be assumed by clinical staff
- Outreach worker/peer mentor – Strongly recommended

1. Qualified professional supervisor: 10 hours weekly on site during hours of operation and on call 24/7. .

2. Qualified professional: Must be available (defined as on site or available by phone) at all times for CI and on site when clinical services are being provided.

3. Caseload size is based on needs of the active individuals to ensure effective, individualized treatment and rehabilitation. For this standard, *active* is defined as being treated at least every 90 days.

4. Counseling groups should not exceed 12 individuals. Educational group size is not restricted.

Level II-D Ambulatory detoxification with extended on-site monitoring
This level of care is an organized outpatient service, which may be delivered in an office setting, health care or addiction treatment facility by trained clinicians, who provide medically supervised evaluation, detoxification and referral services. The care is delivered in an office/health care setting or behavioral health treatment facility.

Appointments for services are regularly scheduled. These services are designed to treat the individual's level of clinical severity to achieve safe and comfortable withdrawal from mood-altering chemicals and to effectively facilitate the individual's entry into ongoing treatment and recovery. Detoxification is conducted on an outpatient basis. It is important for medical and nursing personnel to be readily available to evaluate and confirm that detoxification in the less supervised setting is relatively safe. Counseling services may be available through the detoxification program or may be accessed through affiliation with entities providing outpatient services. Ambulatory detoxification is provided in conjunction with intensive outpatient treatment services (Level II.1).

Admission guidelines
Provides care to patients whose withdrawal signs and symptoms are of moderate intensity but are sufficiently stable enough physically and mentally to permit participation in outpatient treatment. Medical and nursing services must be available on-site during hours of clinic operations and on-call after hours. The focus is on medical stabilization and preparation for transfer to a less intensive level of care.

Assessment/treatment plan review
1. Comprehensive bio-psychosocial assessment completed within 72 hours of admission which substantiates appropriate patient placement. The assessment must be reviewed and signed by a qualified professional.

2. An individualized, interdisciplinary treatment plan which includes problem formulation and articulation of short-term, measurable treatment goals and activities designed to achieve those goals. This plan should be developed in collaboration with the client.

3. The treatment plan is reviewed/updated in collaboration with the client, as needed, or at minimum of every 30 days.

4. Discharge/transfer planning must begin at admission.

5. Referral arrangements made as needed.

Staffing
1. Facility shall have qualified professional medical, nursing counseling and other support staff necessary to provide services appropriate to the bio-psychosocial needs of individuals being admitted to the program.

    a. Physician, medical director –10 hours per week, on site during hours of operation and on call availability 24 hours
    b. PCP – Optional, if medical director is not a PCP – 24-hour availability
    c. Psychologist – NA

d. Nurse (NP/RN or licensed practical nurse (LPN)) –There is a Nurse on call 24/7 and on site no less than 40 hours/week. There is a RN on-site as needed to perform nursing assessments.
e. Licensed or certified clinician or counselor with direct supervision – one clinician per 25 clients and available 40 hours per week
f. Clerical support staff – one to two FTE per day shift
g. Care coordinator – one FTE per day shift, and/or duties may be assumed by clinical staff
h. Physicians, who are available 24 hours a day by telephone. (Or a PA, NP or APRN, may perform duties within the respective scope of their practice as designated by physician)

2. A physician is available to assess the individual within 24 hours of admission (or earlier, if medically necessary) and is available to provide on-site monitoring of care and further evaluation on a daily basis.

3. A RN or other licensed and credentialed nurse is available on call 24 hours per day and on site no less than 40 hours per week and will conduct a nursing assessment on individuals at admission. A nurse is responsible for overseeing the monitoring of the individual's progress and medication. Appropriately licensed and credentialed staff is available to administer medications in accordance with physician orders.

4. An interdisciplinary team of appropriately trained clinicians, such as physicians, nurses, counselors, social workers and psychologists is available to assess and treat the individual and to obtain and interpret information regarding the patient's needs. The number and disciplines of team members are appropriate to the range and severity of the individual's problems.

5. A counselor is available on site 40 hours per week to provide direct client care, utilizing the 12 core functions of substance use counseling and/or specific functions related to professional license. Caseloads not to exceed 25 clients.

6. Qualified professional supervisor: Available for clinical supervision and by telephone for consultation.

Toxicology/drug screening
Urine drug screens are required upon admission and as directed by the treatment plan.
Stabilization plan
Qualified professional shall identify the individual's short-term needs, based on the detoxification history, the medical history and the physical examination and prepare a plan of action.

Detoxification/treatment plan
The detoxification/treatment plan shall be reviewed and signed by the physician and the individual and shall be filed in the individual's record within 24 hours of admission with updates, as needed.

Detoxification progress notes
The program shall implement the detoxification/treatment plan and document the individual's response to and/or participation in scheduled activities. Notes shall include:

- The individual's physical condition, including vital signs
- The individual's mood and behavior
- Statements about the individual's condition and needs
- Information about the individual's progress or lack of progress in relation to detoxification/treatment goals
- Additional notes shall be documented, as needed.

Physician orders
Required for medical and psychiatric management.

Level III.1 Clinically Managed Low Intensity Residential Treatment – Adolescent

Residential programs offer at least five hours per week of a combination of low-intensity clinical and recovery-focused services. All facilities are licensed by DHH.

Treatment is directed toward applying recovery skills, preventing relapse, improving emotional functioning, promoting personal responsibility and reintegrating the individual into the worlds of work, education and family life. Services provided may include individual, group and family therapy, medication management and medication education. Mutual/self-help meetings usually are available on site. Does not include sober houses, boarding houses or group homes where treatment services are not provided.

Admission guidelines:

1. Acute intoxication and/or withdrawal potential – No or minimal/stable withdrawal risk.

2. Biomedical conditions and complications – None or stable. If present, the participant must be receiving medical monitoring.

3. Emotional, behavioral or cognitive conditions and complications – None or minimal. If present, conditions must be stable and not too distracting to the participant's recovery.

4. Readiness to change – Participant should be open to recovery, but in need of a structured, therapeutic environment.

5. Relapse, continued use or continued problem potential – Participant understands the risk of relapse, but lacks relapse prevention skills or requires a structured environment.

6. Recovery environment – Environment is dangerous, but recovery is achievable within a 24-hour structure.

Assessment/treatment plan review

1. Triage screening to determine eligibility and appropriateness (proper patient placement) for admission and referral. The LGE ensures that pre-certification requirements are met for admission.

2. Comprehensive bio-psychosocial assessment completed within seven days, which substantiates appropriate patient placement. The assessment must be reviewed and signed by a qualified professional. The following sections must be completed prior to seven days of admission:
   a. Medical
   b. Psychological
   c. Alcohol
   d. Drug

3. A physical examination performed within a reasonable time, as determined by the client's medical condition.

4. An individualized, interdisciplinary treatment plan, which includes problem formulation and articulation of short-term, measurable treatment goals and activities designed to achieve those goals. This plan should be developed in collaboration with the client.

5. The treatment plan is reviewed in collaboration with the client every 90 days and documented accordingly.

6. Discharge/transfer planning must begin at admission.

7. Referral arrangements made prior to discharge.

Staffing

1. Facility shall have qualified professional staff and support staff necessary to provide services appropriate to the bio-psychosocial needs of individuals being admitted to the program. **In addition to the staffing required by TGH, Adolescent TGH ASAM III.1 must have at least the following staffing:**
   - Physician (MD), medical director – NA
   - PCP - NA
   - Psychologist – NA
   - Nursing– NA
   - Licensed or certified clinician or counselor with direct supervision – one FTE per 8 clients
   - Direct care aide – 2 FTE PA's on all shifts. Ratio cannot exceed 1:8. Ratio must be 1:5 on therapy outings.
   - Clerical support staff – one FTE recommended
   - Activity/occupational therapist – NA
   - Care coordinator – one FTE per 50 clients, and/or duties may be assumed by clinical staff
   - Outreach worker/peer mentor – Strongly recommended

2. Qualified professional supervisor: available for clinical supervision and by telephone for consultation.

3. Qualified professional**:** counselor must be on duty when majority of individuals are awake and on site. Caseload shall not exceed 1:8.

4. House manager: person who supervises activities of the facility when the professional staff is on call, but not on duty. This person is required to have adequate orientation and skills to assess situations related to relapse and to provide access to appropriate medical care when needed.

5. Clerical/support staff recommended.

Level III.1 Clinically Managed Low-Intensity Residential Treatment - Adult

Residential programs offer at least five hours per week of a combination of low-intensity clinical and recovery-focused services. All facilities are licensed by DHH.

Treatment is directed toward applying recovery skills, preventing relapse, improving emotional functioning, promoting personal responsibility and reintegrating the individual into the worlds of work, education and family life. Services provided may include individual, group and family therapy, medication management and medication education. Mutual/self-help meetings usually are available on site. Does not include sober houses, boarding houses or group homes where treatment services are not provided. (Example: halfway house).

Admission guidelines

1. Acute intoxication and/or withdrawal potential – None, or minimal/stable withdrawal risk.

2. Biomedical conditions and complications – None or stable. If present, the participant must be receiving medical monitoring.

3. Emotional, behavioral or cognitive conditions and complications – None or minimal. If present, conditions must be stable and not too distracting to the participant's recovery.

4. Readiness to change – Participant should be open to recovery but in need of a structured, therapeutic environment.

5. Relapse, continued use or continued problem potential – Participant understands the risk of relapse but lacks relapse prevention skills or requires a structured environment.

6. Recovery environment – Environment is dangerous, but recovery is achievable within a 24-hour structure.

Assessment/treatment plan review

1. Triage screening to determine eligibility and appropriateness (proper patient placement) for admission and referral. The LGE ensures that pre-certification requirements are met for admission.

2. Comprehensive bio-psychosocial assessment completed within seven days which substantiate appropriate patient placement. The assessment must be reviewed and signed by a qualified professional. The following sections must be completed prior to seven days of admission:
   a. Medical
   b. Psychological
   c. Alcohol
   d. Drug

3. A physical examination performed within a reasonable time, as determined by the client's medical condition.

4. An individualized, interdisciplinary treatment plan, which includes problem formulation and articulation of short-term, measurable treatment goals and activities designed to achieve those goals. This plan should be developed in collaboration with the client.

5. The treatment plan is reviewed in collaboration with the client every 90 days and documented accordingly.

6. Discharge/transfer planning must begin at admission.

7. Referral arrangements made prior to discharge.

Staffing

1. Facility shall have qualified professional staff and support staff necessary to provide services appropriate to the bio-psychosocial needs of individuals being admitted to the program.

   Adult staffing patterns:
   - Physician (MD), medical director – NA
   - PCP – NA
   - Psychologist – NA
   - Nursing– NA
   - Licensed or certified clinician or counselor with direct supervision – one FTE per 25 clients
   - Direct care aide – I FTE on all shifts. Additional as needed.
   - Clerical support staff – one FTE recommended
   - Activity/occupational therapist – NA
   - Care coordinator – one FTE per 50 clients, and/or duties may be assumed by clinical staff
   - Outreach worker/peer mentor – Strongly recommended

2. Qualified professional supervisor – Available for clinical supervision and by telephone for consultation.

3. Qualified professional counselor – Must be on duty when majority of individuals are awake and on site. Caseload shall not exceed 1:25.

4. House manager – Person who supervises activities of the facility when the professional staff is on call but not on duty. This person is required to have adequate orientation and skills to assess situations related to relapse and to provide access to appropriate medical care when needed.

Level III.2D Clinically Managed Residential Social Detoxification – Adolescent
Residential programs provided in an organized, residential, non-medical setting delivered by an appropriately trained staff that provides safe, 24-hour medication monitoring, observation and support in a supervised environment for a person served, to achieve initial recovery from the effects of alcohol and/or other drugs. All facilities are licensed by DHH.

Social detoxification is appropriate for individuals who are able to participate in the daily residential activities and is often used as a less restrictive, non-medical alternative to inpatient detoxification.

Admission guidelines
Provides care to patients whose withdrawal signs and symptoms are non-severe but require 24-hour inpatient care to address biomedical and recovery environment conditions/complications. Twenty-four hour observation, monitoring and treatment are available. However, the full resources of an acute care general hospital or a medically supported program are not necessary.

Screening/assessment/treatment plan review
1. Triage screening to determine eligibility and appropriateness (proper patient placement) for admission and referral. The LGE ensures that pre-certification requirements are met for admission.

2. Comprehensive bio-psychosocial assessment completed within seven days of admission, which substantiates appropriate patient placement. The assessment must be reviewed and signed by a qualified professional (exclusions: detoxification programs are not required to complete a psychosocial assessment but must screen for proper patient placement and referral).

3. An individualized stabilization/treatment plan. This plan should be developed in collaboration with the client.

4. Daily assessment of progress through detoxification, documented in a manner consistent from individual to individual.

5. Discharge/transfer planning must begin at admission.

6. Referral arrangement made, as needed.

Staffing
1. Facility shall have qualified professional and other support staff necessary to provide services appropriate to the needs of individuals being admitted to the program. **In addition to the staffing required by TGH, Adolescent TGH ASAM III.2D must have at least the following staffing:**

    - Physician (MD), medical director – MD(s) on site as needed for management of psychiatric/ medical needs. 24 hours on-call availability. (NP/APRN/PA in the absence of an MD is acceptable)
    - Psychologist - NA
    - Nursing– Optional
    - Licensed or certified clinician or counselor with direct supervision – One clinician per 16 clients
    - Direct Care aide – Two FTE per shift, Not to exceed 1:10
    - Clerical support staff – One to two FTE per day shift
    - Care coordinator – One FTE per day shift, and/or duties may be assumed by clinical staff
    - Outreach worker/peer mentor – Optional

2. Physicians or a PA, NP or APRN may perform duties within the scope of their practice as designated by physician. Their duties would include:
   - Review and sign off on medical treatment
   - Triage medical needs at admission and through course of stay for all clients

3. Licensed, certified or registered clinicians provide a planned regimen of 24-hour, professionally directed evaluation, care and treatment services for individuals.

4. An interdisciplinary team of appropriately trained clinicians, such as physicians, nurses, counselors, social workers and psychologists, is available to assess and treat the individual and to obtain and interpret information regarding the patient's needs. The number and disciplines of team members are appropriate to the range and severity of the individual's problems.

5. A qualified professional is available on site 40 hours per week to provide direct individual care utilizing the 12 core functions of substance use counseling and/or specific functions related to professional license per 16 individuals (may be combination of two or more professional disciplines).

6. Clinically managed detoxification personnel shall consist of professional and other support staff that are adequate to meet the needs of the individuals admitted to the facility:
   - Qualified professional supervisor: available for clinical supervision and by telephone for consultation

7. Designated medical director may be consultative only.

Emergency admissions
The admission process may be delayed only until the individual can be interviewed, but no longer than 24 hours, unless seen by a physician. Facilities are required to orient direct care employees to monitor, observe and recognize early symptoms of serious illness and to access emergency services promptly.

Minimum standards of practice
1. **History**
The program shall obtain enough medical and psychosocial information about the individual to provide a clear understanding of the individual's present status. Exceptions shall be documented in individual's record.

2. **Medical clearance/screening**
Medical screening, upon arrival, by staff with current CPR and first aid training, with telephone access to RN or MD for instructions for the care of the individual. Individuals who require medication management shall be transferred to medically monitored or medical detoxification program until stabilized.

3. **Toxicology/drug screening**
(Not required in this level of care).

4. **Stabilization/treatment plan**
   a. The stabilization/treatment plan shall be reviewed and signed by the qualified professional and the individual and shall be filed in the individual's record within 24 hours of admission with updates, as needed.
   b. Detoxification/progress notes. The program shall implement the stabilization/treatment plan and document the individual's response to and/or participation in scheduled activities. Notes shall include:
      i. The individual's physical condition, including vital signs
      ii. The individual's mood and behavior
      iii. Individual statements about the individual's condition and needs
      iv. Information about the individual's progress or lack of progress in relation to stabilization goals
      v. Additional notes shall be documented, as needed

5. **Physicians' orders**
   Required for medical and psychiatric management

Level III.2D Clinically Managed Residential Social Detoxification – Adult
Residential programs provided in an organized, residential, non-medical setting delivered by an appropriately trained staff that provides safe, 24-hour medication monitoring observation and support in a supervised environment for a person served to achieve initial recovery from the effects of alcohol and/or other drugs. All facilities are licensed by DHH.

Social detoxification is appropriate for individuals who are able to participate in the daily residential activities and is often used as a less restrictive, non-medical alternative to inpatient detoxification.

Admission guidelines
Provides care to patients whose withdrawal signs and symptoms are non-severe but require 24-hour inpatient care to address biomedical and recovery environment conditions/complications. Twenty-four hour observation, monitoring and treatment are available. However, the full resources of an acute care general hospital or a medically supported program are not necessary.

Screening/assessment/treatment plan review
1. Triage screening to determine eligibility and appropriateness (proper patient placement) for admission and referral. The LGE ensures that pre-certification requirements are met for admission.

2. Comprehensive bio-psychosocial assessment completed within seven days of admission which substantiates appropriate patient placement. The assessment must be reviewed and signed by a qualified professional (exclusions: detoxification programs are not required to complete a psychosocial assessment but must screen for proper patient placement and referral).

3. An individualized stabilization/treatment plan. This plan should be developed in collaboration with the client.

4. Daily assessment of progress, through detoxification, documented in a manner consistent from individual to individual.

5. Discharge/transfer planning must begin at admission.

6. Referral arrangements made, as needed.

Staffing
1. Facility shall have qualified professional and other support staff necessary to provide services appropriate to the needs of individuals being admitted to the program.
   a. Physician (MD), medical director – MD(s) on site as needed for management of psychiatric/ medical needs. 24 hour on-call availability. (NP/APRN/PA in the absence of an MD is acceptable)
   b. PCP – NA
   c. Psychologist – NA
   d. Nursing– Optional
   e. Licensed or certified clinician or counselor with direct supervision – one clinician per 25 clients
   f. Direct care aide– one FTE per shift
   g. Clerical support staff – one to two FTE per day shift
   h. Activity/occupational therapist – NA
   i. Care coordinator – one FTE per day shift, and/or duties may be assumed by clinical staff
   j. Outreach worker/peer mentor – Optional

2. Physicians or a PA, NP or APRN, may perform duties within the scope of their practice as designated by physician. Their duties would include:
   a. Review and sign off on medical treatment
   b. Triage medical needs at admission and through course of stay for all clients

3. Licensed, certified or registered clinicians provide a planned regimen of 24-hour, professionally directed evaluation, care and treatment services for individuals.

