

Georgia Department of Behavioral Health & Developmental Disabilities



PROVIDER MANUAL

FOR

**COMMUNITY MENTAL HEALTH,
DEVELOPMENTAL DISABILITIES AND
ADDICTIVE DISEASES
PROVIDERS**

FOR

**THE DEPARTMENT OF
BEHAVIORAL HEALTH &
DEVELOPMENTAL DISABILITIES**

FISCAL YEAR 2012

Effective Date: April 1, 2012

INTRODUCTION

The FY 2012 Provider Manual for the Department of Behavioral Health and Developmental Diseases (DBHDD) has been designed as an addendum to your contract/agreement with DBHDD to provide you structure for supporting and serving consumers residing in the state of Georgia.

Please Note: The Department of Behavioral Health and Developmental Disabilities continues the work of updating documents that were previously created when the Division of MHDDAD was part of the Department of Human Resources. Therefore, some forms, policies, and processes contained herein may still include references to the Department of Human Resources, yet they remain applicable for the Department of Behavioral Health and Developmental Disabilities.

SUMMARY OF CHANGES

A table listing the changes in the FY 2012 Provider Manual is provided for your convenience. Please click [here](#) to be linked to the Summary of Changes Table.

DEPARTMENT OF BEHAVIORAL HEALTH & DEVELOPMENTAL DISABILITIES

FY 2012 PROVIDER MANUAL

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ALL POLICIES ARE NOW POSTED IN DBHDD POLICYSTAT LOCATED AT <http://dbhdd.georgia.gov/policies>

Details are provided in Policy titled “[Access to DBHDD Policies for Community Providers, 04-100](#)”

The [DBHDD PolicyStat INDEX](#) helps to identify policies applicable for Community Providers

GREEN	Denotes change in policy number
RED	Denotes new or updated policy
POLICY #	NAME
04-100	Access to DBHDD Policies for Community Providers
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21-101	Financial and Reporting Requirements for Community Providers

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▶ PART VIII - Financial Policies, Reporting Requirements and Forms

All Financial Policies, Reporting Requirements and Forms are now posted in DBHDD POLICYPOLICY under a policy entitled:
[“Financial and Reporting Requirements for Community Providers, 21-101”](#)

SUMMARY OF CHANGES TABLE

UPDATED FOR APRIL 1, 2012

As a courtesy for Providers, this Summary of Changes is designed to guide the review of new and revised content contained in this updated version of the Provider Manual. The responsibility for thorough review of the Provider Manual content remains with the Provider.

Item #	Topic	Location	Summary of Changes
1	ACT Team Service Guidelines Admission Criteria	Part I, Section I: MH & AD Consumer Eligibility, Orientation to Authorization Packages, Service Definitions and Guidelines,	UPDATED The ACT Service Guideline was changed to reflect the following: integrates new continuing stay criteria, adds references and related changes to best practice sources, corrects the Practitioner Level for the H0039GTU2 code (from 1 to 2), clarifies the expectations of the nursing role, specifies expectations for periodic reassessment, and clarifies use of Telemedicine within an ACT team.
2	Standard Training Requirements for Paraprofessionals	Part II, Community Service Standards for All Providers, Item U.	UPDATED Standard Training Requirements were updated to reflect the following: Pg-42: Changed "First Aid/CPR" to "First Aid and CPR" Pg-43: Updated the Standard Training Requirements course listing to correct discrepancies between the online course titles and those listed in the Provider Manual. Pg-44: Changed Intensive Crisis Stabilization Program to Intensive Community Support Program in the list of staff who must complete the Standard Training Requirements.
<p style="color: red; font-weight: bold;">ALL POLICIES ARE NOW POSTED IN DBHDD POLICYSTAT LOCATED AT</p> <p style="color: red; font-weight: bold;">http://dbhdd.georgia.gov/policies</p> <p style="color: red; font-weight: bold;">Details are provided in Policy titled "Access to DBHDD Policies for Community Providers, 04-100"</p> <p style="color: red; font-weight: bold;">The DBHDD PolicyStat INDEX helps to identify policies applicable for Community Providers"</p>			
3	Policy 04-100 Access to DBHDD Policies for Community Providers	Part VI Policies and Procedures	NEW POLICY providing information to Community Providers on how to access policies on PolicyStat.
4	Policy 04-104 Criminal History Records Checks for Contractors	Part VI Policies and Procedures	UPDATED to include additional crimes that are prohibitive of employment, establish definitions of Pattern of Arrest or Convictions, and to better align DBHDD's policy with the covered crimes outlined in the Health Facility Regulations.