4. An interdisciplinary team of appropriately trained clinicians, such as physicians, nurses, counselors, social workers and psychologists, is available to assess and treat the individual and to obtain and interpret information regarding the patient's needs. The number and disciplines of team members are appropriate to the range and severity of the individual's problems.

5. A qualified professional is available on site 40 hours per week to provide direct individual care, utilizing the 12 core functions of substance use counseling and/or specific functions related to professional license.

6. Clinically managed detoxification personnel shall consist of professional and other support staff that are adequate to meet the needs of the individuals admitted to the facility:
   a. Qualified professional supervisor: Available for clinical supervision and by telephone for consultation
   b. Qualified professional: 40 hours per week per 25 individuals (may be combination of two or more professional disciplines)

7. Designated medical director may be consultative only.

Emergency admissions
The admission process may be delayed only until the individual can be interviewed but no longer than 24 hours, unless seen by a physician. Facilities are required to orient direct care employees to monitor, observe and recognize early symptoms of serious illness and to access emergency services promptly.

Minimum standards of practice
1. **History**
   The program shall obtain enough medical and psychosocial information about the individual to provide a clear understanding of the individual's present status. Exceptions shall be documented in the individual's record.

2. **Medical clearance/screening**
   Medical screening upon arrival by staff with current CPR and first aid training, with telephone access to RN or MD for instructions for the care of the individual. Individuals who require medication management shall be transferred to medically monitored or medical detoxification program until stabilized.

3. **Toxicology/drug screening**
   (Not required in this level of care).

4. **Stabilization/treatment plan**
   a. The stabilization/treatment plan shall be reviewed and signed by the qualified professional and the individual and shall be filed in the individual's record within 24 hours of admission with updates, as needed.
   b. Detoxification/progress notes. The program shall implement the stabilization/treatment plan and document the individual's response to and/or participation in scheduled activities. Notes shall include:
      i. The individual's physical condition, including vital signs
      ii. The individual's mood and behavior

iii. Individual statements about the individual's condition and needs
iv. Information about the individual's progress or lack of progress in relation to stabilization goals
v. Additional notes shall be documented, as needed

5. **Physicians' orders**
Required for medical and psychiatric management.

Level III.3 Clinically Managed Medium Intensity Residential Treatment - Adult
Residential programs offer at least 20 hours per week of a combination of medium-intensity clinical and recovery-focused services. All facilities are licensed by DHH.

Frequently referred to as extended or long-term care, Level III.3 programs provide a structured recovery environment in combination with medium-intensity clinical services to support recovery from substance-related disorders.

Admission guidelines
1. Acute intoxication and/or withdrawal potential – None, or minimal risk of withdrawal.

2. Biomedical conditions and complications – None or stable. If present, the participant must be receiving medical monitoring.

3. Emotional, behavioral or cognitive conditions and complications – Mild to moderate severity; need structure to focus on recovery; if stable, a co-occurring disorder capable program is appropriate. If not, a co-occurring disorder enhanced program is required. Treatment should be designed to respond to the client's cognitive deficits.

4. Readiness to change – Has little awareness and needs intervention to engage and stay in treatment, or there is high severity in this dimension.

5. Relapse, continued use or continued problem potential – Has little awareness and needs intervention available to prevent continued use, with imminent dangerous consequences because of cognitive deficits.

6. Recovery environment – Environment is dangerous, but recovery is achievable within a 24-hour structure.

Screening/Assessment/Treatment Plan Review
1. Triage screening to determine eligibility and appropriateness (proper patient placement) for admission and referral. The LGE ensures that pre-certification requirements are met for admission.

2. Comprehensive bio-psychosocial assessment completed within seven days, which substantiates appropriate patient placement. The assessment must be reviewed and signed by a qualified professional. The following sections must be completed prior to seven days of admission:
   a. Medical
   b. Psychological
   c. Alcohol
   d. Drug

3. A physical examination performed within a reasonable time, as determined by the client's medical condition.

4. An individualized, interdisciplinary treatment plan, which includes problem formulation and articulation of short-term, measurable treatment goals and activities designed to achieve those goals. This plan should be developed in collaboration with the client.

5. The treatment plan is reviewed in collaboration with the client, as needed, or at a minimum of every 90 days and documented accordingly.

6. Discharge/transfer planning, beginning at admission.

7. Referral arrangements made prior to discharge.

Staffing

1. Facility shall have qualified professional medical, nursing and other support staff necessary to provide services appropriate to the bio-psychosocial needs of individuals being admitted to the program.

Adult staffing patterns

- Physician (MD), medical director – MD(s) on site as needed for management of psychiatric/medical needs. 24 hours on-call availability
- PCP – NA
- Psychologist – NA
- Nursing– one FTE (APRN/NP/RN), 24-hour on-call availability. Nursing availability on site whenever needed to meet professional nursing requirements
- Licensed or certified clinician or counselor with direct supervision – one FTE per 12 clients
- Direct Care aide – One FTE on first, second and third shifts, additional as needed
- Clerical support staff – one FTE recommended
- Activity/occupational therapist – NA
- Care coordinator – one FTE per 50 clients, and/or duties may be assumed by clinical staff
- Outreach worker/peer mentor – Strongly recommended

2. Physicians, who are available 24 hours a day by telephone. (Or a PA, NP or APRN may perform duties within the scope of their practice as designated by physician).

3. Licensed, certified or registered clinicians provide a planned regimen of 24-hour, professionally directed evaluation, care and treatment services for individuals and their families.

4. An interdisciplinary team of appropriately trained clinicians, such as physicians, nurses, counselors, social workers and psychologists is available to assess and treat the individual and to obtain and interpret information regarding the patient's needs. The number and disciplines of team members are appropriate to the range and severity of the individual's problems.

5. A counselor is available on site 40 hours per week to provide direct client care, utilizing the 12 core functions of substance use counseling and/or specific functions related to professional license. Caseloads not to exceed 12 clients.

6. Qualified professional supervisor – Available for clinical supervision and by telephone for consultation.

Level III.5 Clinically Managed High Intensity Residential Treatment – Adolescent

Designed to treat persons who have significant social and psychological problems. All facilities are licensed by DHH.

Programs are characterized by their reliance on the treatment community as a therapeutic agent. Treatment goals are to promote abstinence from substance use and antisocial behavior and to effect a global change in participants' lifestyles, attitudes and values. Individuals typically have multiple deficits, which may include substance-related disorders, criminal activity, psychological problems, impaired functioning and disaffiliation

from mainstream values. (Example: therapeutic community or residential treatment center.) The program must include an in-house education/vocational component if serving adolescents.

Admission guidelines

1. Acute intoxication and/or withdrawal potential: None or minimal risk of withdrawal.

2. Biomedical conditions and complications: None or stable or receiving concurrent medical monitoring.

3. Emotional, behavioral or cognitive conditions and complications: Demonstrates repeated inability to control impulses or a personality disorder requires structure to shape behavior. Other functional deficits require a 24-hour setting to teach coping skills. A co-occurring disorder-enhanced setting is required for severely and persistently mentally ill (SPMI) patients.

4. Readiness to change: Has marked difficulty with or opposition to treatment, with dangerous consequences, or there is high severity in this dimension but not in others. The client, therefore, needs ASAM Level I placement with inclusion of Motivational Enhancement Therapy (MET). MET is a therapeutic intervention and a component part of the program.

5. Relapse, continued use or continued problem potential: Has no recognition of the skills needed to prevent continued use, with imminently dangerous consequences.

6. Recovery environment: Environment is dangerous, and client lacks skills to cope outside of a highly structured 24-hour setting.

Screening/assessment/treatment plan review

1. Triage screening to determine eligibility and appropriateness (proper patient placement) for admission and referral. The LGE ensures that pre-certification requirements are met for admission.

2. Comprehensive bio-psychosocial assessment completed within seven days, which substantiate appropriate patient placement. The assessment must be reviewed and signed by a qualified professional. The following sections must be completed prior to seven days of admission:
   a. Medical
   b. Psychological
   c. Alcohol
   d. Drug

3. A physical examination performed within a reasonable time, as determined by the client's medical condition.

4. An individualized, interdisciplinary treatment plan which includes problem formulation and articulation of short-term, measurable treatment goals and activities designed to achieve those goals. This plan should be developed in collaboration with the client.

5. The treatment plan is reviewed in collaboration with the client, as needed, or at a minimum of every 30 days and documented accordingly.

6. Discharge/transfer planning must begin at admission.

7. Referral arrangements made prior to discharge.

Staffing

1. Facility shall have qualified professional medical, nursing and other support staff necessary to provide

services appropriate to the bio-psychosocial needs of individuals being admitted to the program.

Adolescent staffing patterns

- Physician (MD), medical director – MD(s) on site as needed for management of psychiatric/medical needs. 24 hour on-call availability
- PCP – NA
- Psychologist – Available as needed
- Nursing – One FTE (APRN/NP/RN) 24 hour on-call availability. Nursing availability on site whenever needed to meet professional nursing requirements.
- Licensed or certified clinician or counselor with direct supervision – one clinician per eight clients
- Direct Care aide – Two FTE DCAs on all shifts. Ratio cannot exceed 1: 8 ratio. Ratio must be 1:5 on therapy outings
- Clerical support staff – one to two FTE per day shift
- Activity/occupational therapist – Optional
- Care coordinator – one FTE per day shift, and/or duties may be assumed by clinical staff
- Outreach worker/peer mentor - Optional

2. Qualified professional supervisor – Available for clinical supervision and by telephone for consultation.

3. Qualified professional – 40 hours per week.
4. Caseload not to exceed 1:8 for adolescents.

5. Senior individuals may be utilized as volunteers to assist in the recovery process, provided that facility staff is on site and immediately available, if needed.

Level III.5 Clinically Managed High Intensity Residential Treatment – Adult

Designed to treat persons who have significant social and psychological problems. All facilities are licensed by DHH.

Programs are characterized by their reliance on the treatment community as a therapeutic agent. Treatment goals are to promote abstinence from substance use and antisocial behavior and to effect a global change in participants' lifestyles, attitudes and values. Individuals typically have multiple deficits, which may include substance-related disorders, criminal activity, psychological problems, impaired functioning and disaffiliation from mainstream values. Example: therapeutic community or residential treatment center.

Admission guidelines

1. Acute intoxication and/or withdrawal potential: None, or minimal risk of withdrawal.

2. Biomedical conditions and complications: None or stable or receiving concurrent medical monitoring.

3. Emotional, behavioral or cognitive conditions and complications: Demonstrates repeated inability to control impulses, or a personality disorder requires structure to shape behavior. Other functional deficits require a 24-hour setting to teach coping skills. A Co-Occurring Disorder Enhanced setting is required for SPMI patients.

4. Readiness to change: Has marked difficulty with or opposition to treatment, with dangerous consequences, or there is high severity in this dimension but not in others. The client, therefore, needs ASAM Level I placement with inclusion of Motivational Enhancement Therapy (MET). MET is a therapeutic intervention and a component part of the program.

5. Relapse, continued use or continued problem potential: Has no recognition of the skills needed to prevent continued use, with imminently dangerous consequences.

6. Recovery environment: Environment is dangerous, and client lacks skills to cope outside of a highly structured 24-hour setting.

Screening/assessment/treatment plan review

1. Triage screening to determine eligibility and appropriateness (proper patient placement) for admission and referral. The LGE ensures that pre-certification requirements are met for admission.

2. Comprehensive bio-psychosocial assessment completed within seven days, which substantiate appropriate patient placement. The assessment must be reviewed and signed by a qualified professional. The following sections must be completed prior to seven days of admission:
   a. Medical
   b. Psychological
   c. Alcohol
   d. Drug

3. A physical examination performed within a reasonable time, as determined by the client's medical condition.

4. An individualized, interdisciplinary treatment plan, which includes problem formulation and articulation of short-term, measurable treatment goals and activities designed to achieve those goals. This plan should be developed in collaboration with the client.

5. The treatment plan is reviewed in collaboration with the client, as needed, or at a minimum of every 30 days and documented accordingly

6. Discharge/transfer planning must begin at admission.

7. Referral arrangements made prior to discharge.

Staffing

1. Facility shall have qualified professional medical, nursing and other support staff necessary to provide services appropriate to the bio-psychosocial needs of individuals being admitted to the program.

   Adult staffing patterns

   – Physician (MD), medical director – MD(s) on site as needed for management of psychiatric/medical needs. 24 hour on-call availability
   – PCP – NA
   – Psychologist – Optional
   – Nursing– One FTE Supervisor(APRN/NP/RN), 24 hour on-call availability. One FTE LPN on first and second shift. (APRN/NP/RN) on call availability during third shift
   – Licensed or certified clinician or counselor with direct supervision – one clinician per 12 clients
   – Direct Care aide – Two DCAs on first, second and third shifts
   – Clerical support staff – one to two FTE per day shift
   – Activity/occupational therapist – Optional
   – Care coordinator – one FTE per day shift, and/or duties may be assumed by clinical staff
   – Outreach worker/peer mentor – Optional

2. Physicians, who are available 24 hours a day by telephone. (Or a PA, NP or APRN may perform duties within the scope of their practice as designated by physician).

3. Licensed, certified or registered clinicians provide a planned regimen of 24-hour, professionally directed evaluation, care and treatment services for individuals and their families.

4. An interdisciplinary team of appropriately trained clinicians, such as physicians, nurses, counselors, social workers and psychologists is available to assess and treat the individual and to obtain and interpret information regarding the patient's needs. The number and disciplines of team members are appropriate to the range and severity of the individual's problems.

5. A counselor is available on site 40 hours per week to provide direct client care, utilizing the 12 core functions of substance use counseling and/or specific functions related to professional license. Caseloads not to exceed 12 clients.

6. Qualified professional supervisor – Available for clinical supervision and by telephone for consultation.

Level III.7 Medically Monitored Intensive Residential Treatment – Adult

This co-occurring disorder (COD) residential treatment facility provides 24 hours of structured treatment activities per week including, but not limited to, psychiatric and substance use assessments, diagnosis treatment, habilitative and rehabilitation services to individuals with co-occurring psychiatric and substance disorders (ICOPSD), whose disorders are of sufficient severity to require a residential level of care. All facilities are licensed by DHH.

It also provides a planned regiment of 24-hour professionally directed evaluation, observation and medical monitoring of addiction and mental health treatment in a residential setting. They feature permanent facilities, including residential beds, and function under a defined set of policies, procedures and clinical protocols. Appropriate for patients whose subacute biomedical and emotional, behavior or cognitive problems are so severe that they require co-occurring capable or enhanced residential treatment, but who do not need the full resources of an acute care general hospital. In addition to meeting integrated service criteria, COD treatment providers must have experience and preferably licensure and/or certification in both addictive disorders and mental health.

Admission guidelines

Individuals in this level of care may have co-occurring addiction and mental health disorders that meet the eligibility criteria for placement in a co-occurring disorder-capable program or difficulties with mood, behavior or cognition related to a substance use or mental disorder or emotional behavioral or cognitive symptoms that are troublesome, but do not meet the DSM criteria for mental disorder.

1. Acute intoxication and/or withdrawal potential – None or minimal/stable withdrawal risk.

2. Biomedical conditions and complications – Moderate to severe conditions (which require 24-hour nursing and medical monitoring or active treatment but not the full resources of an acute care hospital).

3. Emotional, behavioral or cognitive conditions and complications – Moderate to severe conditions and complications (such as diagnosable co-morbid Axis I disorders or symptoms). These symptoms may not be severe enough to meet diagnostic criteria but interfere or distract from recovery efforts (for example, anxiety/hypomanic or depression and/or cognitive symptoms (which may include compulsive behaviors, suicidal or homicidal ideation with a recent history of attempts but no specific plan, or hallucinations and delusions without acute risk to self or others) are interfering with abstinence, recovery and stability to such a degree that the individual needs a structured 24-hour, medically monitored (but not medically managed) environment to address recovery efforts.

4. Readiness to change – Participant is in need of intensive motivating strategies, activities and processes available only in a 24-hour structured medically monitored setting (but not medically managed)

5. Relapse, continued use or continued problem potential – Participant is experiencing an escalation of relapse behaviors and/or acute psychiatric crisis and/or re-emergence of acute symptoms and is in need of 24-hour monitoring and structured support.

6. Recovery environment – Environment or current living arrangement is characterized by a high risk of initiation or repetition of physical, sexual or emotional abuse or substance use so endemic that the patient is assessed as unable to achieve or maintain recovery at a less intensive level or care.

Screening/assessment/treatment plan review:

1. Triage screening to determine eligibility and appropriateness (proper patient placement) for admission and referral. The LGE ensures that pre-certification requirements are met for admission.

2. Comprehensive bio-psychosocial assessment completed within seven days, which substantiates appropriate patient placement. The assessment must be reviewed and signed by a qualified professional. The following sections must be completed prior to seven days of admission:
   a. Medical
   b. Psychological
   c. Alcohol
   d. Drug

3. An individualized, interdisciplinary treatment plan, which includes problem formulation and articulation of short-term, measurable treatment goals and activities designed to achieve those goals. This plan should be developed in collaboration with the client.

4. The treatment plan is reviewed/updated in collaboration with the client, as needed, or at a minimum of every 30 days.

5. Discharge/transfer planning must begin at admission.

6. Referral arrangements made prior to discharge.

Staffing

1. Facility shall have qualified professional medical, nursing and other support staff necessary to provide services appropriate to the bio-psychosocial needs of individuals being admitted to the program.

   Adult staffing patterns
   - Physician (MD), medical director – MD(s) on site as needed for management of psychiatric/medical needs. 24 hour on-call availability
   - PCP – N/A
   - Psychologist – Optional
   - Nursing– One FTE Supervisor (APRN/NP/RN), 24 hour on-call availability. One FTE RN/LPN available on site, all shifts
   - Licensed or certified clinician or counselor with direct supervision – one clinician per ten clients
   - Direct Care aide – one direct care aide on duty on all shifts with additional as needed.
   - Clerical support staff – one to two FTE per day shift
   - Activity/occupational therapist – 0.5 FTE
   - Care coordinator – one FTE per day shift, and/or duties may be assumed by clinical staff
   - Outreach worker/peer mentor – Optional

2. Physicians, who are available 24 hours a day by telephone. (Or a PA, NP or APRN may perform duties within the scope of their practice as designated by physician).

3. Licensed, certified or registered clinicians provide a planned regimen of 24-hour, professionally directed evaluation, care and treatment services for individuals and their families.

4. An interdisciplinary team of appropriately trained clinicians, such as physicians, nurses, counselors, social workers and psychologists is available to assess and treat the individual and to obtain and interpret information regarding the patient's needs. The number and disciplines of team members are appropriate to the range and severity of the individual's problems.

5. A counselor is available on site 40 hours per week to provide direct client care, utilizing the 12 core functions of substance use counseling and/or specific functions related to professional license. Caseloads not to exceed 10 clients.

6. Qualified professional supervisor – Available for clinical supervision and by telephone for consultation.

Level III.7D Medically Monitored Residential Detoxification – Adult
Medically monitored residential detoxification is an organized service delivered by medical and nursing professionals, which provide for 24-hour medically supervised evaluation under a defined set of physician-approved policies and physician-monitored procedures or clinical protocols. All facilities are licensed by DHH.

This level provides care to patients whose withdrawal signs and symptoms are sufficiently severe to require 24-hour inpatient care. It sometimes is provided by overlapping with Level IV-D services (as a "step-down" service) in a specialty unit of an acute care general or psychiatric hospital. Twenty-four hour observation, monitoring and treatment are available.

Admission guidelines
Provides care to patients whose withdrawal signs and symptoms are sufficiently severe to require 24-hour inpatient care. It sometimes is provided as a "step-down" service from a specialty unit of an acute care general or psychiatric hospital. Twenty-four hour observation, monitoring and treatment are available. However, the full resources of an acute care general hospital or a medically managed intensive inpatient treatment program are not necessary.

Screening/assessments/treatment plan review
1. Triage screening to determine eligibility and appropriateness (proper patient placement) for admission and referral. The LGE ensures that pre-certification requirements are met for admission.

2. Approval of admission by a physician. A physical examination by a physician, PA or NP within 24 hours of admission and appropriate laboratory and toxicology tests. A physical examination conducted within 24 hours prior to admission may be used, if reviewed and approved by the admitting physician.

3. Comprehensive bio-psychosocial assessment completed within seven days of admission, which substantiates appropriate patient placement. The assessment must be reviewed and signed by a qualified professional (exclusions: detoxification programs are not required to complete a psychosocial assessment but must screen for proper patient placement and referral). An individualized, interdisciplinary stabilization/treatment plan should be developed in collaboration with the client, including problem identification in ASAM Dimensions 2-6.

4. Discharge/transfer planning must begin at admission.

5. Referral arrangements made, as needed.

6. Daily assessment of client's progress, which should be documented accordingly.

Staffing

1. Facility shall have qualified professional medical, nursing and other support staff necessary to provide services appropriate to the bio-psychosocial needs of individuals being admitted to the program.
   a. Physician (MD), medical director – MD(s) on site as needed for management of psychiatric/medical needs. 24 hour on-call availability
   b. PCP – NA
   c. Psychologist – NA
   d. Nursing – One FTE Supervisor (APRN/NP/RN), 24 hour on-call availability. One nurse on duty during all shifts with additional as needed based upon the provider's census and the clients' acuity levels.
   e. Licensed or certified clinician or counselor with direct supervision – one clinician per 10 clients;
   f. Direct Care aide – One direct care aide on all shifts with additional as needed based upon the provider's census and the clients' acuity levels.
   g. Clerical support staff – one to two FTE per day shift
   h. Activity/occupational therapist – NA
   i. Care coordinator – one FTE per day shift, and/or duties may be assumed by clinical staff
   j. Outreach worker/peer mentor – Optional

2. Physicians, who are available 24 hours a day by telephone. (Or a PA, NP or APRN may perform duties within the scope of their practice as designated by physician).

3. A physician is available to assess the individual within 24 hours of admission (or earlier, if medically necessary) and is available to provide on-site monitoring of care and further evaluation on a daily basis.

4. A RN or other licensed and credential nurse is available on-call 24 hours per day and on-site no less than 40 hours per week and will conduct a nursing assessment on individuals at admission.

5. A nurse is responsible for overseeing the monitoring of the individual's progress and medication administration on an hourly basis, if needed.

6. Appropriately licensed and credentialed staff is available to administer medications in accordance with physician orders.

7. Licensed, certified or registered clinicians provide a planned regimen of 24-hour, professionally directed evaluation, care and treatment services for individuals and their families.

8. An interdisciplinary team of appropriately trained clinicians, such as physicians, nurses, counselors, social workers and psychologists is available to assess and treat the individual and to obtain and interpret information regarding the patient's needs. The number and disciplines of team members are appropriate to the range and severity of the individual's problems.

9. A counselor is available on site 40 hours per week to provide direct client care, utilizing the 12 core functions of substance use counseling and/or specific functions related to professional license. Caseloads not to exceed 10 clients.

10. Qualified professional supervisor – Available for clinical supervision and by telephone for consultation.

Toxicology/drug screening

Medically monitored. Physician may waive drug screening if and when individual signs list of drugs being used and understands that his/her dishonesty could result in severe medical reactions during detoxification process.

Stabilization plan

Qualified professional shall identify the individual's short-term needs based on the detoxification history, the medical history and the physical examination, if available, and prepare a plan of action until individual becomes physically stable.

Detoxification/treatment plan
Medically monitored. The detoxification/treatment plan shall be reviewed and signed by the physician and the individual and shall be filed in the individual's record within 24 hours of admission with updates, as needed.

Detoxification progress notes
The program shall implement the detoxification/treatment plan and document the individual's response to and/or participation in scheduled activities. Notes shall include:

- The individual's physical condition, including vital signs
- The individual's mood and behavior
- Statements about the individual's condition and needs
- Information about the individual's progress or lack of progress in relation to detoxification/treatment goals
- Additional notes shall be documented, as needed

Physicians' orders
Required for medical and psychiatric management.

Section 4.6: Louisiana State Adolescent Treatment Enhancement and Dissemination Program (LA SAT-ED)

Definition
SAMHSA funded initiative to enhance and improve treatment and recovery services for substance use or co-occurring substance use and mental disorders provided to adolescents (ages 12-18) and their families/primary caregivers. Implemented through the development of a learning laboratory with two collaborating local community based treatment provider sites and four additional sites trained in evidence-based practices in 2015. The evidence-based practices selected and implemented include: GAIN (Global Appraisal of Individual Needs), ACRA (Adolescent Community Reinforcement Approach), and ACC (Assertive Continuing Care).

Provider Qualifications	Eligibility Criteria
GAIN: Bachelor level staff at a minimum A-CRA/ACC: Licensed or eligible for licensure (under supervision)	Adolescents ages 12 through 18 that reside in catchment area served by the six trained sites in Louisiana.

Limitations/Exclusions	Allowed Mode(s) of Delivery
SAMHSA does not allow services to incarcerated youth to be provided through grant funds.	Individual, group, family.

Chapter 5:
Outpatient & Inpatient Hospital & PRTF

Outpatient and Inpatient Hospital and Psychiatric Residential Treatment Facility Services

Section 5.1: Outpatient and Inpatient Hospital

Definition

All costs for inpatient acute care hospital admissions for the uninsured whose treatment has been determined medically necessary by the ASO and who are hospitalized in a facility with a Cooperative Endeavor Agreement with OBH are funded through OBH.

Level IV D: Medically Managed Intensive Inpatient Addiction Disorder Treatment:
This hospital level of care is appropriate for those individuals whose acute biomedical, emotional, behavioral and cognitive problems are so severe they require primary medical and nursing care. This program encompasses a planned regimen of 24-hour medically directed evaluation and withdrawal management in an acute care inpatient setting. Although treatment is specific to substance use problems, the skills of the interdisciplinary team and the availability of support services allow the conjoint treatment of any co-occurring biomedical conditions and mental disorders that need to be addressed. A licensee providing inpatient treatment shall assign one qualified staff for every four clients in residence. The licensee shall maintain sufficient employees on duty 24 hours a day to meet the needs and protect the safety of clients. Employees on duty shall be awake on all shifts. The program must include an in-house education/vocation component if serving adolescents.

A licensee providing inpatient treatment shall provide a licensed physician or nurse on site or on call, and licensed medical or nursing staff to monitor and administer medications on a 24-hour per day basis.

Admission guidelines
Provides care to patients whose withdrawal signs and symptoms are sufficiently severe enough to require primary medical and nursing services on a 24-hour basis. This program offers intensive physical health and/or psychiatric care in a hospital setting. The focus is on stabilization and preparation for transfer to a less intensive level of care.

Screening/assessments/treatment plan review
1. Triage screening to determine eligibility and appropriateness (proper patient placement) for admission and referral. The LGE ensures that pre-certification requirements are met for admission.

2. Approval of admission by a physician. A physical examination by a physician, PA or NP within 24 hours of admission and appropriate laboratory and toxicology tests. A physical examination conducted within 24 hours prior to admission may be used if reviewed and approved by the admitting physician.

3. Comprehensive bio-psychosocial assessments are not required for this level of care:

   – An individualized, interdisciplinary stabilization/treatment plan should be developed in collaboration with the client, including problem identification in ASAM Dimensions 2-6.
   – Daily assessments of client's progress should be documented.
   – Discharge/transfer planning must begin at admission.
   – Referral arrangements prior to discharge.

Staffing
1. Facility shall have qualified professional medical, nursing and other support staff necessary to provide services appropriate to the bio-psychosocial needs of individuals being admitted to the

program.

a. Physician (MD), medical director – MD(s) on site as needed for management of psychiatric/medical needs. 24 hour on-call availability
b. PCP – NA
c. Psychologist – NA
d. Nursing – One FTE Supervisor (APRN/NP/RN), 24 hour on-call availability. At least three FTE (NP/RN/LPN) on all shifts or 1:6 ratio
e. Licensed or certified clinician or counselor with direct supervision – one clinician per ten clients; and available 40 hours per week. A counselor is available 40 hours per week.
f. Direct Care aide – Two DCAs on all shifts or 1:10 ratio.
g. Clerical support staff – one to two FTE per day shift
h. Activity/occupational therapist – NA
i. Care coordinator – one FTE per day shift, and/or duties may be assumed by clinical staff
j. Outreach worker/peer mentor – Optional.

2. Physicians, who are available 24 hours a day by telephone. (Or a PA, NP or APRN may perform duties within the scope of their practice as designated by physician).

3. A physician is available to assess the individual within 24 hours of admission (or earlier, if medically necessary) and is available to provide on-site monitoring of care and further evaluation on a daily basis.

4. A RN or other licensed and credentialed nurse is available on call 24 hours per day and on site no less than 40 hours per week and will conduct a nursing assessment on individuals at admission.

5. A nurse is responsible for overseeing the monitoring of the individual's progress and medication administration on an hourly basis, if needed.

6. Appropriately licensed and credentialed staff is available to administer medications in accordance with physician orders. The level of nursing care is at a ratio of one nurse per every 6 individuals.

7. Licensed, certified or registered clinicians provide a planned regimen of 24-hour, professionally directed evaluation, care and treatment services for individuals and their families.

8. An interdisciplinary team of appropriately trained clinicians, such as physicians, nurses, counselors, social workers and psychologists is available to assess and treat the individual and to obtain and interpret information regarding the patient's needs. The number and disciplines of team members are appropriate to the range and severity of the individual's problems.

9. A counselor is available on site 40 hours per week to provide direct client care, utilizing the 12 core functions of substance use counseling and/or specific functions related to professional license. Caseloads not to exceed 10 clients.

10. Qualified professional supervisor – Available for clinical supervision and by telephone for consultation.

Toxicology/drug screening
Urine drug screens are required upon admission and as directed by the treatment plan.

Stabilization plan
Qualified professional shall identify the individual's short-term needs, based on the detoxification history, the medical history and the physical examination and prepare a plan of action.

Detoxification/treatment plan
The detoxification/treatment plan shall be reviewed and signed by the physician and the individual and shall be filed in the individual's record within 24 hours of admission with updates, as needed.

Detoxification progress notes
The program shall implement the detoxification/treatment plan and document the individual's response to and/or participation in scheduled activities. Notes shall include:

- The individual's physical condition, including vital signs
- The individual's mood and behavior
- Statements about the individual's condition and needs
- Information about the individual's progress or lack of progress in relation to detoxification/treatment goals
- Additional notes shall be documented, as needed

Physicians' orders
Required for medical and psychiatric management.

Provider Qualifications	Eligibility Criteria
General hospital outpatient and inpatient settings for adults and children. Psychiatric hospital inpatient settings for children under age 21.	All Medicaid-eligible adults All Medicaid-eligible children

Limitations/Exclusions and Fee Schedules	Allowed Mode(s) of Delivery
N/A	Inpatient

Section 5.2: Psychiatric Residential Treatment Facility (PRTF)

Definition

Psychiatric Residential Treatment Facilities are required to ensure that all medical, psychological, social, behavioral and developmental aspects of the recipient's situation are assessed and that treatment for those needs are reflected in the Reccommended Services and Supports (RSS) plan. In addition, the PRTF must ensure that the resident receives all treatment needed for those identified needs. In addition to services provided by and in the facility, when they can be reasonably anticipated on the active treatment plan, the PRTF must ensure that the resident receives all treatment identified on the active treatment plan and any other medically necessary care required for all medical, psychological, social, behavioral and developmental aspects of the recipient's situation. The facility must provide treatment meeting State regulations per LAC 48:I. Chapter 90.

Services must meet active treatment requirements, which mean implementation of a professionally developed and supervised individual plan that is developed and implemented no later than 72 hours after admission and designed to achieve the recipient's discharge from inpatient status at the earliest possible time. “Individual Plan” means a written plan developed for each recipient to improve his condition to the extent that inpatient care is no longer necessary. The Plan must:

- Be based on a diagnostic evaluation conducted within the first 24 hours of admission in consultation with the child and the parents/legal guardian that includes examination of the medical, psychological, social, behavioral and developmental aspects of the recipient's situation and reflects the need for inpatient psychiatric care.
- Be developed by a team of professionals in consultation with the child and the parents, legal guardians or others in whose care the child will be released after discharge.
- State treatment objectives.
- Prescribe an integrated program of therapies, activities and experiences designed to meet the objectives.
- Include, at an appropriate time, post-discharge plans and coordination of inpatient services, with partial discharge plans and related community services to ensure continuity of care with the recipient's family, school and community upon discharge.

The plan must be reviewed as needed or at a minimum of every thirty days by the facility treatment team to:

- Determine that services being provided are or were required on an inpatient basis.
- Recommend changes in the plan, as indicated by the recipient's overall adjustment as an inpatient.

The facility treatment team develops and reviews the individual plan. The individual plan must be developed by an interdisciplinary team of physicians and other personnel who are employed by, or provide services to, patients in the facility. The individual plan must be based on education and experience, preferably including competence in child psychiatry. The team must be capable of:

- Assessing the recipient's immediate and long-range therapeutic needs, developmental priorities and personal strengths and liabilities in accord with the plan development requirements above.
- Assessing the potential resources of the recipient's family.
- Setting treatment objectives in accord with the requirements above.
- Prescribing therapeutic modalities to achieve the plan's objectives.

The team must include, as a minimum, either:

- A board-eligible or board-certified psychiatrist.
- A clinical psychologist who has a doctoral degree and a physician licensed to practice medicine or osteopathy.
- A physician licensed to practice medicine or osteopathy, with specialized training and experience in the diagnosis and treatment of mental diseases, and a psychologist who has a master's degree in clinical psychology or who has been certified by the State psychological association. *Note: Louisiana does not consider individuals with a master's degree in clinical psychology to practice and be considered "psychologists". Facilities wishing to utilize this option under federal and state regulations must ensure that State psychology scope of practice is followed. In this case it would mean that the psychologist must be a licensed or medical psychologist.*

The team must also include one of the following:

- A psychiatric social worker.
- A RN with specialized training or one year's experience in treating mentally ill individuals.
- An occupational therapist who is licensed, if required by the State, and who has specialized training or one year of experience in treating mentally ill individuals.
- A psychologist who has a master's degree in clinical psychology or who has been certified by the State psychological association. *Note: Louisiana does not consider individuals with a master's degree in clinical psychology to practice and be considered "psychologists". Facilities wishing to utilize this option under federal and state regulations must ensure that State psychology scope of practice is followed. In this case it would mean that the psychologist must be a licensed or medical psychologist.*

In all cases, it is preferred that team members also have experience treating children and adolescents.

Because the PRTF is not in itself a specific research-based model, it must instead incorporate research-based models developed for a broader array of settings that respond to the specific presenting problems of the clients served. Each PRTF program should incorporate appropriate research-based programming for both treatment planning and service delivery.

For milieu management, all programs should also incorporate some form of research-based, trauma-informed programming and training, if the primary research-based treatment model used by the program does not (e.g., LAMod). Annually, facilities must submit documentation demonstrating compliance with at least two EBP fidelity monitoring or ASAM criteria. The State must approve the auditing body providing the EBP/ASAM fidelity monitoring. PRTF may specialize and provide care for sex offenders, substance use or individuals with co-occurring disorders. If a program provides care to any of these categories of youth, the program must submit documentation regarding the appropriateness of the research-based, trauma-informed programming and training, as well as compliance with the ASAM level of care being provided.

In addition, programs may propose other models, citing the research base that supports use of that model with the target population (e.g., gender-specific approaches). They may also work with the purveyors of research-based models to develop more tailored approaches, incorporating other models.

The specific research-based models to be used should be incorporated into the program description and submitted to the State for approval by the ASO, subject to OBH review. All research-based programming in PRTF settings must be approved by the State.

Staffing for the facility must be consistent with State licensure regulations on an FTE basis. For example, if State licensure requires a staff to client ratio of 1:25 and the facility has 16 child residents, then the facility must have at least .64 FTE for the 16 children. If the facility has eight beds, then the facility must have at least .32 FTE for the eight children.

Prior to admission, the ASO team, including a physician with competence in diagnosis and treatment of mental illness, preferably in child psychiatry and has knowledge of the individual's situation, must certify need that:

- Ambulatory care resources available in the community do not meet the treatment needs of the recipient
- Proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician
- The services can reasonably be expected to improve the recipient's condition or prevent further regression so that the services will no longer be needed

Children/adolescents receiving services in a PRTF program must have access to education services, including supports to attend public school if possible, or in-house educational/vocational components if serving adolescents. Educational/vocational expenses are not Medicaid expenses. In addition, supports to attend public school outside of the PRTF are not considered activities provided by and in the PRTF and on the active treatment plan.

Level III.7 Medically Monitored Intensive Residential Treatment – Adolescent
This COD residential treatment facility provides 24 hours of structured treatment activities per week including, but not limited to, psychiatric and substance use assessments, diagnosis treatment, habilitative and rehabilitation services to individuals with ICOPSD, whose disorders are of sufficient severity to require a residential level of care. All facilities are licensed by DHH.