Item #	Topic	Location	Summary of Changes
5	Policy 02-1102 Behavior Program Review Committee for Developmental Disabilities	Part VI Policies and Procedures	NEW POLICY The policy establishes committees of behavioral professionals for the purpose of quality control and monitoring of behavior programs developed to address challenging behaviors exhibited by individuals with developmental disabilities.
6	Policy 15-101 Responsibilities of Language Access Coordinators	Part VI Policies and Procedures	NEW POLICY replacing the previous LEP/SI Policy in the Provider Manual. This is part of an overall re-write of our LEP/SI policy and procedures.
7	Policy 15-102 Notification of Rights regarding Limited English Proficiency/Sensory Impairment	Part VI Policies and Procedures	NEW POLICY replacing the previous LEP/SI Policy in the Provider Manual. This is part of an overall re-write of our LEP/SI policy and procedures.
8	Policy 01-110 Form 1013 – Certificate Authorizing Transport to Emergency Receiving Facility and Report of Transportation (MH)	Part VI Policies and Procedures	NEW POLICY with an effective date of March 31, 2012.
<p>All Financial policies, Reporting Requirements and Forms are now posted in DBHDD PolicyStat under a policy entitled: “Financial and Reporting Requirements for Community Providers, 21-101”</p>			
9	Policy 21-101 Financial and Reporting Requirements for Community Providers	Part VI Policies and Procedures	NEW POLICY All Financial Policies, Reporting Requirements and Forms previously posted under PART VIII of the Provider Manual are now moved into a newly created policy in Chapter 21- Procurement and Contracts, and posted on the DBHDD PolicyStat.

Item #	Topic	Location	Summary of Changes																												
10	Change in Policy numbers	Part VI Policies and Procedures	<p data-bbox="961 168 1776 196">The following Policy Numbers have been changed in PolicyStat:</p> <table border="1" data-bbox="1010 245 1864 797"> <thead> <tr> <th data-bbox="1010 245 1438 310">NEW POLICY NUMBERS</th> <th data-bbox="1438 245 1864 310">OLD POLICY NUMBERS</th> </tr> </thead> <tbody> <tr><td data-bbox="1010 310 1438 354">➤ 01-108</td><td data-bbox="1438 310 1864 354">6001-601</td></tr> <tr><td data-bbox="1010 354 1438 397">➤ 03-502</td><td data-bbox="1438 354 1864 397">6805-201</td></tr> <tr><td data-bbox="1010 397 1438 441">➤ 04-103</td><td data-bbox="1438 397 1864 441">6001-501</td></tr> <tr><td data-bbox="1010 441 1438 485">➤ 04-109</td><td data-bbox="1438 441 1864 485">6203-101</td></tr> <tr><td data-bbox="1010 485 1438 529">➤ 04-110</td><td data-bbox="1438 485 1864 529">6203-102</td></tr> <tr><td data-bbox="1010 529 1438 573">➤ 15-101, 15-102</td><td data-bbox="1438 529 1864 573">1701</td></tr> <tr><td data-bbox="1010 573 1438 617">➤ 16-101</td><td data-bbox="1438 573 1864 617">1244</td></tr> <tr><td data-bbox="1010 617 1438 660">➤ 23-104</td><td data-bbox="1438 617 1864 660">3.200-06</td></tr> <tr><td data-bbox="1010 660 1438 704">➤ 23-105</td><td data-bbox="1438 660 1864 704">3.200-01</td></tr> <tr><td data-bbox="1010 704 1438 748">➤ 23-106</td><td data-bbox="1438 704 1864 748">3.200-10</td></tr> <tr><td data-bbox="1010 748 1438 792">➤ 23-107</td><td data-bbox="1438 748 1864 792">3.200-08</td></tr> <tr><td data-bbox="1010 792 1438 836">➤ 24-101</td><td data-bbox="1438 792 1864 836">Legal Summary</td></tr> <tr><td data-bbox="1010 836 1438 880">➤ 25-101</td><td data-bbox="1438 836 1864 880">7901</td></tr> </tbody> </table>	NEW POLICY NUMBERS	OLD POLICY NUMBERS	➤ 01-108	6001-601	➤ 03-502	6805-201	➤ 04-103	6001-501	➤ 04-109	6203-101	➤ 04-110	6203-102	➤ 15-101, 15-102	1701	➤ 16-101	1244	➤ 23-104	3.200-06	➤ 23-105	3.200-01	➤ 23-106	3.200-10	➤ 23-107	3.200-08	➤ 24-101	Legal Summary	➤ 25-101	7901
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PART I

Eligibility, Service Definitions and Requirements

**Provider Manual for
Community Mental Health,
Developmental Disabilities and
Addictive Diseases
Providers**

Fiscal Year 2012

(Section I updated for April 1, 2012 Implementation)



**Georgia Department of Behavioral Health &
Developmental Disabilities**

April 2012

Part I

Eligibility, Service Definitions and Requirements

SECTION I

***MH and AD Consumer
Eligibility, Orientation to
Authorization Packages,
Service Definitions and
Service Guidelines***

Fiscal Year 2012

(Updated for April 1, 2012 Implementation)



**Georgia Department of Behavioral Health &
Developmental Disabilities**

April 2012

CONSUMER ELIGIBILITY- CHILD AND ADOLESCENT CORE CUSTOMER FOR MENTAL HEALTH AND ADDICTIVE DISEASE SERVICES

A. SERVICE ACCESS

Many youth/families approach the state service delivery system looking for help. Not everyone who seeks assistance is in need of mental health or addictive disease services. In order to efficiently and expeditiously address the needs of those seeking assistance, a quick assessment of the presenting circumstances is warranted. A brief assessment should be initiated by all community-based service providers on all youth who present for services or who are referred by the Georgia Crisis and Access Line (GCAL) for an evaluation. For the purposes of this definition, a brief assessment refers to a rapid determination of a youth's need for services and whether there are sufficient indications of a mental illness and/or substance related disorder to warrant further diagnostic assessment and admission to at least Brief Stabilization services.