It also provides a planned regiment of 24-hour professionally directed evaluation, observation and medical monitoring of addiction and mental health treatment in a residential setting. They feature permanent facilities, including residential beds, and function under a defined set of policies, procedures and clinical protocols. Appropriate for patients whose subacute biomedical and emotional, behavior or cognitive problems are so severe that they require co-occurring capable or enhanced residential treatment, but who do not need the full resources of an acute care general hospital. In addition to meeting integrated service criteria, COD treatment providers must have experience and preferably licensure and/or certification in both addictive disorders and mental health. Children/adolescents receiving services in a PRTF program must have access to education services, including supports to attend public school if possible, or in-house educational/vocational components if serving adolescents.

Admission guidelines
Individuals in this level of care may have co-occurring addiction and mental health disorders that meet the eligibility criteria for placement in a co-occurring-capable program or difficulties with mood, behavior or cognition related to a substance use or mental disorder, or emotional behavioral or cognitive symptoms that are troublesome, but do not meet the DSM criteria for mental disorder.

1. Acute intoxication and/or withdrawal potential – None or minimal/stable withdrawal risk.

2. Biomedical conditions and complications – Moderate to severe conditions (which require 24-hour nursing and medical monitoring or active treatment but not the full resource of an acute care hospital).

3. Emotional, behavioral or cognitive conditions and complications – Moderate to severe conditions and complications (such as diagnosable co-morbid Axis I disorders or symptoms). These symptoms may not be severe enough to meet diagnostic criteria but interfere or distract from recovery efforts (for example, anxiety/hypomanic or depression and/or cognitive symptoms, which may include compulsive behaviors, suicidal or homicidal ideation, with a recent history of attempts but no specific plan, or hallucinations and delusions without acute risk to self or others) are interfering with abstinence, recovery and stability to such a degree that the individual needs a structured 24-hour, medically monitored (but not medically managed) environment to address recovery efforts.

4. Readiness to change – Participant is in need of intensive motivating strategies, activities and processes available only in a 24-hour structured medically monitored setting (but not medically managed.)

5. Relapse, continued use or continued problem potential – Participant is experiencing an escalation of relapse behaviors and/or acute psychiatric crisis and/or reemergence of acute symptoms and is in need of 24-hour monitoring and structured support.

6. Recovery environment – Environment or current living arrangement is characterized by a high risk of initiation or repetition of physical, sexual or emotional abuse or substance use so endemic that the patient is assessed as unable to achieve or maintain recovery at a less intensive level or care.

Screening/assessment/treatment plan review:

1. Triage screening to determine eligibility and appropriateness (proper patient placement) for admission and referral. The LGE ensures that pre-certification requirements are met for admission.

2. Comprehensive bio-psychosocial assessment completed within seven days, which substantiates appropriate patient placement. The assessment must be reviewed and signed by a qualified professional. The following sections must be completed prior to seven days of admission:
   a. Medical
   b. Psychological
   c. Alcohol
   d. Drug

3. An individualized, interdisciplinary treatment plan, which includes problem formulation and articulation of short-term, measurable treatment goals and activities designed to achieve those goals. This plan should be developed in collaboration with the client.

4. The treatment plan is reviewed/updated in collaboration with the client, as needed, or at a minimum of every 30 days.

5. Discharge/transfer planning must begin at admission.

6. Referral arrangements made prior to discharge.

Staffing

1. Facility shall have qualified professional medical, nursing and other support staff necessary to provide services appropriate to the bio-psychosocial needs of individuals being admitted to the program.

Adolescent staffing patterns

- MD, medical director – MD(s) on site as needed for management of psychiatric/medical needs. 24 hour on-call availability
- Psychologist – As needed
- Nursing – One FTE Supervisor (APRN/NP/RN), 24 hour on-call availability. One FTE (RN/LPN) available on site 7a.m. – 11 p.m.
- Licensed or certified clinician or counselor with direct supervision – one clinician per eight clients
- Direct care aide – Two FTE PA's on all shifts. Ratio cannot exceed 1:8. Ratio must be 1:3 on therapy outingsClerical support staff – two FTE per day shift
- Activity/occupational therapist – one FTE
- Care coordinator – one FTE per day shift, and/or duties may be assumed by clinical staff
- Outreach worker/peer mentor – Optional

2. Physicians, who are available 24 hours a day by telephone. (Or a PA, NP or APRN may perform duties within the scope of their practice as designated by physician).

3. Licensed, certified or registered clinicians provide a planned regimen of 24-hour, professionally directed evaluation, care and treatment services for individuals and their families.

4. An interdisciplinary team of appropriately trained clinicians, such as physicians, nurses, counselors, social workers and psychologists is available to assess and treat the individual and to obtain and interpret information regarding the patient's needs. The number and disciplines of team members are appropriate to the range and severity of the individual's problems.

5. A counselor is available on site 40 hours per week

6. Qualified professional supervisor – Available for clinical supervision and by telephone for consultation.

7. Qualified professional – Available 40 hours per week. to provide direct client care, utilizing the 12 core functions of substance use counseling and/or specific functions related to professional license. Caseloads not to exceed 8 clients.

Level III.7D Medically Monitored Residential Detoxification - Adolescent
Medically monitored residential detoxification is an organized service delivered by medical and nursing professionals, which is provided for 24-hour medically supervised evaluation under a defined set of physician-approved policies and physician-monitored procedures or clinical protocols. All facilities are licensed by DHH. Children/adolescents receiving services in a PRTF program must have access to education services, including supports to attend public school if possible, or in-house educational/vocational components if serving adolescents.

This level provides care to patients whose withdrawal signs and symptoms are sufficiently severe to require 24-hour inpatient care. It sometimes is provided by overlapping with Level IV-D services (as a "step-down" service) in a specialty unit of an acute care general or psychiatric hospital. Twenty-four hour observation, monitoring and treatment are available.

Admission guidelines
Provides care to patients whose withdrawal signs and symptoms are sufficiently severe to require 24-hour inpatient care. It sometimes is provided as a "step-down" service from a specialty unit of an acute care general or psychiatric hospital. Twenty-four hour observation, monitoring and treatment are available. However, the full resources of an acute care general hospital or a medically managed intensive inpatient treatment program are not necessary.

Screening/assessments/treatment plan review
1. Triage screening to determine eligibility and appropriateness (proper patient placement) for admission and referral. The LGE/provider ensures that pre-certification requirements are met for admission.

2. Approval of admission by a physician. A physical examination by a physician, PA or NP within 24 hours of admission, and appropriate laboratory and toxicology tests. A physical examination conducted within 24 hours prior to admission may be used if reviewed and approved by the admitting physician.

3. Comprehensive bio-psychosocial assessment completed within seven days of admission, which substantiates appropriate patient placement. The assessment must be reviewed and signed by a qualified professional (exclusions: detoxification programs are not required to complete a psychosocial assessment but must screen for proper patient placement and referral). An individualized, interdisciplinary stabilization/treatment plan should be developed in collaboration with the client,

including problem identification in ASAM Dimensions 2-6.

4. Discharge/transfer planning must begin at admission.

5. Referral arrangements made, as needed.

6. Daily assessment of client's progress, which should be documented accordingly.

Staffing

1. Facility shall have qualified professional medical, nursing and other support staff necessary to provide services appropriate to the bio-psychosocial needs of individuals being admitted to the program.
    a. Physician (MD), MD(s) on site as needed for management of psychiatric and/medical needs.
    b. MD(s) availability on call 24/7.
    c. Psychologist – Available As Needed
    d. Nurse (NP/RN or LPN) – 1 FTE Supervisor APRN/NP /RN, on call 24/7; 2FTE NP/RN/LPN on 1st and 2nd shifts and 1 LPN 3rd shift 1:8 Ratio
    e. Licensed or certified clinician or counselor with direct supervision – one clinician per 10 clients and available 40 hours per week. A counselor is available 40 hours per week
    f. Direct Care aide – Two DCAs on first, second, and third shift. Not to exceed 1:10 ratio.
    g. Clerical support staff – One to two FTE per day shift
    h. Activity/occupational therapist – NA
    i. Care coordinator – One FTE per day shift, and/or duties may be assumed by clinical staff
    j. Outreach worker/peer mentor – Optional

2. Physicians, who are available 24 hours a day by telephone.

3. A physician is available to assess the individual within 24 hours of admission (or earlier, if medically necessary) and is available to provide on-site monitoring of care and further evaluation on a daily basis.

4. A RN or other licensed and credentialed nurse is available on-call 24 hours per day and on site no less than 40 hours per week and will conduct a nursing assessment on individuals at admission.

5. A nurse is responsible for overseeing the monitoring of the individual's progress and medication administration on an hourly basis, if needed.

6. Appropriately licensed and credentialed staff is available to administer medications in accordance with physician orders. The level of nursing care is at a ratio of one nurse per every 8 individuals.

7. Licensed, certified or registered clinicians provide a planned regimen of 24-hour, professionally directed evaluation, care and treatment services for individuals and their families.

8. An interdisciplinary team of appropriately trained clinicians, such as physicians, nurses, counselors, social workers and psychologists is available to assess and treat the individual and to obtain and interpret information regarding the patient's needs. The number and disciplines of team members are appropriate to the range and severity of the individual's problems.

9. A counselor is available on site 40 hours per week to provide direct client care, utilizing the 12 core functions of substance use counseling and/or specific functions related to professional license. Caseloads not to exceed 10 clients.

10. Qualified professional supervisor – Available for clinical supervision and by telephone for consultation.

Toxicology/drug screening
Medically monitored. Physician may waive drug screening if and when individual signs a list of drugs being used and understands that his/her dishonesty could result in severe medical reactions during detoxification process.

Stabilization plan
Qualified professional shall identify the individual's short-term needs based on the detoxification history, the medical history and the physical examination, if available, and prepare a plan of action until individual becomes physically stable.

Detoxification/treatment plan
Medically monitored. The detoxification/treatment plan shall be reviewed and signed by the physician and the individual and shall be filed in the individual's record within 24 hours of admission with updates, as needed.

Detoxification progress notes
The program shall implement the detoxification/treatment plan and document the individual's response to and/or participation in scheduled activities. Notes shall include:

- The individual's physical condition, including vital signs
- The individual's mood and behavior
- Statements about the individual's condition and needs
- Information about the individual's progress or lack of progress in relation to detoxification/treatment goals
- Additional notes shall be documented, as needed

Physicians' orders
Required for medical and psychiatric management.

Provider Qualifications	Eligibility Criteria
Licensed as a PRTF by DHH per LAC 48:I.Chapter 90. The PRTF must be physician directed and meet the requirements of 42 CFR 441.151, including requirements referenced therein to 42 CFR 483 subpart G. The psychiatric facility must be accredited by: • The Joint Commission on the Accreditation of Health Care Organizations • The Council on Accreditation for Children and Family Services • The Commission on Accreditation of Rehabilitation Facilities For inpatient levels of care, a staffing ratio of 1:4 during awake hours (day and evening shifts) is typical, with an emphasis on nursing staff. The Joint Commission does not specify a ratio for adolescent residential treatment. Research and clinical	Children under age 21 when: 1. Ambulatory care resources available in the community do not meet the treatment needs of the recipient. 2. Proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician. 3. The services can be reasonably expected to improve the recipient's condition or prevent further regression, so that the services will no longer be needed. The independent ASO team authorizing the PRTF stay must: 1. Include a physician. 2. Have competence in diagnosis and treatment of mental illness, preferably in child psychiatry.

experience regarding therapeutically effective residential care established the 1:4 ratio for mental health workers, as a minimum, in addition to a 1:6 requirement for mental health professionals.	3. Have knowledge of the individual's situation.

Limitations/Exclusions	Allowed Mode(s) of Delivery
The facility must comply with seclusion and restraint requirements found at LAC 48:I.Chapter 90 and 42 CFR 483 subpart G. *Reasonable activities* includes PRTF treatment provided by and in the facility when it was found, during the initial evaluation or subsequent reviews, to be treatment necessary to address a medical, psychological, social, behavioral or developmental aspect of the child'scare.. The PRTF reasonable activities are child-specific and must be necessary for the health and maintenance of health of the child while he or she is a resident of the facility. The medically necessary care must constitute a need that contributes to the inpatient treatment of the child and is dependent upon the expected length of stay of the particular child in that facility (e.g., dental hygiene may be necessary for a child expected to reside in the facility for 12 months but not 30 days).	On-site

Chapter 6: Outpatient Therapy by Licensed Practitioners

Outpatient Therapy Services by Licensed Practitioners

Section 6.1: Other Licensed Practitioner Outpatient Therapy

Definition	
Individual, family, group outpatient psychotherapy and mental health assessment, evaluation and testing.	
Provider Qualifications	**Eligibility Criteria**
A licensed mental health practitioner is an individual who is licensed in the State of Louisiana to diagnose and treat mental illness or substance use, acting within the scope of all applicable State laws and their professional license. A LMHP includes individuals licensed to practice independently: • Medical psychologists • Licensed psychologists • Licensed clinical social workers • Licensed professional counselors • Licensed marriage and family therapists • Licensed addiction counselors • Advanced practice registered nurses – must be a nurse practitioner specialist in adult psychiatric and mental health, and family psychiatric and mental health, or a certified nurse specialist in psychosocial, gerontological psychiatric mental health, adult psychiatric and mental health and child-adolescent mental health and may practice to the extent that services are within the APRN's scope of practice Note: Psychiatrists often are employed by agencies that employ other licensed practitioners. Prior authorization or authorization beyond an initial authorization level of benefit is not a required element for psychiatrist services under the Louisiana State Plan; however, the ASO may choose to require prior authorization for psychiatrist services or may prior authorize psychiatrist services beyond an initial authorization level of benefit at their option.	All non-Medicaid-eligible children and adults who meet medical necessity criteria.
Limitations/Exclusions	**Allowed Mode(s) of Delivery**
Providers cannot provide services or supervision under this section if they are a provider who is excluded from participation in federal health care programs under either Section 1128 or Section 1128A of the Social Security Act. In addition, they may not be debarred, suspended or otherwise excluded from participating in procurement activities under the State and federal laws, regulations and policies, including the federal Acquisition Regulation, Executive Order No.12549 and Executive Order No. 12549. In addition, providers who are an affiliate, as defined in the federal	• Individual • Family • Group • On-site • Off-site • Tele-video

Acquisition Regulation, of a person excluded, debarred, suspended or otherwise excluded under State and federal laws, regulations and policies may not participate. All services must be authorized. Services which exceed the limitation of the initial authorization must be approved for re-authorization prior to service delivery. All neuropsychological testing must be prior authorized. Service providers that offer addiction services must demonstrate competency, as defined by the DHH, State law (RS 37:3386 et seq.) and regulations. "Serious mental illness" means any of the following diagnoses: a. Schizophrenia or schizoaffective disorder b. Bipolar disorder c. Panic disorder d. Obsessive-compulsive disorder e. Major depressive disorder-moderate to severe f. Anorexia/bulimia g. Intermittent explosive disorder h. Autism i. Psychosis NOS, when diagnosed in a child under seventeen years of age j. Rett's disorder k. Tourette's disorder l. Dementia LMFTs may practice and provide marriage and family therapy, including the application of psychotherapeutic and family systems theories and techniques in the assessment and treatment of individuals and families, while rendering professional marriage and family therapy services to individuals, couples and families, singly or in groups. APRN: Collaborative Practice Agreement required. APRNs have certified nurse specializations as specified in the authorities' documents. Inpatient hospital visits are limited to those ordered by the individual's physician. Visits to nursing facilities are allowed for psychologists, if a pre-admission screening and resident review indicates it is medically necessary treatment. Social worker visits are included in the nursing visit.Evidence-based practices require prior approval and fidelity reviews on an ongoing basis, as determined necessary by the Department of Health and Hospitals. A unit of service is defined according to the Health Care Financing Administration common procedure coding system approved code set, unless otherwise specified.	

Additional Service Criteria

Services provided to children and youth must include communication and coordination with the family and/or legal guardian. Coordination with other child-serving systems should occur, as needed, to achieve the treatment goals. All coordination must be documented in the youth's medical record.

All services below have an initial authorization level of benefit. Services which exceed the limitation of the initial authorization must be approved for re-authorization prior to service delivery:

- Admission evaluation is authorized for five evaluations per calendar year.
- Individual therapy, family therapy, and group therapy are authorized for 24 sessions combined per calendar year per member.
- Psychological testing is preauthorized by the administrative services organization (ASO).

Face-to-face for OLP includes a therapist in a different room/location from the client/family, but in the same building, with real-time visual and audio transmission from the therapy room and two-way audio transmission between client and/or family member and therapist. If the therapist is working with a single client/family, then family or individual therapy requirements and reimbursement would apply. If the therapist is working with more than one client/family, group therapy requirements and reimbursement would apply. Must be provided by licensed or qualified MA-level staff. MA-level staff must have appropriate oversight when providing treatment through real-time visual and audio transmission. The practice must be in accord with documented EBPs or promising practices approved by OBH (or the ASO). If not in the same building, then telemedicine requirements and reimbursement would apply.

An LMHP is an individual who is licensed in the State of Louisiana to diagnose and treat mental illness or substance use, acting within the scope of all applicable State laws and their professional license. A LMHP includes individuals licensed to practice independently:

- Medical psychologists
- Licensed psychologists
- LCSWs
- LPCs
- LMFTs
- LACs

Telehealth:

Consultations, office visits, individual psychotherapy and pharmacological management services may be reimbursed when provided via telecommunication technology. Per Act 442: "'Healthcare provider' means a person, partnership, limited liability partnership, limited liability company, corporation, facility, or institution licensed or certified by this state to provide health care or professional services as a physician assistant, hospital, nursing home, dentist, registered nurse, advanced practice registered nurse, licensed practical nurse, … psychologist, medical psychologist, social worker, licensed professional counselor…." "'Telehealth' means a mode of delivering healthcare services that utilizes information and communication technologies to enable the diagnosis, consultation, treatment, education, care management, and self-management of patients at a distance from healthcare providers. Telehealth allows services to be accessed when providers are in a distant site and patients are in the originating site. Telehealth facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchronous store and forward transfers."

Section 6.2: Medical, Physician/Psychiatrist, Outpatient Medical Services

Definition	
Medication management, psychiatric evaluation, medication administration, individual therapy with medical evaluation and management and case consultation.	
Provider Qualifications	**Eligibility Criteria**
Physician, psychiatrist or PA working under protocol of a psychiatrist. Registered nurse working within the scope of practice. Collaborative Practice Agreement required. APRNs have certified nurse specializations as specified in the authorities' documents.	All eligible children and adults who meet medical necessity criteria. All non-Medicaid-eligible children who are eligible to receive services through OJJ, DCFS and OBH.
Limitations/Exclusions	**Allowed Mode(s) of Delivery**
All services below have an initial authorization level of benefit. Services which exceed the limitation of the initial authorization must be approved for re-authorization prior to service delivery.	• Individual • On-site • Off-site • Tele-video
Additional Service Criteria	
Services provided to children and youth must include communication and coordination with the family and/or legal guardian. Coordination with other child-serving systems should occur, as needed, to achieve the treatment goals. All coordination must be documented in the youth's medical record.	

Chapter 7:
Services
For the Homeless

Section 7.1: Projects for Assistance in Transition from Homelessness (PATH)

Definition

The Projects for Assistance in Transition from Homelessness (PATH) program is administered by the Center for Mental Health Services, a component of the Substance Abuse and Mental Health Services Administration (SAMHSA). These services are for individuals with serious mental illnesses and those with co-occurring substance use disorders who are homeless or at imminent risk of becoming homeless. PATH services include community-based outreach, mental health, substance use, case management and other support services, as well as a limited set of housing services. States are encouraged to develop a uniform permanent supportive housing resources policy framework, priority population targeting criteria and defined pathways for entry into housing. This approach coupled with street outreach and case management should result in strong linkages and referrals to permanent supportive housing for persons with serious mental illnesses and co-occurring substance use disorders that are homeless or at imminent risk of becoming homeless.

Components

- Outreach services;
- Screening and diagnostic treatment services;
- Habilitation and rehabilitation services;
- Community mental health services including recovery support services, such as peer specialist/recovery coaches;
- Alcohol or drug treatment services;
- Staff training, including the training of individuals who work in shelters, mental health clinics, substance use programs, and other sites where individuals who experience homelessness require services;
- Case management services, including:
  - Preparing a plan for the provision of community mental health services to eligible homeless individuals involved, and reviewing such plan not less than once every 3 months;
  - Providing assistance in obtaining and coordinating social and maintenance services for eligible individuals who experience homelessness, including services relating to daily living activities, peer support services, personal financial planning, transportation services, and habilitation and rehabilitation services, prevocational and vocational services, and housing services;
  - Providing assistance to eligible individuals who experience homelessness in obtaining income support services, including housing assistance, food stamps, and supplemental security income benefits;
  - Referring eligible individuals who experience homelessness for such other services as may be appropriate; and
  - Providing representative payee services in accordance with section 1631(a)(2) of the Social Security Act if the eligible individuals who experience homelessness are receiving aid under title XVI of such act and if the applicant is designated by the Secretary to provide such services;
- Supportive and supervisory services in residential services;
- Referral for primary health services, job training, educational services, and relevant housing services; and
- Housing services as specified in Section 522(b)(10) of the Public Health Service (PHS) Act, including:
  - Minor renovation, expansion, and repair of housing;

- Planning of housing;
- Technical assistance in applying for housing assistance;
- Improving the coordination of housing services;
- Security deposits;
- Costs associated with matching eligible individuals who are experiencing homelessness with appropriate housing situations; and
- One-time rental payments to prevent eviction.

Provider Qualifications	Eligibility Criteria

• Section 522 of the PHS Act requires that the states and territories must expend their payments under the Act only for making grants to political subdivisions of the state (or territories), and to nonprofit private entities (including community-based veterans' organizations and other community organizations) for providing services specified in the Act.	• 18 Years of Age or Older
	  • Serious Mental Illnesses or Co-occurring Substance Use Disorders
	  • Homeless or at Imminent Risk of Becoming Homeless

Limitations/Exclusions

Grant funds may not be expended:

- To support emergency shelters;
- For inpatient psychiatric treatment;
- For inpatient substance use treatment;
- To make cash payments to intended recipients of mental health or substance use services;
- To pay for the purchase or construction of any building or structure to house any part of the grant program; or
- For lease arrangements beyond the project period, nor may the portion of the space leased with PATH funds be used for purposes not supported by the grant.

Section 7.2: Housing Assistance: Mental Health America of Louisiana

Definition

The purpose of this contract is to provide statewide "Bridge Funding" that will provide financial assistance to clients discharging from state institutional care facilities, transitional housing programs, and substandard residential housing facilities to independent living in permanent housing. Provision of funding will also be available for homeless prevention assistance and maintenance of community housing. The ultimate goal is to ensure a successful transition for these clients from institutional care or substandard housing to self-sufficiency and long-term permanent housing with appropriate supports. This is a statewide program through which referrals will come from OBH funded and/or run programs with request being routed through to Mental Health America of Louisiana (MHAL). Total expenditures, per client, should not exceed $2,000. It is anticipated this contract will serve a minimum of fifty (50) clients from state run/funded institutional care facilities, transitional housing programs and other substandard community housing programs into community housing that is appropriate with the necessary supports. Additional persons will be served if persons requiring services do not require the maximum of $2,000.

Components

- Tenant move-in costs including security and utility deposits and application fees (security deposit cannot exceed the amount of one month of the contract rent for the unit).
- Durable goods such as essential furniture and other household goods (see list below for eligible items and additional requirements).
    - Not to exceed $1,000 per item; individual items in excess of $500 will require prior approval by the OBH contract monitor.
- Travel funds in order to make doctor's appointments and other community support needs.
    - Not to exceed $20/month worth of bus tokens.
- Short-term/emergency rental assistance
    - $520/month for unlicensed facilities
    - $620/month for licensed facilities
- Hygiene assistance bags, not to exceed $25 per person.
- Clothing, not to exceed $60 per person.
- Costs of birth certificates, driver's licenses, or other forms of identification.

Eligibility Criteria

MUST have a psychiatric diagnosis, which may be accompanied by a co-occurring substance use disorder.

Tier I.

- ❑ Schizophrenia
- ❑ Other Psychotic Disorder ***(Schizoaffective Disorder, Substance Induced Psychotic Disorder)***
- ❑ Bi-Polar Disorder
- ❑ Major Depressive Disorder

Tier II.

- ❑ Obsessive Compulsive and Related Disorders

- ❑ Anxiety Disorder
- ❑ Depressive Disorder
- ❑ Trauma and Stress Related Disorders

Tier III.

- ❑ Other (Attach documentation)

Level of Need –

- ❑ Persistent and severe symptoms of a psychiatric disability that interferes with the ability to function in daily life and puts individual at risk of becoming homeless and/or institutionalized.
- ❑ Currently residing in an inpatient bed, but clinically assessed to be able to live in a more independent situation if intensive services were provided.
- ❑ Inability to meet basic survival needs or residing in substandard housing, homeless, or at imminent risk of becoming homeless.

Limitations/Exclusions

Funds through this program are not permitted to be used for the following:

- To make cash payments directly to tenants; payment must be made to the vendor;
- To cover food, alcohol, entertainment and long-term shelter; or
- To cover support services costs.

Any durable item purchased with Housing Assistance dollars shall not exceed $1,000. All durable items purchased must be tracked on a spreadsheet. A list of allowable items follows:

Dining Room:

- Dining table

Living Room:

- Sofa
- Love seat or chair

Bedroom(s):

- Dresser
- Full or queen bed

Other items or appliances, will require prior approval by OBH contract monitor.

Additional Service Criteria

Referring facility will complete the ***"Housing Assistance Referral Form"*** and forward Psychiatric Evaluation and/or Continuity of Care Form.

Individuals should be indigent, with assets not to exceed $2,000.

Section 7.3 Cooperative Agreement to Benefit Homeless Individuals (CABHI) States Grant and CABHI Supplement

Description

The ultimate goal of the first CABHI States Grant program is to reduce chronic homelessness by increasing access to permanent housing, engagement and retention in treatment for those with the primary diagnosis of a substance use disorder who may also have a co-occurring mental illness. In addition the grant provides for supportive services to maintain permanent housing, and access to mainstream resources. The CABHI States supplement then added the ability to provide treatment and support services to those with the primary diagnosis of mental illness who may be dually disordered with a substance use disorder and to provide these same services to Veterans with either a mental illness, substance use disorder or both. Veterans served in this grant can be either homeless or chronically homeless.

General Requirements

- Completion of online application for new providers or paper re-application as directed for existing providers. Application should include:
  - Mission/vision statement of the agency/organization
  - Organizational chart of the agency/organization
  - Agency/organization budget
  - Drug and Alcohol Free Workplace policy
  - Current inspections and certifications from Board of Health and Fire Marshal (not required for licensed clinical treatment, housing and childcare facilities since this paperwork is part of the annual license renewal process)
  - Proof of established links to other behavioral health or primary care organizations with existing reimbursements systems for covered services.
  - Proof of links to other systems that will assist the client with application to mainstream benefits such as SSI or Veterans benefits
  - Proof that SOAR services are provided
  - 2-5 page Program Summary narrative
  - Current financial statements completed by a CPA in good standing with the State Board of Certified Public Accountants of Louisiana
  - Disclosure of ownership
  - The following provider agreements:
    - DHH/OBH Direct Deposit (EFT) Authorization
    - DHH/OBH Direct Deposit (EFT) Account Information (a voided check or signed letter from a bank representative on the institution's letterhead must be included)
    - Louisiana Chronic Homelessness Assistance and Treatment Services Provider Requirements and Conditions
    - Louisiana Chronic Homelessness Assistance and Treatment Services (LaCHATS) Code of Conduct and Conduct Definitions
    - Provider Acceptance of LaCHATS Requirements and Conditions (must be notarized)
  - The following paperwork for all employees:
    - Employee Survey Form
    - Employee Acknowledgement of Code of Conduct
    - Resume

- Copies of all licenses/certifications.
- Professional Liability Insurance (as applicable)
- Louisiana Chronic Homelessness Assistance and Treatment Services Criminal Conviction Disclosure
- Criminal Background Check

- Must be incorporated with Louisiana Secretary of State as a corporation (for-profit or non-profit) or a limited liability company
- General liability insurance of $1 million for all clinical facilities and transportation, childcare, and housing recovery support providers; $500,000 of general liability insurance required for all other recover support providers.
- Computers with internet access and e-mail capability
- Completion of all mandatory training requirements outlined in Section 7.0 LaCHATS Provider Training Requirements

Clinical Treatment Components	Provider Eligibility	Eligibility Criteria
General Requirements	• Three letters of support from business associates, community leaders, consumers, and/or constituents. At least one letter must be from another funding source. If the provider has no other funding source, a strategic plan and efforts to obtain other funding must be described. Only one letter of support from a consumer (client) is permitted. • Adherence to the Substance Abuse-Addiction Treatment Facilities Minimum Standards licensing law at all times • Annual submission of renewal license Other requirements are listed for each service.	To be eligible, patients must meet one of the following criteria: ▪ Chronically homeless individuals with substance use disorder who may have a co-occurring mental disorder ▪ Chronically homeless individuals with a primary concern of mental illness ▪ Homeless veterans with mental illness, substance use disorder, or both
Licensed Substance Abuse/Addiction Treatment Facilities or BHSP	• Must be licensed as a Substance Abuse/Addiction Treatment Facility or BHSP by DHH, Health Standards Section. • If not licensed as a Substance Abuse/Addiction Treatment Facility or BHSP, must have licensed mental health practitioners with experience in providing treatment for substance use disorders. • Six months of operation as a licensed Substance Abuse/Addiction Treatment Facility or BHSP prior to being accepted as provider required	
Outpatient/ Intensive Outpatient	• Licensed through the Bureau of Health Standards. Staff qualified and licensed as appropriate • Compliance with all applicable provisions of LAC 48:I.Chapter 74. • Intensive Outpatient alcohol and/or drug use treatment with or without medication, totaling at least 9 clinical contact hours/week and at least 3 days/week. • Outpatient alcohol and/or drug use treatment services with or without medications at prescribed intervals that are less intensive and continue for a greater period of time than intensive outpatient.	

	• Provide recovery aftercare and rehabilitation services, including counseling and supportive services. • Provide outreach services for social, mental and physical health issues and link to referral services as part of a comprehensive treatment plan.	
Comprehensive Assessment Providers	• Trained by an OBH designated trainer or by the in-house training protocol (see Section 7.0 LaCHATS Provider Training Requirements) and approved by OBH to use the Addiction Severity Index (ASI) for adults. • Trained by an OBH designated trainer and/or approved in Patient Placement Decision Making and Writing Clinical Justifications. • Completion of all re-certification trainings as mandated by OBH.	
Recovery Support Services	**Provider Eligibility**	**Eligibility Criteria**
Recovery Support Caregiver	• Compliance with 42 CFR, Part 2 and HIPAA disclosure and signature requirements • Meet licensure, certification, registration or accreditation requirements, as appropriate, or if this does not apply, have experience in providing the service they seek to offer for a minimum of six (6) months • Operate according to an OBH approved curriculum, plan, or agenda.	To be eligible, patients must meet one of the following criteria: ▪ Chronically homeless individuals with substance use disorder who may have a co-occurring mental disorder ▪ Chronically homeless individuals with a primary concern of mental illness ▪ Homeless veterans with mental illness, substance use disorder, or both
Peer Navigators and Peer Support Specialists	• Minimum of a high school diploma required; college degree preferred. • Minimum of 3 years experience in case management. • Will have lived experience in recovery from substance use disorders, mental health disorders, and/or homelessness and demonstrate successful recovery and ability to navigate public health systems • Successful completion of OBH-recognized Certified Peer Support Specialist Training • Veterans preferred for hiring of Peer Navigators and Peer Support Specialists for the supplement.	
Case Manager	• Minimum of 3 years case management experience • Relevant experience working with the chronically homeless and persons with behavioral health disorders, to include substance use disorders and mental health disorders • Successful completion of an OBH-recognized Certified Peer Support Specialist training. • Minimum of a high school diploma required; preferably a college degree	

Transportation	• Use/own a vehicle suitable for transporting clients as determined by the Manager. Pick-up trucks and two-door car are not permitted. • Drivers must be over 21 years of age and possess a Louisiana Chauffeurs' License (Class D or higher) from the Office of Motor Vehicles • Must submit a current copy of each driver's online driver record from the Office of Motor Vehicles • Each driver must submit proof of successfully completing a National Safety Council approved Defensive Driving course. • Complete the LACHATS Driver Information Form for each agency driver. • Initial and sign the LACHATS Transportation Requirements and Conditions. • Maintain commercial automobile liability of $100,000 per person and $300,000 per accident or a combined service limit of $300,000 at the minimum in addition to the general liability insurance policy. • Submit a certificate of insurance for commercial automobile liability and commercial general liability stating that the policy has been paid in advance for a minimum of 90 days. Insurance identification cards and insurance binders are not acceptable. • Submit all required paperwork for any additional vehicles used/owned and/or new employees/drivers while an LACHATS provider. • OBH cannot be billed for transporting clients to inherently religious activities, such as worship activities, church, bible study, or church choir practice	
Permanent Supportive Housing	• No arbitrary limits for the length of a tenant's stay as long as the tenant complies with the lease requirements consistent with Louisiana landlord tenant law • Must offer a range of supportive services aimed at promoting recovery from mental and/or substance use disorders • SAMHSA considers the following programs funded under HUD's McKinney Vento programs to be permanent supportive housing: Shelter Plus Care (including tenant-based rental assistance, sponsor-based rental assistance, project-based rental assistance and single room occupancy) and the Supportive Housing Program's (SHP's) permanent supportive housing. • A person in housing funded through the Housing Opportunities for Persons with AIDS program may be eligible if (s)he was chronically homeless prior to entering the program and is provided with permanent housing.	

	• If permanent housing is funded through a resource other than HUD, must provide a letter from the funding source verifying the following: a current, executed grant agreement; a brief description of the funding source, including any funding requirements and/or restrictions; amount of funding provided per year for the applicant's permanent supportive housing program; type of supportive housing and number of units provided; amount program participants pay from their income toward housing; and information about the consumer's choice in housing, option in level and type of services received, and tenancy rights	
Job Readiness-Education and Employment Supports	• Operate based on an OBH approved curriculum, plan, or agenda, and sessions should be planned systematically and in advance. • A session should last a minimum of 45 minutes. • A session may be an individual session or a small group setting that does not exceed 25 participants. • Inherently religious activities, such as worship activities, church, church choir practice, or bible study, may not be billed to OBH as job readiness or any other recovery support services.	
Life Skills	• Must operate based on an OBH approved curriculum, plan, or agenda. Sessions should be planned systematically and in advance. • A session may be an individual session or a small group setting that does not exceed 25 participants. • A session should last a minimum of 45 minutes. • Inherently religious activities, such as worship activities, church, church choir practice, or bible study, may not be billed to OBH as life skills or any other recovery support services.	

Addenda

Addendum A: Medical necessity definition

Medical Necessity Criteria

A. Medically necessary services are defined as those health care services that are in accordance with generally accepted evidence-based medical standards or that are considered by most physicians (or other independent licensed practitioners) within the community of their respective professional organizations to be the standard of care.

B. In order to be considered medically necessary, services must be:

   (1) Deemed reasonably necessary to diagnose, correct, cure, alleviate or prevent the worsening of a condition or conditions that endanger life, cause suffering or pain or have resulted or will result in a handicap, physical deformity or malfunction.

   (2) Those for which no equally effective, more conservative and less costly course of treatment is available or suitable for the recipient.

C. Any such services must be individualized, specific and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment and neither more nor less than what the recipient requires at that specific point in time.

D. Services that are experimental, non-FDA approved, investigational or cosmetic will be deemed "not medically necessary".

Addendum B: Additional service criteria for EBPs

Assertive Community Treatment (ACT) service description and requirements
Service definition: ACT services are therapeutic interventions that address the functional problems of individuals who have the most complex and/or pervasive conditions associated with a major mental illness or co-occurring addictions disorder. These interventions are strength-based and focused on promoting symptom stability, increasing the individual's ability to cope and relate to others and enhancing the highest level of functioning in the community.