1. If the youth does not have sufficient indications of a mental illness and/or substance related disorder, or if the youth does not appear to meet Core Customer functional criteria for at least Brief Stabilization services, then an appropriate referral to other services or agencies is provided.
2. If the youth does appear to have a mental illness and/or substance related disorder, and does appear to meet Core Customer functional criteria, then the youth may either begin in Brief Stabilization services or have their status as a Core Customer of Ongoing Support and Recovery services determined as a part of a more comprehensive assessment process (possibly resulting in the youth moving directly into Ongoing Services).

For all services, a provider must request a Prior Authorization via a MICP form. For additional information on the use of the MICP please see MICP User Guide available at www.apsero.com.

B. CORE CUSTOMER CLASSIFICATION AND ELIGIBILITY DETERMINATION

There are four variables for consideration to determine whether a youth qualifies as a "core customer" for child and adolescent mental health and addictive disease services.

1. **Age:** A youth must be under the age of 18 years old. Youth aged 18-21 years (children still in high school, in DJJ or DFCS custody or when it is otherwise developmentally/clinically indicated) may be served to assist with transitioning to adult services.
2. **Diagnostic Evaluation:** The state DBHDD system utilizes the Diagnostic and Statistical Manual of Mental Disorders (DSM) classification system to identify, evaluate and classify a youth's type, severity, frequency, duration and recurrence of symptoms. The diagnostic evaluation must yield information that supports an emotional disturbance and/or substance related disorder primary diagnosis (or diagnostic impression) on Axis I in accordance with the latest edition of the DSM. The diagnostic evaluation must be documented adequately to support the diagnosis.
3. **Functional/Risk Assessment:** Information gathered to evaluate a child/adolescent's ability to function and cope on a day-to-day basis comprises the functional/risk assessment. Such information includes child and family resource utilization and the child's role performance, social and behavioral skills, cognitive skills, communication skills, personal strengths and adaptive skills, needs and risks as related to an emotional disturbance, substance related disorder or co-occurring disorder. The functional/risk assessment must yield information that supports a behavioral health diagnosis (or diagnostic impression) on Axis I in accordance with the DSM.
4. **Financial Eligibility:** Please see **Policy: Payment for Community Mental Health and Addictive Diseases Services** located in Part IV of this Provider Manual.

C. PRIORITY FOR SERVICES

The following youth are priority for services:

1. The first priority group for services is:
 - Youth at risk of out-of home placements;
 - Youth who are in out of home placements; and,
 - Youth currently in a state operated psychiatric facility or a community-based crisis residential service including a crisis stabilization unit.
2. The second priority group for services is:
 - Youth with a history of one or more hospital admissions for psychiatric/addictive disease reasons within the past 3 years;
 - Youth with a history of one or more crisis stabilization unit admissions within the past 3 years;
 - Youth with a history of enrollment on an Intensive Family Intervention team within the past 3 years;
 - Youth with court orders to receive services;
 - Youth under the correctional community supervision with mental illness or substance use disorder or dependence;
 - Youth released from secure custody (county/city jails, state YDCs/RVDCs, diversion programs, forensic inpatient units) with mental illness or substance use disorder or dependence;
 - Pregnant youth;
 - Youth who are homeless; or,
 - IV drug Users.

The timeliness for providing these services is set within the agency's contract/agreement with the DBHDD.

D. EARLY INTERVENTION AND STABILIZATION- CHILD AND ADOLESCENT MENTAL HEALTH AND ADDICTIVE DISEASES

The length of Early Intervention and Stabilization services is 90 days or less. Early Intervention and Stabilization services are subject to the service and unit allowances in the Brief Registration package delineated in the Orientation to Services portion of this section of the Provider Manual:

Early Intervention and Stabilization services **must take place within a ninety (90) day timeframe**. Youth must be registered/authorized for Early Intervention and Stabilization services (complete Registration-type Multipurpose Information Consumer Profile [MICP]) prior to service provision (excluding any initial screening by the Agency). Providers have 48 hours from initial contact to submit the MICP Registration. While those registered in Early Intervention and Stabilization services, will not need the more comprehensive prior authorization for services ("Ongoing" MICP), a service plan must still be completed to guide the provision of services in accordance with the Department's standards and the provider's accrediting entity, and the plan must be maintained in the youth's record.

For any youth registered with a MICP Registration, a Diagnostic Impression is allowed for 30 days after the initial engagement with the youth and, after 30 days, the youth must have a verified diagnosis in order to continue to meet the diagnostic criteria and continue services.