Interventions may address adaptive and recovery skill areas, such as supportive or other types of housing, school and training opportunities, daily activities, health and safety, medication support, harm reduction, money management and entitlements and service planning and coordination.

a. The primary goals of the ACT program and treatment regimen are:

- To lessen or eliminate the debilitating symptoms of mental illness each individual consumer experiences and to minimize or prevent recurrent acute episodes of the illness
- To meet basic needs and enhance quality of life
- To improve functioning in adult social and employment roles and activities
- To increase community tenure
- To lessen the family's burden of providing care

b. The fundamental principles of this program are that:

- The ACT team is the primary provider of services and, as such, functions as the fixed point of responsibility for the consumer
- Services are provided in the community
- The services are person-centered and individualized to each particular person

Target population
ACT serves persons who have a serious and persistent mental illness (SPMI) listed in the diagnostic nomenclature (current diagnosis per DSM 5) that seriously impairs their functioning in the community.

a. The individual must have one of the following diagnoses:
   - Schizophrenia
   - Other psychotic disorder
   - Bipolar disorder
   - Major depressive disorder

b. These may also be accompanied by any of the following:
   - Substance use disorder
   - Developmental disability

c. Include one or more of the following service needs:
   - Two or more acute psychiatric hospitalization and/or four or more emergency room visits in the last six months

- Persistent and severe symptoms of a psychiatric disability that interferes with the ability to function in daily life
- Two or more interactions with law enforcement in the past year for emergency services due to mental illness or substance use (this includes involuntary commitment, ACT/forensic assertive community treatment [FACT])
- Currently residing in an inpatient bed, but clinically assessed to be able to live in a more independent situation if intensive services were provided
- One or more incarcerations in the past year related to mental illness and/or substance use (FACT)
- Psychiatric and judicial determination that FACT services are necessary to facilitate release from a forensic hospitalization or pre-trial to a lesser restrictive setting (FACT)
- Recommendations by probation and parole, or a judge with a FACT screening interview, indicating services are necessary to prevent probation/parole violation (FACT)

d. Must have one of the following:
   - Inability to participate or remain engaged or respond to traditional community-based services
   - Inability to meet basic survival needs, or residing in substandard housing, homeless or at imminent risk of becoming homeless
   - Services are necessary for diversion from forensic hospitalization, pretrial release or as a condition of probation to a lesser restrictive setting (FACT)

e. Must have three (3) of the following:
   - Evidence of co-existing mental illness and substance use/dependence
   - Significant suicidal ideation, with a plan and ability to carry out within the last two (2) years
   - Suicide attempt in the last two (2) years
   - History of violence due to untreated mental illness/substance use within the last two (2) years
   - Lack of support systems
   - History of inadequate follow-through with treatment plan, resulting in psychiatric or medical instability
   - Threats of harm to others in the past two (2) years
   - History of significant psychotic symptomatology, such as command hallucinations to harm others
   - Global assessment of functioning of 50 or less

f. Exception criteria:
   - The individual does not meet medical necessity criteria I or II, but is recommended as appropriate to receive ACT services by the funding agency or designee, the ACT team leader, clinical director and psychiatrist, in order to protect public safety and promote recovery from acute symptoms related to mental illness

Program requirements
ACT services must be provided by an interdisciplinary team. Individuals on this team shall have sufficient individual competence, professional qualifications and experience to provide service coordination; crisis assessment and intervention; symptom assessment and management; individual counseling and psychotherapy; medication prescription, administration, monitoring and documentation; substance use treatment; work-related services; activities of daily living services; social, interpersonal relationship and leisure-time activity services; support services or direct assistance to ensure that individuals obtain the basic necessities of daily life; direct assistance to ensure that individuals obtain supportive housing, as needed; and education, support, and consultation to individuals' families and other major supports. ACT is a medical, comprehensive case management and psychosocial intervention program provided on the basis of the following principles:

1. The service is available 24 hours a day, seven days a week

2. An individualized service plan and supports are developed

3. At least 90% of services are delivered as community-based outreach services

4. An array of services are provided based on individual patient medical need

5. The service is consumer-directed

6. The service is recovery-oriented

The ACT team must:

1. Operate a continuous after-hours on-call system with staff that is experienced in the program and skilled in CI procedures. The ACT team must have the capacity to respond rapidly to emergencies, both in person and by telephone.

2. Provide mobilized CI in various environments, such as the recipient's home, schools, jails, homeless shelters, streets and other locations.

3. Arrange or assist consumers to make a housing application, meet their housing obligations and gain the skills necessary to maintain their home.

4. Be involved in psychiatric hospital admissions and discharges and actively collaborate with inpatient treatment staff.

The ACT program provides three levels of interaction with the participating individuals:

1. Face-to-face encounter – At least 60% of all ACT team activities must be face-to-face, with approximately 90% of these encounters occurring outside of the office.

2. Collateral encounter – Collateral refers to members of the recipient's family or household or significant others (e.g., landlord or property manager, criminal justice staff and employer) who regularly interact with the recipient and are directly affected by, or have the capability of affecting, his or her condition and are identified in the service plan as having a role in treatment. A collateral contact does not include contacts with other mental health service providers or individuals who are providing a paid service that would ordinarily be provided by the ACT team (e.g., meeting with a shelter staff person who is assisting an ACT recipient in locating housing).

3. Assertive outreach – Refers to the ACT team being 'assertive' about knowing what is going on with an individual and acting quickly and decisively when action is called for, while increasing client independence. The team must closely monitor the relationships that the individual has within the community and intervene early if difficulty arises.

ACT staff must provide a minimum of six encounters with the service recipient or collateral contacts monthly and must document clinically appropriate reasons if this minimum number of encounters can not be made monthly.

The teams will provide comprehensive, individualized services, in an integrated, continuous fashion, through a collaborative relationship with persons with SPMI.

The ACT program utilizes a treatment model that is non-confrontational, follows behavioral principles, considers interactions of mental illness and substance use and has gradual expectations for abstinence.

The teams will provide the following supports and services to consumers:

1. Needs assessment and individualized care plan development:
This will include items relevant for any specialized interventions, such as linkages with the forensic system for consumers involved in the judicial system. In particular, the assessment will include items related to court orders, which must be identified within 30 days of admission and updated every 90 days or as new court orders are received.

2. Crisis assessment and intervention.

3. Symptom management and mediation.

4. Individual counseling.

5. Medication administration, monitoring, education and documentation.

6. Skills training in activities related to self-care and daily life management, including utilization of public transportation, maintenance of living environment, money management, meal preparation, locating and maintaining a home, skills in landlord/tenant negotiations and renter's rights and responsibilities.

7. Social skills training necessary for functioning in a work, educational, leisure or other community environment.

8. Peer support.

9. Addiction treatment and education, including counseling, relapse prevention, harm reduction, anger and stress management.

10. Referral and linkage or direct assistance to ensure that individuals obtain the basic necessities of daily life, including medical, social and financial supports.

11. Education, support and consultation to individuals' families and other major supports.

12. Monitoring and follow-up to help determine if psychiatric, substance use, mental health support and health related services are being delivered, as set forth in the care plan, adequacy of services in the plan and changes, needs or status of consumer.

13. The team will assist the consumer in applying for benefits. This includes Social Security Income, Medicaid and Patient Assistance Program enrollment.

14. For those clients with forensic involvement, the team will liaise with the forensic coordinators, providing advocacy, education and linkage with the criminal justice system to ensure the consumer's needs are met in regards to their judicial involvement, and that they are compliant with the court orders.

15. Service provision for ACT will be based on comprehensive history and ongoing assessment of:
    a. Psychiatric history, status and diagnosis
    b. Level of Care Utilization System (LOCUS)
    c. Telesage Outcomes Measurement System, as appropriate
    d. Psychiatric evaluation
    e. Housing and living situation
    f. Vocational, educational and social interests and capacities

g. Self-care abilities
h. Family and social relationships
i. Family education and support needs
j. Physical health
k. Alcohol and drug use
l. Legal situation
m. Personal and environmental resources

Each of these assessments will be completed within 30 days of admission. The LOCUS, psychiatric evaluation and treatment plan will be updated every six months, with an additional LOCUS score being completed prior to discharge.

Provider qualifications for all ACT teams
Each ACT team shall have sufficient numbers of staff to provide treatment, rehabilitation and support services 24 hours a day, seven days per week. Each ACT team shall have the capacity to provide the frequency and duration of staff-to-program participant contact required by each recipient's individualized service plan.

Each ACT team shall have the capacity to increase and decrease contacts based upon daily knowledge of the program participant's clinical need, with a goal of maximizing independence. The team shall have the capacity to provide multiple contacts to persons in high need and a rapid response to early signs of relapse. The nature and intensity of ACT services are adjusted through the process of daily team meetings. Each ACT team shall include at least:

- One qualified ACT team leader
- One board-certified or board-eligible psychiatrist
- Two nurses, at least one of whom shall be a RN
- One other licensed mental health professional
- One substance use service provider
- One employment specialist
- One housing specialist
- One peer specialist

Each ACT team shall have a staff-to-individual ratio that does not exceed 10:1. Any ACT team vacancies that occur will be filled in a timely manner to ensure that these ratios are maintained. All professional staff must be currently and appropriately licensed by the applicable professional board. Prior to providing the service, each member receives an assessment of initial training needs based on the skills and competencies necessary to provide ACT services. Each staff person must meet the required skills and competencies within six months of their employment on an ACT team. Successful completion of DHH-approved ACT team training can satisfy this requirement.

Planning and documentation requirements:
A comprehensive assessment must be completed within 40 days of admission to the program. A service plan, responsive to the individual's preferences and choices and signed by the individual, must be developed and in place at the time services are rendered. Each individual service plan must consist of the following:

1. The individual's specific mental illness diagnosis.

2. Plans to address all psychiatric conditions.

3. The individual's treatment goals and objectives (including target dates), preferred treatment approaches and related services.

4. The individual's educational, vocational, social, wellness management, residential or recreational goals, associated concrete and measurable objectives and related services.

5. The individual's goals and plans, and concrete and measurable objectives necessary for a person to get and keep their housing.

6. When psycho-pharmacological treatment is used, a specific service plan, including identification of target symptoms, medication, doses and strategies to monitor and promote commitment to medication, must be used.

7. A crisis/relapse prevention plan, including an advance directive.

8. An integrated substance use and mental health service plan for individuals with co-occurring disorders.

Documentation shall be consistent with the ACT Fidelity Scale. The individual service plan will include input of all staff involved in treatment of the individual, as well as involvement of the individual's and collateral others' of the individual's choosing. In addition, the plan must contain the signature of the psychiatrist, the team leader involved in the treatment and the individual's signature (refusals must be documented). The individual service plan is reviewed and updated every six months. A tracking system is expected of each ACT team for services and time rendered for or on behalf of any individual.

Exclusions:
ACT services are comprehensive of all other services, with the exception of psychological evaluation or assessment and medication management. These may be provided and billed separately for a recipient receiving ACT services.

ACT shall not be billed in conjunction with the following services:

1. Behavioral health services by licensed and unlicensed individuals, other than medication management and assessment.

2. Residential services, including professional resource family care.

Note: Individualized substance use treatment will be provided to those consumers for whom this is appropriate; co-occurring disorder treatment groups will also be provided off-site of the ACT administrative offices, though they do not take the place of individualized treatment. Substance use/mental health treatment will also include dialectical behavioral therapy, CBT and motivational enhancement therapy.

Multi-systemic therapy (MST)

The provider agency must have a current license issued by the MST Services, Inc. The licensed entity has agreed to assume responsibility for this service under its license. The provider contracts with MST Services, Inc. for training, supervision and monitoring of services. This occurs primarily through a MST national consultant. The provider will also have a contractual relationship with MST Services, Inc. allowing the provider to deliver the licensed MST model.

Definition:
Multi-systemic therapy provides an intensive home/family and community-based treatment for youth who are at risk of out-of-home placement or who are returning from out-of-home placement. The MST model is based on empirical data and evidence-based interventions that target specific behaviors with individualized

behavioral interventions. Services are primarily provided in the home, but workers also intervene at school and in other community settings.

Target population characteristics:
MST services are targeted for youth primarily demonstrating externalizing behaviors, such as conduct disorder, antisocial or illegal behavior or acts that lead to costly and, oftentimes, ineffective out-of-home services or excessive use of child-focused therapeutic support services. Depression and other disorders are considered, as long as the existing mental and behavioral health issues manifest in outward behaviors that impact multiple systems (i.e., family, school, community). Youth with substance use issues may be included if they meet the criteria below, and MST is deemed clinically more appropriate than focused drug and alcohol treatment.

- Referral/target ages of 12-17 years
- Youth exhibits significant externalizing behavior, such as **chronic or violent juvenile offenses**
- Child is at risk for out-of-home placement or is transitioning back from an out-of-home setting
- Externalizing behaviors symptomatology, resulting in a DSM-5 diagnosis of conduct disorder or other diagnoses consistent with such symptomatology (octachlorodibenzo-p-dioxin, behavioral disorder not otherwise specified, etc.)
- Ongoing multiple system involvement due to high risk behaviors and/or risk of failure in mainstream school settings due to behavioral problems
- Less intensive treatment has been ineffective or is inappropriate
- The youth's treatment planning team recommends that he/she participate in MST
- Functional impairment must not solely be a result of pervasive developmental disorder or mental retardation

MST services may not be clinically appropriate for individuals who meet the following conditions:

1. Youth who meet the criteria for out-of-home placement due to suicidal, homicidal or psychotic behavior.

2. Youth living independently, or youth whom a primary caregiver cannot be identified despite extensive efforts to locate all extended family, adult friends or other potential surrogate caregivers.

3. The referral problem is limited to serious sexual misbehavior.

4. Youth has a primary diagnosis of autism spectrum disorder or mental retardation.

5. Low-level need cases.

6. Youth who have previously received MST services or other intensive family- and community-based treatment.

   Exception: Youth may be allowed an additional course of treatment if all of the following criteria are met:
   a. MST program eligibility criteria are currently met
   b. Specific conditions have been identified that have changed in the youth's ecology, compared to the first course of treatment
   c. It is reasonably expected that successful outcomes could be obtained with a second course of treatment
   d. Program entrance is subject to prior authorization by the ASO

Criteria for continuing services

Individuals receiving MST services must meet all of the following criteria for continuing treatment with MST:

1. Treatment does not require more intensive level of care.

2. The treatment plan has been developed, implemented and updated based on the youth's clinical condition and response to treatment, as well as the strengths of the family, with realistic goals and objectives clearly stated.

3. Progress is clearly evident in objective terms, but goals of treatment have not yet been achieved, or adjustments in the treatment plan to address the lack of progress are evident.

4. The family is actively involved in treatment, or there are active, persistent efforts being made which are expected to lead to engagement in treatment.

Criteria for discharge from services

Individuals who meet the following criteria no longer meet medical necessity criteria for MST and shall be discharged from MST treatment:

1. The recipient's treatment plan goals or objectives have been substantially met.

2. The recipient meets criteria for a higher or lower level of treatment, care or services.

3. The recipient, family, guardian and/or custodian are not engaging in treatment or not following program rules and regulations, despite attempts to address barriers to treatment.

4. Consent for treatment has been withdrawn, or youth and/or family have not benefitted from MST, despite documented efforts to engage, and there is no reasonable expectation of progress at this level of care, despite treatment.

Philosophy* and *treatment approach

The MST approach views individuals as being surrounded by a natural network of interconnected systems that encompass individual, family and extra-familial (peer, school and neighborhood) factors. The MST approach believes that it is often necessary to intervene in a number of these systems to achieve positive results. All interventions implemented during treatment come from evidenced-based treatment approaches. Through a combination of direct service contacts and collateral contacts, significant improvement in family functioning occurs, thereby reducing the need for continued professional services.

MST is based on the philosophy that the most effective and ethical way to help children and youth is by helping their families. MST views caregivers as valuable resources, even when they have serious and multiple needs of their own. One goal of MST is to empower caregivers to effectively parent their children. MST treatment reaches across all of the youth's life domains and is highly individualized around each case, as described below.

MST treatment principles

1. The primary purpose of assessment is to understand the fit between the identified problems and their broader systemic context.

2. Therapeutic contacts emphasize the positive and use systemic strengths as levers for change.

3. Interventions are designed to promote responsible behavior and decrease irresponsible behavior among family members.

4. Interventions are present-focused and action-oriented, targeting specific and well-defined problems.

5. Interventions target sequences of behavior within and between multiple systems that maintain the identified problems.

6. Interventions are developmentally appropriate and fit the developmental needs of the youth.

7. Interventions are designed to require daily or weekly efforts by family members.

8. Intervention effectiveness is evaluated continuously from multiple perspectives, with the provider assuming accountability for overcoming barriers to successful outcomes.

9. Interventions should be designed to promote treatment generalization and long-term maintenance of therapeutic change by empowering caregivers to address family members' needs across multiple systemic contexts.

These nine principles guide treatment and the development of interventions to address referral behaviors. The treatment theory draws from social-ecological and family systems theories of behavior. Supervision and consultation to staff are focused on facilitating use of the MST model, and a variety of measures are in place to monitor a program's adherence to the MST model and ensure that fidelity to the model is maintained to the greatest extent possible (as described below).

Goals
MST is designed to accomplish the following:

1. Reduce the frequency of referral behaviors and increase pro-social behaviors, reduce symptoms, maladaptive and externalizing behaviors, so that the child/youth can be treated in a lower level of community-based care. Child/youth no longer demonstrating ongoing risk of deliberate attempts to inflict serious injury on self or others.

2. Decrease association with deviant peers and increase association with pro-social peers and involvement in positive recreational activities.

3. Help caregivers develop effective parenting skills and skills to manage the consumer's mental health needs, improve caregiver decision-making and limit setting.

4. Improve family relationships.

5. Improve school or vocational success, as indicated by improved grade point average, a decrease in disciplinary referrals, unexcused absences and tardies and/or a decrease in job terminations.

6. Support involvement in restorative measures, such as community services, if involved with Juvenile Justice (Office of Children, Youth and Families resources will oversee and fund the participation in restorative measures, rather than the MST service provider).

7. Reduce likelihood of out-of-home placement and reduce the utilization of out-of-home therapeutic resources (i.e., therapeutic foster care, residential treatment facility, etc.).

8. Develop natural supports for the consumer and family.

Specific treatment goals will always be individualized and tied to behavioral health needs.

Specific design of the service:
On average, a youth receives MST for three to six months but, typically, no longer than six months. The therapist meets with the youth or family at least weekly but often multiple times per week, depending on need. Families typically see therapists less frequently as they get closer to discharge. On average, families receive about 60 hours of face-to-face treatment over a four-month period, as well as about 35 hours of non-direct contact provided to the ecology of the youth (e.g., consultation and collaboration with other systems). Services occur in the family's home or community at times that are convenient for the family. Staff members are expected to work on weekends and evenings, for the convenience of their clients. Therapists and/or their supervisors are on call for families 24/7. Supervisors are available to therapists around-the-clock for support. Each therapist carries a small caseload (four to six families) at any one time.

MST includes:

- Assessment
- Ongoing treatment planning
- Family therapy
- Parent counseling (related to empowering caregivers to parent effectively and address issues that pose barriers to treatment goals)
- Consultation to and collaboration with other systems, such as school, juvenile probation, children and youth and job supervisors
- Individual therapy may occur but is not the primary mode of treatment
- Referral for psychological assessment, psychiatric evaluation and medication management, if needed

MST therapists do not provide individual therapy to caregivers or other family members, nor do they provide marital therapy beyond addressing couples' issues that directly impact the youth's treatment.

MST is a practical and goal-oriented treatment that specifically targets the factors in a youth's social network that are contributing to the problem behaviors. Specific treatment techniques draw from therapies with the most empirical support, such as cognitive, cognitive behavioral, behavioral and pragmatic family therapies, such as structural family therapy. Interventions are developed based on an assessment of the "fit" for a specific behavior (specifically, what factors are driving the behavior, which are always individualized). Interventions always target specific, well-defined problems, focus on present conditions and are action-oriented. Families are often given "assignments" that require daily or weekly efforts, capitalize on strengths, build skills and encourage responsible behavior by the youth and family. By empowering caregivers to address their families' needs, MST interventions promote generalization and maintenance of positive changes. The help of natural supports, such as extended family or school, is often enlisted. Therapists are totally responsible for engaging the family and other key participants in the youth's environment (e.g., teachers, school administrators, community members, workers from agencies with mandated involvement). MST requires a solution-focused, strengths-based orientation from therapists.

The effectiveness of interventions is closely monitored from week-to-week from multiple perspectives (e.g., caregivers, identified youth, teachers and the MST team). While overarching goals are established at the beginning of treatment, specific, measurable objectives are set each week. Family members and therapists work together to design the treatment plan, which ensures family involvement. However, therapists and the provider agency are held accountable for achieving change and for positive case outcomes.

The MST program has a hands-off policy and does not utilize any restraints or restrictive procedures.

Description of individualization for youth and family

Treatment planning
Upon receiving a referral and before services begin, a child and family team (CFT) meeting is scheduled, and an initial treatment plan is developed based off the RSS plan from the ASO. A licensed practitioner must recommend and oversee the service on an ongoing basis. Required information is sent to the behavioral health-administrative services organization (ASO) to request prior authorization, usually for six months of service.

The CFT includes the client, family, referral source, a representative of the ASO and representatives of other systems involved with the child (e.g., OJJ, DCFS, OBH). If the youth presents with behavioral issues impacting school, a representative of the school district is asked to participate. The team may also include friends, extended family and any other parties requested by the youth and caregiver(s).

The treatment plan is developed by the CFT, based on the referral behaviors and the goals of the youth and family. The treatment plan is discussed, put into writing by the MST therapist and signed by the caregiver and the youth, if age 14 or older. Overarching goals are established at the beginning of treatment, while specific objectives are updated each week and closely monitored.

Cultural concerns:
MST treatment is attuned to the importance of ethnicity and culture for all clients referred for services. Cultural values and concerns should be reflected in the MST therapist's assessment of the youth and family and incorporated into interventions, as appropriate. Weekly clinical supervision should include responsiveness to problems related to racism or discrimination. Cultural competence may be addressed in MST booster trainings if it is identified as an area of need by the MST supervisor and system supervisor.

Child integration to community:
The treatment objectives must demonstrate that MST focuses on community integration by striving to reduce out-of-home placements, improve school attendance and academic success and build natural supports for the family and so on.

By maintaining the youth within the community, the least restrictive environment, MST treatment interventions strengthen the family and youth's relationship with community resources and the people managing them. This is important for creating sustainable treatment outcomes. Also, the MST model is strengths-focused and competency-based in its treatment approach. The general goal of MST is to promote increased emotional and social health in youth and families.

Provider qualifications:
Agencies must be licensed to provide MST services by MST Services, Inc. or any of its approved subsidiaries. An MST agency must be a behavioral health/substance use provider organization, which is a legally recognized entity in the United States and is qualified to do business in Louisiana and, though serving the uninsured, meets the standards established by the Bureau of Health Services Financing (BHSF) or its designee.

The provider will provide all client services. MST therapists and supervisors are employees of the provider. Ultimate responsibility for services provided lies with the provider. The provider contracts with a network partner for training, supervision and monitoring of services. This occurs primarily through an MST system supervisor provided by the network partner. Network partner status, granted to the network partner's MST program by MST Services, Inc. allows for the development of MST teams supported and monitored directly

by the network partner. The provider also has a contractual relationship with MST Services, Inc. allowing the provider to deliver the licensed MST model.

Staff education level/qualifications and training topics

Education/qualifications:
The MST program at the provider consists of one or more MST teams, each with an MST clinical supervisor and two to four MST therapists. There is a system supervisor from the network partner, who is responsible for the clinical fidelity of the MST team. All staff will have background checks on file before working alone with youth and families.

A. MST clinical supervisor: The supervisor for an MST team is an independently licensed master-level mental health professional with a graduate degree in a clinical mental health field and experience providing mental health treatment. A minimum of three years experience is preferred. The supervisor facilitates weekly team supervision, reviews weekly case summaries in preparation for supervision and is available to therapists 24/7. The MST supervisor will, at times, take therapy cases, if needed, due to demand and staff availability. A full-time supervisor may supervise two teams; a half-time supervisor may supervise one team. Clinical services and supervision must be provided by licensed behavioral health practitioners in accordance with their respective licensing board regulations. All practitioners must hold an unrestricted Louisiana license.

B. MST therapist: Therapists are master-level mental health professionals with graduate degrees in a clinical field, a background in family, youth and community service and a minimum of two years experience preferred. Highly skilled bachelor's-level professionals may be selected, with certain hiring conditions. These conditions include: (1) education in a human services field, (2) a minimum of three years experience working with family and/or children/youth services and (3) the provider has actively recruited for master-level therapists but has not found any acceptable candidates *or* the bachelor's-level applicant is clearly better qualified than the master-level applicants. Bachelor's level staff must have a degree in social work, counseling, psychology or a related human services field and must have at least three years of experience working with the target population (children/adolescents and their families) Therapists are responsible for providing direct service to a caseload of four to six families. The expectation is that the usage of bachelor's-level staff will not exceed one bachelor's-level staff person for every two master-level staff persons per team.

C. MST system supervisor (MST consultant from the network partner): The system supervisor is a master-level, mental health professional with a graduate degree in a clinical field and experience as an MST clinical supervisor. The system supervisor provides weekly clinical consultation to the MST teams, monthly clinical consultation to the MST supervisors, quarterly booster trainings for the MST teams and monitors adherence to the MST model. A network manager from MST Services, Inc. is assigned to the network partner to monitor and train system supervisors.

Training:
System supervisors are responsible for the training of MST therapists and MST clinical supervisors. All therapists and supervisors attend a 30-hour (five-day) MST orientation training within two months of hire. This training covers such topics as: engagement and alignment, parent–child interventions, marital interventions, school-based interventions, confidentiality and ethics, peer interventions, social supports, individual interventions, safety issues, substance use interventions and psychiatric consultation. All participants take a test at the end of the training week. Individual results of the tests are used to identify areas of strength and weakness for continued clinical development.

Booster trainings are conducted for one and a half days each quarter. The entire MST team attends a full day of booster training (minimum seven hours), while the half-day (minimum three and a half hours) may be attended by the entire team or only the supervisors. Topics for booster trainings are derived from planning discussions between the system supervisor and MST clinical supervisors as they reflect on challenges over the previous months. Examples of booster trainings include family contracting, interventions for families affected by divorce, safety planning, preventing burnout, caregiver substance use and school-based assessment and intervention. Orientation and booster trainings are led by MST-licensed system supervisors.

Supervision:
Intensive supervision and clinical consultation are an integral part of the MST model and are focused on promoting consistent application of the MST model to all cases. Training is monitored through the licensing agreements and contractual arrangement that the provider has with the network partner, and they with MST Services, Inc.

Supervision and consultation in MST includes the following:

- MST therapists receive weekly team supervision with their MST supervisor, typically lasting two hours. If an MST supervisor has two teams, supervision is provided separately to each team. Prior to supervision meetings, the supervisor reviews weekly case summaries, makes notes and creates an agenda for the supervision meeting.

- Each MST team receives weekly telephone consultation from an MST system supervisor, typically for one hour. Each week the system supervisor reviews case summaries and MST clinical supervisor notes, in preparation for the consultation session.

- Each MST therapist has a clinical plan (professional development plan) to guide him/her to effective levels of MST adherence.

- MST clinical supervisors are available around-the-clock to provide support to MST therapists.

- The MST clinical supervisors receive monthly telephone consultation from the system supervisor to monitor and develop their supervisory effectiveness. This supervision involves close review of audiotapes of supervision sessions and case reviews.

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

> ***Therapist Adherence Measure-Revised (TAM-R):*** This is an objective, standardized instrument that evaluates a therapist's adherence to the MST model as reported by the primary caregiver of the family. It has been shown to have significant value in measuring a MST therapist's adherence to MST principles and to predicting treatment outcomes. The TAM-R has been validated in clinical trials with serious chronic, juvenile offenders and is now implemented by all licensed MST programs. The TAM-R takes 10 to 15 minutes to complete. It is administered during the second week of treatment and every four weeks thereafter. A staff person will contact the family in-person or by phone to complete the measure. Data is entered onto an online database managed by the MST Institute, and results are reviewed by the MST supervisor and therapist.
>
> ***Supervisor Adherence Measure (SAM):*** This measure evaluates the MST clinical supervisor's adherence to the MST model of supervision. This 10 to 15 minute measure is completed by MST therapists, who are prompted to complete the SAM every two months and enter their responses

directly onto the on-line database. Results are shared with the MST system supervisor, who then shares a summary of the feedback with the MST clinical supervisor during a consultation meeting.

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

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

Exclusions:
MST services are comprehensive of all other services, with the exception of psychological evaluation or assessment and medication management. These may be provided and billed separately for a recipient receiving MST services.

MST shall not be billed in conjunction with the following services:

1. Behavioral health services by licensed and unlicensed individuals, other than medication management and assessment.

2. Residential services, including professional resource family care.

Homebuilders®
The provider agency must be an approved Homebuilders® provider for Louisiana. The licensed entity has agreed to assume responsibility for this service under its license. The provider contracts with Institute for Family Development (IFD) for training, supervision and monitoring of services. This occurs primarily through a Homebuilders® national consultant. The Institure for Family Development (IFD) provides training and consultation to teams as part of a contract with DCFS. Teams are expected to maintain Homebuilders® standards or they can be put on a Quality Improvement plan (and possible "probation."

Homebuilders® is an intensive, in-home Evidence-Based Program utilizing research based strategies (e.g. Motivational Interviewing, Cognitive and Behavioral Interventions, Relapse Prevention, Skills Training), for families with children (birth to 18 years) at imminent risk of out of home placement (requires a person with placement authority to state that the child is at risk for out of home placement without Homebuilders), or being reunified from placement. Homebuilders® is provided through the Institute for Family Development (IFD). Homebuilders® participants demonstrate the following characteristics:

- Children/youth with serious behavioral and/or emotional problems in the home, school, and/or community;
- Family members with substance use problems, mental health problems, poverty-related concerns (lack of adequate housing, clothing and/or food);
- Babies that were born substance-exposed or considered failure to thrive
- Teenagers/adolescents that runaway from home, have suicidal risk, have attendance and/or behavioral problems at school, have drug and alcohol use, and/or experience parent-teen conflict(s);
- Children/youth who have experienced abuse, neglect, or exposures to violence or other trauma.

The primary intervention components of the Homebuilders® model are engaging and motivating family members, conducting holistic, behavioral assessments of strengths and problems, developing outcome-based goals. Therapists provide a wide range of counseling services using research-based motivation enhancement and cognitive behavioral interventions, teaching skills to facilitate behavior change and developing and enhancing ongoing supports and resources. In addition, therapists help families enhance their social support network and access basic needs such as food, shelter, and clothing. Homebuilders® programs have been successfully implemented in diverse and multi-ethnic/multicultural communities across the United States and other countries.

Homebuilders® consists of:

- Intensity: An average of 8 to 10 hours per week of face to face contact, with telephone contact between sessions. Services average 38 face to face hours. Therapists schedule sessions during the day, evening and on weekends with 3-5 or more sessions per week based on safety and intervention needs.
- Duration: Four to six weeks. Extensions beyond 4 weeks must be approved by the Homebuilders Consultant. Two aftercare 'booster sessions' totaling five hours are available in the six months following referral. Additional booster sessions can be approved by the Homebuilders Consultant.
- Crisis Intervention: Homebuilders® therapists are available 24/7 for telephone and face to face crisis intervention.
- Booster session: A Homebuilders® booster session is a home visit provided by the therapist to the family within 6 months of a successful intervention. The booster may be requested by the family, the referring worker or the provider. During the session, the therapist can reinforce skills learned during the intervention and help work through any issues (old or new). It's a way to check in with a family and offer support. It is not needed for every family, just those that are identified as needing this "boost."

Target population:
Goals of Homebuilders® are to reduce child abuse and neglect, family conflict, and child behavior problems, and improve parenting skills, family interactions, and family safety to prevent the imminent need for placement or successfully reunify children.

The Homebuilders® model is designed to eliminate barriers to service while using research-based interventions to improve parental skills, parental capabilities, family interactions, children's behavior, and well- being, family safety and the family environment.

The children are returning from, or at risk of, placement into foster care, group or residential treatment, psychiatric hospitals or juvenile justice facilities. Homebuilders® is specifically aimed toward children and families identified with:

- Caregiver and/or child emotional/behavioral management problems
- Trauma exposure
- Incorrigibility
- Academic problems
- Delinquency
- Truancy
- Running away
- Family conflict and violence
- Poor/ineffective parenting skills
- Single parent families
- Sibling antisocial behavior

- Parental/caregiver use of physical punishment, harsh, and/or erratic discipline practices
- Substance use
- Mental health concerns (depression/mood disorders, anxiety, etc.)
- Additional topics such as: poverty, lack of education, substandard housing, lack of supports and resources

Therapeutic goals

Goals of Homebuilders® are to improve parenting skills, family functioning, parent/caregiver and children's behavior and emotion management skill, increase safety of all family members, in order for children/youth to live safely at home.

Homebuilders® includes a homework/practice component:

- Homework is individually tailored based on family goals; usually includes practicing skills and implementing interventions.

The core program strategies are:

- **Engagement:** Use a collaborative and collegial approach, and Motivational Interviewing to engage and motivate families.
- **Assessment and Goal Setting:** Use client-directed assessment across life domains, ongoing safety assessment and planning, domestic violence assessment, suicide assessment, and crisis planning. Develop behaviorally specific and measurable goals, and specific service/treatment plans.
- **Behavior Change**: Use cognitive and behavioral research-based practices and interventions.
- **Skills Development:** Teach parents and children a wide variety of "life skills." Use "teaching interaction" process including demonstrations, practice, feedback; utilize homework to help parents and children practice new skills between visits
- **Concrete Services:** Provide and/or help the family access concrete goods and services that are directly related to achieving the family's goals, while teaching them to meet these needs on their own.
- **Community Coordination and Interactions:** Coordinate, collaborate, and advocate with state, local, public, and community services and systems affecting the family, while teaching clients to advocate and access support for themselves.
- **Immediate Response to Referral:** Accept referrals 24 hours a day, 7 days a week. Therapist and Supervisor are available 24-hours a day, 7 days a week.
- **Service Provided in the Natural Environment:** Provide services in the families' homes and communities.
- **Caseload Size:** Carry caseloads of two families at a time on average.
- **Flexibility and Responsiveness:** Tailor services and sessions to each family's needs, strengths, lifestyle, and culture.
- **Time-limited and low caseload.** Families receive four to six weeks of intensive intervention with up to two "booster sessions." Therapists typically serve two families at a time and provide 80 to100 hours of service, with an average of 38 hours of face-to-face contact with the family.
- **Strengths-based.** Therapists help clients identify and prioritize goals, strengths and values and help them use and enhance strengths and resources to achieve their goals.
- **Ecological/holistic assessment and individualized treatment planning.** Assessments of family strengths, problems and barriers to service/treatment and outcome-based goals and treatment plans utilized with each family.
- **Research-based treatment practices.** Therapists use evidence-based treatment practices, including motivational interviewing, behavioral parent training, cognitive behavioral therapy strategies and relapse prevention. Therapists teach family members a variety of skills, including child behavior management,

effective discipline, positive behavioral support, communication skills, problem-solving skills, resisting peer pressure, mood management skills, safety planning and establishing daily routines.

- **Support and resource building.** Therapists help families assess their formal and informal supports and develop and enhance ongoing supports and resources for maintaining and facilitating changes.
- **Critical thinking framework.** Therapists, supervisors and managers use a critical thinking framework for assessing, planning, implementing and evaluating progress and outcomes.

The North Carolina Family Assessment Scale (NCFAS or NCFAS-R R for reunification cases) is a tool utilized during treatment to summarize the overall assessment, and is used as a pre/post measurement tool to observe change, and to guide the service plan created for treatment.

Limitations:
When Homebuilders® is utilized for the clinical goals of a non-Medicaid individual or other goals consistent with the Homebuilders® model, the referring agency or the family will reimburse. Homebuilders® may also be used for stabilization referrals where children are transitioning from a more restrictive to a less restrictive placement (such as a move from a group home to foster home or relative, only for stabilization purposes) or may be used for to stabilize a foster placement that is at risk of dissolution as long as the child demonstrates the listed characteristics.

Staff Education level/qualifications and training topics

Education/ Qualifications

Homebuilders® therapists:
Master's degree in psychology, social work, counseling, or a related field, or Bachelor's degree in same fields plus two years of experience working with families.

Homebuilders® supervisor:
Master's degree in psychology, social work, counseling or a related field, or Bachelor's degree in same fields plus two years of experience providing the program, plus one year supervisory/management experience.

Training includes the following steps:

Year 1: Therapists: 11-13 days of workshop training
Year 1: Supervisors: same as therapists plus 3-5 days of supervisor workshop training
Year 1: Program Mangers: minimum of Homebuilders® Core Curriculum, Online Data Manager (ODM) training and 3-5 days of Supervisor workshop training.
Year 2: Therapists: 5-7 days of workshop training
Year 2: Supervisors: same as therapists plus 2-3 days of supervisor workshop training
Year 2: Program Mangers: minimum of 2-3 days of supervisor workshop training

Webinar training throughout as needed.

Supervision:

Weekly team consultation/supervision with the Homebuilders® consultant (via telephone or Skype), individual supervision and consultation available 24/7. Homebuilders® consultant also consults individually with the supervisor as needed, and is available for emergency consultation 24/7. Sites are required to consult with Homebuilders® consultant for specified issues. Also there is also required consultation with the supervisor or program manager for specified situations. IFD has clear guidelines for when therapists must consult with their supervisor, and when supervisors must consult with their program manager, and when Homebuilders® consultant(s) should be included.

One of the important variables impacting the overall level of consultation provided is the "level" of the supervisor. Supervisors will move to levels 3 and in level 4 they take on more of the responsibility to do their own site reviews (with our oversight), and monthly consultation time is reduced. When a team has supervisor turnover, the new supervisor starts at level 1 and the consultation moves back to level 1 oversight and consultation.