Early Intervention: Indicates interventions taking place after a problem (e.g. an emotional disturbance and/or substance related disorder) is already suspected or identified, but that occur early enough to potentially avoid escalation of the problem into a crisis situation or into a chronic/significantly disabling disorder. In order for an youth to qualify for **Child and Adolescent Mental Health and Addictive Diseases Early Intervention services**, certain diagnostic and functional criteria must be met, including the following:

1. **Diagnostic-** The child or adolescent must have a primary diagnosis or diagnostic impression on Axis I, consisting of an emotional disturbance and/or substance related disorder.
2. **Functional-** The child/adolescent's level of functioning must meet **at least one** of the following criteria:
 - a. is affected by an emotional disturbance or substance related disorder;
 - b. has shown early indications of behaviors that could be disruptive to the community and the family/support system if behaviors intensified,
 - c. has shown early indications behaviors/functional problems that could cause risk of removal from the home if problems intensified;
 - d. has shown early indications of poor school performance (poor grades, disruptive behavior, lack of motivation, suspension);
 - e. has shown early indications of delinquent behaviors that could result in legal system involvement; and/or
 - f. has shown early indications of behavioral/functional problems that could result in multiple agency involvement if problems intensified.

Stabilization: Indicates interventions taking place after a problem has been identified (e.g. an emotional disturbance and/or substance related disorder) and has either developed into a crisis situation or become disabling enough to warrant at least short-term stabilization interventions. In order for a youth to qualify for **Child and Adolescent MENTAL HEALTH AND ADDICTIVE DISEASES STABILIZATION services**, certain diagnostic and functional criteria must be met, including the following:

1. **Diagnostic-** The child or adolescent must have a primary diagnosis or diagnostic impression (allowable for 30 days only) on Axis I, consisting of an emotional disturbance and/or substance related disorder.
2. **Functional -** The child/adolescent's level of functioning must meet **at least one** of the following criteria:
 - a. is significantly affected by a serious emotional disturbance or substance related disorder;
 - b. results in behaviors that demonstrate a risk of harm to self, others, or property;
 - c. causes a risk of removal from the home;
 - d. results in school problems such as poor grades, school failure, disruptive behavior, lack of motivation, drop out, suspension or expulsion;
 - e. results in legal system involvement;
 - f. indicates the need for detoxification services; and/or
 - g. is significantly disruptive to the community or the family/support system.

E. ONGOING SUPPORT AND TREATMENT- CHILD AND ADOLESCENT MENTAL HEALTH

Ongoing Support and Treatment: Indicates interventions taking place after an emotional disturbance of a severe and longer-term nature has been identified and has become disabling enough to warrant ongoing service provision to help support the child and family in order to improve the child's level of functioning and resilience. The length of Ongoing Support and Treatment services is anticipated to be longer than 90 days (though how much longer varies by medical necessity, need/s, resiliency, and biopsychosocial factors affecting functioning). A youth may either start out in Ongoing Support and Treatment services or be transitioned into this category at any point during or following Early Intervention and Stabilization services due to changes in clinical presentation, needs, circumstances or stressors. For a youth/family to qualify for **Child and Adolescent MENTAL HEALTH ONGOING SUPPORT AND TREATMENT** services, certain diagnostic and functional criteria must be met, including the following:

1. **Diagnostic-** The child/adolescent must have a primary diagnosis of a serious emotional disturbance on Axis I, (*for example*: major depression, an anxiety disorder, or other serious emotional disturbance). ***This must be a verified diagnosis, not just a diagnostic impression.*** The disturbance must have persisted for at least one year or be likely to persist for at least one year without treatment, and must require ongoing, longer-term support and treatment services. Without such services, out of home placement or hospitalization is probable.
2. **Functional-** The child/adolescent's ability to function has been significantly affected by the serious emotional disturbance to the extent that there is impairment in ability to function at an age appropriate level and difficulty with age appropriate role performance. Functional impairment must be demonstrated by ***one of the following three indicators***:
 - a. A total score of 60 or higher on the 8 subscales of the Child and Adolescent Functional Assessment Scale (CAFAS),
--OR--
 - b. **Either** a score of 20 or higher (*moderate to severe impairment*) on the "Behavior Toward Others", the "Self-Harmful Behavior" or the "Thinking" CAFAS subscale, or a score of 30 (*severe impairment*) on the "Moods/Emotions" CAFAS subscale,
--OR--
 - c. The child or adolescent has been in services for an extended period of time (six months or longer) with a qualifying Axis I diagnosis, but does not currently meet the functional criteria. Without the supports/services provided, the child/adolescent would *likely* be unable to maintain his or her current level of functioning to the extent that functioning would revert back to meeting the functional criteria.

F. ONGOING SUPPORT AND RECOVERY- CHILD AND ADOLESCENT ADDICTIVE DISEASES

Ongoing Support and Recovery: Indicates interventions taking place after a substance-related disorder has been identified and has become disabling enough to warrant ongoing service provision to assist in stabilizing/supporting the child and family, and to facilitate the child's recovery. The length of service is anticipated to be longer than 90 days (though how much longer varies by medical necessity, need/s, resiliency, and biopsychosocial factors affecting functioning/recovery). A youth may either start out in Ongoing Support and Recovery services or be transitioned into this category at any point during or following Early Intervention and Stabilization services due to changes in clinical presentation, needs, circumstances or stressors. For a person to qualify for **Child and Adolescent ADDICTIVE DISEASES ONGOING SUPPORT AND RECOVERY** services, certain diagnostic and functional criteria must be met, including the following:

1. **Diagnostic-** The child/adolescent must have a primary diagnosis on Axis I of a substance related disorder (excluding substance intoxication). Substances can refer to a drug of abuse, a medication or a toxin (Caffeine and nicotine are excluded). ***This must be a verified diagnosis, not just a diagnostic impression.***
2. **Functional-** The child/adolescent's ability to function has been significantly affected by the substance related disorder to the extent that there is impairment in ability to function at an age appropriate level and difficulty with age appropriate role performance. This functional difficulty must be demonstrated by ***one of the following indicators:***
 - a. A score of 20 or higher (moderate to severe impairment) on the 'Substance Abuse' subscale of the Child and Adolescent Functional Assessment Scale (CAFAS).
--OR--
 - b. The child or adolescent has been in services for an extended period of time (six months or longer) with a qualifying Axis I diagnosis, but does not currently meet the functional criteria. Without the supports/services provided, the child/adolescent would *likely* be unable to maintain his or her current level of functioning to the extent that functioning would revert back to meeting the functional criteria.

G. DIAGNOSTIC CATEGORIES APPROVED FOR STATE FUNDED SERVICES

1. Child and Adolescent Mental Health:

- a. Axis I disorders classified in the most recent version of the DSM.
- b. By definition, an Adjustment Disorder must resolve within 6 months of the termination of the stressor *or* its consequences.
- c. Exclusions: The following disorders are ***excluded*** unless co-occurring with a qualifying primary Axis I emotional disturbance or substance related disorder that is the focus of treatment:
 1. Tic disorders;
 2. Mental Retardation;
 3. Learning Disorders;
 4. Motor Skills Disorders;
 5. Communication Disorders;
 6. Organic Mental Disorders;
 7. Pervasive Developmental Disorders; and,
 8. V Codes

2. Child and Adolescent Addictive Diseases:

- a. Substance Related Disorders including but not limited to substance abuse, substance dependence, and substance withdrawal as classified in the most recent version of the DSM.
- b. The severity and duration of substance related disorders are not considered in regard to the Core Customer criteria (except as they may be inherent to the definition of a disorder).
- c. Exclusions: The following disorders are ***excluded:***
 1. Caffeine-Induced Disorders;
 2. Nicotine-Related Disorders; and,
 3. Substance Intoxication- only excluded for Ongoing Services.

NOTE: *The presence of co-occurring emotional disturbances, substance related disorders and/or developmental disabilities is not uncommon and typically results in a more complicated clinical presentation. Youth diagnosed with the excluded Axis I disorders listed above and/or with Axis II disorders may receive services **ONLY** when these disorders co-occur with a qualifying primary Axis I emotional*

disturbance or substance related disorder. The qualifying Axis I emotional disturbance or substance related disorder must be the presenting problem and the primary diagnosis/focus of treatment, and the youth must meet the functional criteria listed above.

H. CONTINUED REVIEW OF ELIGIBILITY

Eligibility will be reviewed as consumers' MICP service reauthorizations become due.

CONSUMER ELIGIBILITY- ADULT CORE CUSTOMER FOR MENTAL HEALTH AND ADDICTIVE DISEASE SERVICES

A. SERVICE ACCESS

Many individuals approach the state service delivery system looking for help. Not everyone who seeks assistance is in need of mental health or addictive disease services. In order to efficiently and expeditiously address the needs of those seeking assistance, a quick assessment of the presenting circumstances is warranted. A brief assessment should be initiated by all community-based service providers on all individuals who present for services or who are referred by the Georgia Crisis and Access Line (GCAL) for an evaluation. For the purposes of this definition, a brief assessment refers to a rapid determination of an individual's need for services and whether there are sufficient indications of a mental illness and/or substance related disorder to warrant further evaluation and admission to at least Brief Stabilization services.

1. If the individual does not have sufficient indications of a mental illness and/or substance related disorder, or if the individual does not appear to meet Core Customer functional criteria for at least Brief Stabilization services, then an appropriate referral to other services or agencies is provided.
2. If the individual does appear to have a mental illness and/or substance related disorder, and does appear to meet Core Customer functional criteria, then the individual may either begin in Brief Stabilization services or have their status as a Core Customer of Ongoing Support and Recovery services determined as a part of a more comprehensive assessment process (possibly resulting in the individual moving directly into Ongoing Services).

For all services, a provider must request a Prior Authorization via a MICP form. For additional information on the use of the MICP please see MICP User Guide available at www.apsero.com.

B. CORE CUSTOMER CLASSIFICATION AND ELIGIBILITY DETERMINATION

There are four variables for consideration to determine whether an individual qualifies as a "Core Customer" for adult mental health and addictive disease services.