The Homebuilders® consultants are IFD staff who have years of experience delivering, supervising and /or managing Homebuilders® programs. All are MA/MSW or Ph.D. licensed (in Mental Health Counseling, Social Work or Marriage and Family). The range of Homebuilders® experience for the consultants is 8 to over 30. The consultants also deliver Homebuilders® training through the US and in other countries.

Monitoring and assessment of service delivery:

All programs are required to use the web-based client documentation and data system (called Online Data Manager – ODM). All client documentation is entered (with guidelines about when this occurs) into ODM, and data reports are generated from the information that go into part of the fidelity and site reviews.

Site reviews:
There are two onsite visits a year:

- A mid-year review (go out on home visits, observe team consultation, meet with administrators, etc.), with only quantitative data run and reported;
- A year-end full-site review (visit with home visits, team consultation reviews, file reviews, etc.) – After full site reports are completed, Professional Development Plans (PDPs) and Quality Enhancement Plans (QE plans) are developed after.

IFD supports the creation of PDPs for individuals and QE plans for the team. When/if serious problems occur Quality Improvement plans (QI plans) are developed and are time limited, and can result in individual or teams not being allowed to deliver Homebuilders®.

Please see the website for more information: www.institutefamily.org

Exclusions:
Homebuilders® services are comprehensive of all other services, with the exception of psychological evaluation or assessment and medication management. These may be provided and billed separately for a recipient receiving Homebuilders® services.

Homebuilders® shall not be billed in conjunction with the following services:

3. Behavioral health services by licensed and unlicensed individuals, other than medication management and assessment.

4. Residential services, including professional resource family care.

Functional Family Therapy (FFT):
The provider agency must have a current certification issued by FFT LLC. The licensed entity has agreed to assume responsibility for this service under its license. The provider contracts with FFT LLC. for training, supervision and monitoring of services. This occurs primarily through a FFT national consultant. The provider will also have a contractual relationship with FFT LLC, allowing the provider to deliver the licensed FFT model.

FFT services are targeted for youth primarily demonstrating externalizing behaviors or at risk for developing more severe behaviors, which affect family functioning. Youth behaviors include antisocial behavior or acts, violent behaviors and other behavioral issues that impair functioning. Youth may also meet criteria for a disruptive behavior disorder (ADHD, oppositional defiant disorder and/or conduct disorder). Youth with other mental health conditions, such as anxiety and depression, may also be accepted as long as the existing mental and behavioral health issues manifest in outward behaviors that impact the family and multiple systems. Youth with substance use issues may be included if they meet the criteria below, and FFT is deemed clinically more appropriate than focused drug and alcohol treatment. However, acting out behaviors must be present to the degree that functioning is impaired and the following terms are met:

- Youth, ages 10-18, typically referred by other service providers and agencies on behalf of the youth and family, though other referral sources are also appropriate.
- At least one adult caregiver is available to provide support and is willing to be involved in treatment.
- An Axis 1 DSM-5 diagnosis as primary focus of treatment. Symptoms and impairment must be the result of a primary disruptive/externalizing behavior disorder, although internalizing psychiatric conditions and substance use disorders may be secondary.
- Functional impairment not solely a result of pervasive developmental disorder or intellectual disability.
- Youth displays externalizing behavior which adversely affects family functioning. Youth's behaviors may also affect functioning in other systems.
- Documented medical necessity for an intensive in-home service.
- Youth's interagency service planning team recommends that he/she participate in FFT.

FFT is deemed a best practice/family-based approach to providing treatment to youth who are between the ages of 10 and 18 and are exhibiting significant externalizing behaviors. It is a systems-based model of intervention/prevention, which incorporates various levels of the client's interpersonal experiences to include cognitive, emotional and behavioral experiences, as well as intrapersonal perspectives which focus on the family and other systems (within the environment) and impact the youth and his or her family system. FFT is a strengths-based model of intervention, which emphasizes the capitalization of the resources of the youth, their family and those of the multi-system involved. Its purpose is to foster resilience and ultimately decrease incidents of disruptive behavior for the youth. More specifically, some of the goals of the service are to reduce intense/ negative behavioral patterns, improve family communication, parenting practices and problem-solving skill, and increase the family's ability to access community resources.

The FFT model of intervention/prevention is based on three core principles for understanding the following three components of the treatment: the clients who are served, the problems the youth and families are faced with and the process of providing the therapeutic service. More specifically, the three core principles can be generally defined as:

- Core Principle One: Understanding clients – This is a process whereby the therapist comes to understand the youth and family in terms of their strengths on the individual, family system and multi-systemic level.
- Core Principle Two: Understanding the client systemically – This is a process whereby the therapist conceptualizes the youth's behaviors in terms of their biological, relational, family, socio-economic and environmental etiology. Subsequently, the therapist assesses the youth's relationships with family, parents, peers, their school and their environment and how these roles/relationships contribute to the maintenance and change of problematic behaviors.
- Core Principle Three: Understanding therapy and the role of the therapist as a fundamentally relational process – This is a process where the therapist achieves a collaborative alliance with the youth and family. Subsequently, the therapist ensures that the therapy is systematic and purposeful, while maintaining clinical integrity. More specifically, the therapist follows the model but also responds to the emotional processes (needs/feelings/behaviors) that occur in the immediacy during clinical practice.

Specific design of the service:
On average, a youth receives FFT for approximately three to five months. Over the course of this period, the therapist works with the family in twelve to fifteen one- to two-hour sessions for less severe cases and up to thirty one- to two-hour sessions for youth with more complex needs. The frequency of the sessions varies on a case-by-case basis and over the course of the treatment; sessions could occur daily to weekly, as needed. Services occur in the office, family's home and/or community at times that are convenient for the family. In addition to being available to families as needed (intensity is based on family risk and protective factors), FFT therapists provide regular telephonic follow-up and support to families between sessions. FFT is carried out in the context of five distinct phases. Each phase consists of an assessment, goal-setting and an intervention component; all services rendered are carried-out based upon the theoretical framework of the three core principles.

The intervention program itself consists of five major components, in addition to pretreatment activities: (1) Engagement; (2) Motivation to change; (3) Relational/Interpersonal assessment and planning for behavior change; (4) Behavior change; and (5) Generalization across behavioral domains and multiple systems:

- **Pretreatment:** The goals of this phase involve responsive and timely referrals, a positive "mindset" of referring sources and immediacy. Activities include establishing collaborative relationships with referring sources, ensuring availability, appraising multidimensional (e.g., medical, educational, justice) systems already in place and reviewing referral and other formal assessment data.
- **Engagement phase:** The goals of this phase involve enhancing perception of responsiveness and credibility, demonstrating a desire to listen, help, respect and "match" and addressing cultural competence. The main skills required are demonstrating qualities consistent with positive perceptions of clients, persistence, cultural/population sensitivity and matching. Therapist focus is on immediate responsiveness and maintaining a strength-based relational focus. Activities include high availability, telephone outreach, appropriate language and dress, proximal services or adequate transportation, contact with as many family members as possible, "matching" and respectful attitude.
- **Motivation phase:** The goals of this phase include creating a positive motivational context, minimizing hopelessness and low self-efficacy and changing the meaning of family relationships to emphasize possible hopeful experience. Required phase skills consist of relationship and interpersonal skills, a nonjudgmental approach, plus acceptance and sensitivity to diversity. Therapist focus is on the relationship process, separating blaming from responsibility while remaining strength-based. Activities include the interruption of highly negative interaction patterns and blaming (e.g., divert and interrupt), changing meaning through a strength-based relational focus, pointing process, sequencing and reframing of the themes by validating negative impact of behavior, while introducing possible benign/noble (but misguided) motives for behavior. Finally, the introduction of themes and sequences that imply a positive future are important activities of this phase.
- **Relational assessment phase:** The goals of relational assessment include eliciting and analyzing information pertaining to relational processes, as well as developing plans for behavior change and generalization. The skills of perceptiveness and understanding relational processes and interpersonal functions are required. The focus is directed to intrafamily and extrafamily context and capacities (e.g., values, attributions, functions, interaction patterns, sources of resistance, and resources and limitations). Therapist activities involve observation, questioning; inferences regarding the functions of negative behaviors and switching from an individual problem focus to a relational perspective.
- **Behavior change phase:** Behavior change goals consist of skill building, changing habitual problematic interactions and other coping patterns. Skills, such as structuring, teaching, organizing and understanding behavioral assessment, are required. Therapists focus on communication training, using technical aids, assigning tasks and training in conflict resolution. Phase activities are focused on modeling and prompting positive behavior, providing directives and information and developing creative programs to change behavior, all while remaining sensitive to family member abilities and interpersonal needs.

- **Generalization phase:** The primary goals in the generalization phase are extending positive family functioning, planning for relapse prevention and incorporating community systems. Skills include a multisystemic/systems understanding and the ability to establish links, maintain energy and provide outreach. The primary focus is on relationships between family members and multiple community systems. Generalization activities involve knowing the community, developing and maintain contacts, initiating clinical linkages, creating relapse prevention plans and helping the family develop independence.

Additional points to cover:
Outreach and linkages made with community supports are an essential part of the model, particularly during pre-treatment, engagement, and generalization phases; this includes non-face-to face and telephonic contact with these sources, with or without the client present.

Description of individualization for youth and family:
The FFT must work with any treatment planning team to develop an individualized treatment plan.

FFT's requirements for measuring individual outcome include the following:

There are four domains of assessment used to monitor progress towards goals:

1. Client assessment (through the use of the outcomes questionnaire (OQ) family measures pre-assessment, risk and protective factors assessments pre-assessment, relational assessment):
   – Helps understand individual, family and behavior in a context functioning
   – Adds to clinical judgment, helps target behavior change targets, tool in treatment

2. Adherence assessment (through the use of the Family Self Report and Therapist Self Report, and Clinical Services System (CSS) tracking/adherence reports, global therapist ratings):
   – Identify adherence to FFT to enhance learning and supervision
   – Judge clinical progress, monitor clinical decisions

3. Outcome assessment (through the use of therapist outcome measure, counseling outcome measure parent/adolescent and post assessment OQ family measures and post risk and protective factors assessment):
   – To understand the outcome of your work – accountability
   – Changes in client functioning (pre-post)

4. Case monitoring and tracking (client service system reports)
   – Every client contact/planned contact, outcome of that contact (helps monitor practice)

Cultural and ethical concerns:
FFT treatment is attuned to the importance of ethnicity and culture for all clients referred for services. Cultural values and concerns are addressed in the context of the family system and the multi-systems which influence the intervention. Cultural sensitivity is an integral part of understanding the child and family from a systems perspective. FFT can be carried out by therapists from diverse backgrounds. Thus, intervention involves the use of fostering resilience and identifying resources within the family systems and multi-systems. Inevitably, this will include understanding the family and multi-systems within the context of their cultural backgrounds.

Child integration to community:
The treatment objectives demonstrate that FFT focuses on fostering resilience for youth and family and capitalizing on resources within the family system and multi-systems (to include the community). Thus, in

order to achieve generalization, the youth and family need to demonstrate their ability to utilize resources within the community and demonstrate integration prior to discharge.

The FFT model is consistent with the Child and Adolescent Services System Program principles, which are critical treatment standards important to all families in Louisiana. For example, by maintaining the youth within the community, the least restrictive environment, FFT treatment interventions strengthen the family and youth's relationship with community resources and the people managing them. This is important for creating sustainable treatment outcomes. FFT is delivered as an in-home community-based service. FFT clinicians cannot directly bill for travel time.

Staff education level/qualifications and training topics

Education/qualifications:

FFT therapists
The FFT program at the provider level will consist of one site. This site will be comprised of (three to eight) therapists. Therapists are master-level staff with graduate degrees in a clinical field. Other human service degrees may be accepted. Highly skilled bachelor's-level professionals may also be selected under certain hiring conditions. These conditions include: (1) the provider has actively recruited for master-level therapists but has not found any acceptable candidates *or* the bachelor's-level applicant is clearly better qualified than the master-level applicants and (2) the bachelor's degree must be in a human services field. A degree in a mental health field is preferred.

All FFT therapists must have a background in family, youth and community service and a minimum of two years experience working with children, adolescents and families. FFT therapists will meet the guidelines for training outlined below.

FFT site supervisor
At the cessation of Phase One, (approximately nine to twelve months after the initial training) the FFT site supervisor is expected to emerge and be appointed. The site can appoint a site supervisor prior to the cessation of Phase Two; however, it is expected that this person follow FFT training guidelines which are outlined below.

Site supervisors are master-level mental health professionals with graduate degrees in a clinical discipline. A background in family, youth and community service and a minimum of two years experience working in these areas is required.

FFT national consultant
The provider will work with a national FFT national consultant, who will provide the monitoring, supervision, and training during the first two phases (typically the first two years) of site implementation. This person will have been involved in the delivery of FFT services for five years, has been a site supervisor, had training and is employed by FFT LLC.

All staff will have background checks on file before working alone with youth and families.

Training:
FFT services must maintain treatment integrity and meet fidelity criteria developed by FFT LLC. FFT fidelity is achieved through a specific training model and a sophisticated client assessment, tracking, and monitoring system that provides for specific clinical assessment and outcome accountability. FFT therapists maintain fidelity by regularly staffing cases, attending follow-up trainings, and participating in individual and group supervision. FFT clinical supervisors participate in regular consultation with a national FFT LLC consultant.

The following is the process the provider will use to become an approved site by FFT LLC. This training regimen will be completed in order to ensure fidelity to the FFT model.

1. The provider will appoint individual therapists who have met the criteria for education and qualifications outlined above.

2. After the provider has identified appropriate staff, they will call FFT LLC to set-up the initial one-day orientation training. The provider has arranged for their team and all stakeholders to attend in order to learn the process of referring youth for FFT in the provider's particular community. During this training, the site members will have learned successful implementation of FFT to include use of assessment tools and protocols and the use of the CSS. At the cessation of this training, the provider will have agreed to have at least five referrals for FFT for each team member to begin with after they have completed the next training session, which is the initial clinical training (CT1).

3. Approximately one to two weeks after the initial one-day orientation training, the provider will arrange to have all FFT therapists attend the CT1 training. This will be conducted over a two-day period and be carried out on the site of the provider. An FFT LLC developer or national consultant will conduct this training.

4. Six weeks post CT1, the site is eligible for site certification.

5. Immediately following the initial training, the therapists at the provider sites will begin to see their cases and engage in weekly supervision with the FFT LLC national consultant. Each weekly supervision session will be conducted for approximately one hour. The National consultant will use a staffing procedure which reinforces the model, will review all CSS paperwork and provide feedback to the team or teams. In addition, the provider will ensure that the FFT team/teams are meeting for an additional hour per week for peer supervision.

6. At six weeks, four to five months, and eight to ten months after the initial clinical training, the FFT national consultant will come to the provider's site and complete two-day follow-up trainings. All FFT therapists employed by the provider will attend the follow-up trainings. The purpose of these follow-up trainings will be to review phase goals and assessments, update therapists on current events or changes and to provide specialized training to the team in regard to their specific cases.

7. At six months following CT1, the provider's FFT team(s) will attend the second clinical training (CT2). This will be conducted by the FFT developers or the national consultant (please note this is a new requirement by FFT LLC).

8. At approximately nine months, a lead should emerge or have been appointed, who will serve as the FFT supervisor. The provider will ensure that this staff member attends the FFT externship. This externship will consist of three, three-day trainings occurring every month during the duration of the externship. This training will be conducted by FFT externship trainers. At the cessation of this externship, it will be determined whether the selected FFT supervisor will continue to serve in this role.

9. Once the site supervisor has completed the externship and is deemed qualified, the provider will be considered to be in Phase Two (approximately Year Two). At this time, the provider will ensure that the supervisor attends supervision trainings (two trainings), and he or she will begin taking over the supervision of the FFT therapists. The site supervisor and therapists will also take part in one two-day training session conducted on site by the FFT LLC national consultant.

10. Should there be any staff turnover, the provider will ensure that new FFT therapists attend the replacement trainings either in–state, if offered, or out-of-state, if need be.

Supervision
Intensive supervision and clinical consultation are an integral part of the FFT model and are focused on promoting consistent application of the FFT model to all cases. Supervision is built into the training protocol and certification process.
Supervision in FFT includes the following:

- The FFT LLC national consultant will provide the monitoring, supervision and training during the first two years of the provider's implementation of FFT:
  - This supervision will include one, one-hour weekly phone consult with the site during Year One of implementation.
  - During Year Two, the FFT LLC national consultant will provide two one-hour supervision sessions to the site supervisor in training.
- During Year Two of implementation, the provider's site supervisor will provide oversight to the therapists and will complete all required trainings outlined by FFT LLC. The site supervisor will hold one-hour weekly sessions with the therapists.
- FFT therapists at the provider will also engage in one one-hour weekly peer supervision sessions during Year One. During Year Two, this requirement is left up to the site. Typically, the site supervisor holds one- to two-hour weekly supervisions then. Please indicate your site's intention regarding these supervision times.
- Phase/Year Three is considered a maintenance phase. A national consultant is assigned to monitor the site monthly through a call with the site supervisor, and this national consultant will do one site visit per year.

Additional supervision
Child psychiatrists and/or psychologists or medical psychologists provide consultation to the FFT teams, as needed. Psychiatrists and/or psychologists are employees/subcontractors of the provider. All analysis of problem behaviors must be performed under the supervision of a licensed psychologist/medical psychologist.

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

- Assessments of risk and protective factors (Risk and Protective Factors Assessment)
- Relationship assessments (this is embedded in the progress note)
- Individual functioning (pre- and post-intervention) (OQ-45.2)
- Functioning within the context of the assessments (pre- and post-intervention) YOQ 2.01 and YOQ SR
- Assessments of family and therapist agreement (Family Self Report)
- Fidelity Ratings (Weekly adherence ratings – by national consultant in Year One and by site supervisor in Year Two and beyond)
- FFT global therapist rating
- Completion rates (CSS closed case summary)
- Drop-out rates (CSS closed case summary)
- Time of drop-out (CSS closed case summary or case review report)
- Outcome data (family and therapist perspective) at time of discharge (TOM, COM-A and COM-P)

Each FFT therapist will receive a log on and password for the CSS for referencing their own clients only. The provider will receive an administrator/evaluator log on and password. The FFT LLC national consultant will also have access to the data from the CSS.

Please see the FFT LLC website for additional information: www.fftllc.com

Exclusions:
FFT services are comprehensive of all other services, with the exception of psychological evaluation or assessment and medication management. These may be provided and billed separately for a recipient receiving FFT services.

FFT shall not be billed in conjunction with the following services:

1. Behavioral health services by licensed and unlicensed individuals, other than medication management and assessment.
2. Residential services, including professional resource family care.