1. **Age:** An individual must be over the age of 18 years old. Individuals under age 18 may be served in adult services if they are emancipated minors under Georgia Law, and if adult services are otherwise clinically/developmentally indicated.
2. **Diagnostic Evaluation:** The state DBHDD system utilizes the Diagnostic and Statistical Manual of Mental Disorders (DSM) classification system to identify, evaluate and classify an individual's type, severity, frequency, duration and recurrence of symptoms. The diagnostic evaluation must yield information that supports a psychiatric disorder and/or substance related disorder primary diagnosis (or diagnostic impression) on Axis I in accordance with the latest edition of the DSM. The diagnostic evaluation must be documented adequately to support the diagnostic impression/diagnosis.
3. **Functional/Risk Assessment:** Information gathered to evaluate an individual's ability to function and cope on a day-to-day basis comprises the functional/risk assessment. Such information includes the individual's resource utilization, role performance, social and behavioral skills, cognitive skills, communication skills, independent living skills, personal strengths and adaptive skills, needs and risks as related to a psychiatric disorder, substance related disorder or co-occurring disorder. The functional/risk assessment must yield information that supports a behavioral health diagnosis (or diagnostic impression) on Axis I in accordance with the DSM.

4. **Financial Eligibility:** Please see **Policy: Payment for Community Mental Health and Addictive Diseases Services** located in Part IV of this Provider Manual.

C. PRIORITY FOR SERVICES

The following individuals are the priority for ongoing support services:

1. The first priority group for services is individuals currently in a state operated psychiatric facility (including forensic individuals), state funded/paid inpatient services, a crisis stabilization unit or crisis residential program.
2. The second priority group for services is:
 - Individuals with a history of one or more hospital admissions for psychiatric/addictive disease reasons within the past 3 years;
 - Individuals with a history of one or more crisis stabilization unit admissions within the past 3 years;
 - Individuals with a history of enrollment on an Assertive Community Treatment team within the past 3 years;
 - Individuals with court orders to receive services (especially related to restoring competency);
 - Individuals under the correctional community supervision with mental illness or substance use disorder or dependence;
 - Individuals released from secure custody (county/city jails, state prisons, diversion programs, forensic inpatient units) with mental illness or substance use disorder or dependence;
 - Individuals aging out of out of home placements or who are transitioning from intensive C&A services, for whom adult services are clinically and developmentally appropriate.
 - Pregnant women;
 - Individuals who are homeless; or,
 - IV drug Users.

The timeliness for providing these services is set within the agency's contract/agreement with the DBHDD.

D. BRIEF STABILIZATION- ADULT MENTAL HEALTH AND ADDICTIVE DISEASES

The length of Brief Stabilization services is 90 days or less. Brief Stabilization services are subject to the service and unit allowances in the Brief Registration package delineated in the Orientation to Services portion of this section of the Provider Manual.

Brief Stabilization services must take place within a ninety (90) day timeframe. Individuals must be registered/authorized for Brief Stabilization services (complete Registration-type MICP) prior to service provision (excluding any initial screening by the Agency). Providers have 48 hours from initial contact to submit the MICP Registration. While those registered in Brief Stabilization services, will not need the more comprehensive prior authorization for services ("Ongoing" MICP), a service plan must still be completed to guide the provision of services in accordance with the Department's standards and the provider's accrediting entity, and the plan must be maintained in the consumer's record.

For any individual registered with a MICP Registration, a Diagnostic Impression is allowed for 30 days after the initial engagement with the individual and, after 30 days, the individual must have a verified diagnosis in order to continue to meet the diagnostic criteria and continue services.

Brief Stabilization indicates interventions taking place after a problem has been identified (e.g. a psychiatric disturbance/disorder and/or substance related disorder), which has either already developed into a crisis situation or has become disabling enough to warrant at least short-term, low intensity outpatient stabilization interventions. In order for an individual to qualify for Adult Mental Health and Addictive Diseases Brief Stabilization services, certain diagnostic **and** functional criteria must be met, including the following:

1. **Diagnostic-** The person must have a verified Axis I diagnosis or diagnostic impression of a mental illness and/or a substance related disorder.
2. **Functional-** Item **"a"** **AND** at least item **"b"** **OR** **"c"** must be present:
 - a. The person's level of functioning must be significantly affected by the presenting mental health and/or addictive disease issue; and one or more of the following:
 - b. The person displays behaviors that are significantly disruptive to the community, to the individual's family/support system, or to the individual's ability to maintain his or her current employment/schooling, housing or personal health/safety; **and/or**
 - c. The person displays behaviors that demonstrate a potential risk of harm to self or others.

E. ONGOING SUPPORT AND RECOVERY- ADULT MENTAL HEALTH

An individual may either begin in Ongoing Support and Recovery services or be transitioned from Brief services into Ongoing Support and Recovery services either during or following the 90 day Brief services allowable time period due to changes in clinical presentation, needs, circumstances/stressors, clinician's evolving understanding of the individual's clinical issues etc. An agency must complete and submit a MICP "New Episode" or "Ongoing" for approval for individuals for whom Ongoing Support and Recovery services are desired.

Ongoing Support and Recovery: Indicates interventions taking place after a psychiatric disorder of a severe and longer-term nature has been identified and has become disabling enough to warrant ongoing service provision to help support the individual in order to improve his or her level of functioning and recovery. The length of Ongoing Support and Recovery services varies based on individual service needs and biopsychosocial factors affecting functioning in accordance with service utilization guidelines. An individual may either start out in the Ongoing services category or be transitioned to this category at any point during or following Brief Stabilization services due to changes in clinical presentation, needs, circumstances or stressors etc. In order for an individual to qualify for Adult Mental Health Ongoing Support and Recovery Services, certain diagnostic **and** functional criteria must be met, including the following:

1. **Diagnostic-** The individual must have a verified Axis I diagnosis (**note:** not just a diagnostic impression) of a severe and persistent mental illness such as schizophrenia, major depression, bipolar disorder or other severely disabling mental disorder that requires ongoing and long-term support, treatment and recovery services. The prognosis indicates a long-term, severe disability. Without supports, hospitalization or other institutionalization (e.g. incarceration) is probable.
2. **Functional-** The individual's ability to function has been **significantly affected by the mental disorder** to the degree that there is impairment in activities of daily living with an inability to function independently in the community. This difficulty with activities of daily living and difficulty in functioning independently must be demonstrated **EITHER** by **both "a" and "b"** below, **OR** by **"c" alone**.
 - a. The individual's score on the Level Of Care Utilization System (LOCUS) indicates that the individual would be appropriate for a Level 1 level of care.

--AND--

- b. The individual has been in services for an extended period of time (six months or longer) with a qualifying Axis I diagnosis, and functioning does not currently meet the criteria for a LOCUS Level 2 or higher level of care. Without the supports/services provided, the individual would likely be unable to maintain his or her current level of recovery to the extent that his or her functioning would revert back to meeting the criteria for a LOCUS Level 2 or higher level of care.

--OR--

- c. The individual's score on the Level of Care Utilization System (LOCUS) indicates that the individual would be appropriate for a Level 2 or above level of care.

F. ONGOING SUPPORT AND RECOVERY- ADULT ADDICTIVE DISEASES

An individual may either begin in Ongoing Support and Recovery services or be transitioned from Brief services into Ongoing services either during or following the 90 day Brief services allowable time period due to changes in clinical presentation, needs, circumstances/stressors, clinician's evolving understanding of the individual's clinical issues etc. An agency must complete and submit a MICP "New Episode" or "Ongoing" form for approval for individuals for whom Ongoing Support and Recovery services are desired.

Ongoing Support and Recovery: Indicates interventions taking place after a substance-related disorder has been identified, and has become disabling enough to warrant ongoing service provision to help support the individual to improve his or her level of functioning and recovery. The length of Ongoing Support and Recovery services varies considering support and recovery needs and by other bio-psycho-social factors affecting functioning against criteria set forth in service utilization guidelines. In order for a person to qualify for **Adult ADDICTIVE DISEASE ONGOING SUPPORT AND RECOVERY services**, certain diagnostic and functional criteria must be met, including the following:

1. **Diagnostic-** The person has a verified Axis I diagnosis (**note:** not just a diagnostic impression) of a substance related disorder (excluding substance intoxication). Substances can refer to a drug of abuse, a medication or a toxin.
2. **Functional** - The individual's level of functioning has been significantly affected by the substance related disorder to the degree that there is a marked decrease in health and in ability to function. This decrease in health or in functioning must be demonstrated **EITHER** by **both "a" and "b"** below, **OR by "c" alone**.
 - a. The individual's score on the Level Of Care Utilization System (LOCUS) indicates that the individual would be appropriate for a Level 1 level of care.

--AND--

- b. The individual has been in services for an extended period of time (six months or longer) with a qualifying Axis I diagnosis, and functioning does not currently meet the criteria for a LOCUS Level 2 or higher level of care. Without the supports/services provided, the individual would likely be unable to maintain his or her current level of recovery to the extent that his or her functioning would revert back to meeting the criteria for a LOCUS Level 2 or higher level of care.

--OR--

- c. The individual's score on the Level Of Care Utilization System (LOCUS) indicates that the individual would be appropriate for a Level 2 or above level of care.

G. DIAGNOSTIC CATEGORIES APPROVED FOR STATE FUNDED SERVICES

1. Adult Mental Health:

- a. Schizophrenia and Other Psychotic Disorders
- b. Mood Disorders
- c. Anxiety Disorders
- d. Adjustment Disorders (By definition, an Adjustment Disorder must resolve within 6 months of the termination of the stressor or its consequences)
- e. Mental Disorders Due to a General Medical Condition Not Elsewhere Classified
- f. **Exclusions:** The following disorders are **excluded** unless co-occurring with a qualifying primary Axis I mental or substance related disorder that is the focus of treatment:
 1. Tic disorders,
 2. Mental Retardation
 3. Learning Disorders
 4. Motor Skills Disorders
 5. Communication Disorders
 6. Organic Mental Disorders
 7. Pervasive Developmental Disorders
 8. Personality Change Due to a General Medical Condition
 9. Mental Disorder NOS Due to a General Medical Condition
 10. V Codes

2. Adult Addictive Diseases

- a. Substance-Related Disorders including but not limited to substance abuse, substance dependence, and substance withdrawal.
- b. Note that severity and duration of substance related disorders are not considered in regard to the Core Customer criteria (except as they may be inherent to the definition of a disorder).
- c. Exclusions:
 1. Caffeine-Induced Disorders
 2. Nicotine-Related Disorders
 3. Substance Intoxication- only excluded for Ongoing Services.

NOTE: *The presence of co-occurring mental illnesses, substance related disorders and/or developmental disabilities is not uncommon and typically results in a more complicated clinical presentation. Individuals diagnosed with the excluded Axis I mental disorders listed above and/or with Axis II disorders may receive services **ONLY** when these disorders co-occur with a qualifying primary Axis I mental illness or substance related disorder. The qualifying Axis I mental illness or substance related disorder must be the presenting problem and the primary diagnosis/focus of treatment, and the individual must meet the functional criteria listed above.*

H. CONTINUED REVIEW OF ELIGIBILITY

Eligibility will be reviewed as individuals' MICP reauthorizations become due.

Mental Health and Addictive Disease

Orientation to Services

Overview of Service Packages

In order to make it easier for providers to request groups of services that are frequently provided concurrently, the DBHDD has created service packages which can be requested to support an individual. These packages work in a manner similar to the current Brief Registration package. When a request for a package is approved, the response includes authorization for all of the services in the package without the need for the provider to individually select each of the component services. In addition, when compared to services selected individually from the À la carte menu, packages may have different authorization periods and may authorize different quantities of units within the package to reflect the particular needs of the target group of individuals. In order to utilize a package, it is not necessary that the individual receive all of the services and/or units in the package (unless otherwise noted in a specific guideline for that service).

Orders and Treatment Plans

Orders for services and treatment plans must still indicate which specific services from the package are being requested for an individual. The treatment plan must reference the individual services and the frequency with which they will be provided. The order and treatment plan must conform to the requirements listed in the *Documentation Guidelines* in Part II, Section IV of this manual.

Adding Additional Services to Packages

If additional services are needed once a package is authorized, providers may add services by using an MICP Update request type. Providers should be aware that, if the number of days remaining on the package is greater than the length of the authorization period for the additional a' la carte service selected, the end date of the package's authorization period will be rolled back to reflect the shorter authorization period of the additional service. For example, if there are 200 days remaining on a Medication Maintenance package and Individual Counseling (180-day authorization period) is added, the end of the Medication Maintenance package will be rolled back to 180 days from the date Individual Counseling is added. If there had been 150 days remaining on the Medication Maintenance package at the time Individual Counseling was added, the length of authorization for both the Medication Maintenance package and the added Individual Counseling service would remain at 150 days. The only exception to this is the Crisis Stabilization Program service, which has an authorization period of 20 days and which will continue to "float" over any other services authorized and will not cause the authorization periods for other services to be rolled back.

The available packages are detailed below:

A. Brief Registration

The Brief Registration Package is designed to provide a comprehensive package of services that can be provided to new consumers for up to 90 days. It may be requested only through submission of a MICP Registration. This package includes the services determined to be essential to completing the initial assessments and individualized resiliency/recovery plan, crisis intervention services, and a brief period of therapy and skills training services. The following table lists the services, maximum daily unit limits, and maximum units currently available during the 90-day authorization period.

Package Code	Package Name	Service Groups Included	Service Group Name	Auth Period in Days	Max Auth Units	Max Daily Units
P0001	Brief Registration	10101	Beh Health Assmt & Serv Plan Development	90	32	24
		10102	Psychological Testing	90	5	5
		10103	Diagnostic Assessment	90	2	2
		10110	Crisis Intervention	90	20	16
		10120	Psychiatric Treatment	90	6	1
		10130	Nursing Assessment & Care	90	12	12
		10140	Medication Administration	90	6	1
		10150	Community Support	90	200	96
		10160	Individual Outpatient Services	90	8	1
		10170	Group Outpatient Services	90	480	16
		10180	Family Outpatient Services	90	32	8
		21202	Community Transition Planning	90	10	10

This package may only be requested for new consumers. It cannot be requested for existing consumers, cannot follow any existing MICP authorization, and must either be followed by a MICP Discharge or a MICP Ongoing request.

B. Medication Maintenance

This package is designed for the provider to request the units of service necessary to support an individual whose mental health or substance abuse problems are essentially stable and whose needs include ongoing medication management and relatively fewer supports. The authorization period for this package is 365 days and it may be requested by submission of a *MICP New Episode* or *MICP Ongoing* request with the **Medication Maintenance** package selected.

The following table lists the services, maximum daily unit limits, and maximum units currently available during the 365-day authorization period:

Package Code	Package Name	Service Groups Included	Service Group Name	Auth Period in Days	Max Auth Units	Max Daily Units
P0002	Medication Maintenance	10101	Beh Health Assmt & Serv Plan Development	365	6	6
		10103	Diagnostic Assessment	365	2	2
		10120	Psychiatric Treatment	365	6	1
		10130	Nursing Assessment & Care	365	8	8
		10140	Medication Administration	365	30	1
		10150	Community Support	365	48	48

C. Crisis Stabilization Program

This package is designed for use by providers that operate Crisis stabilization units of 16 beds or less off the grounds of a state hospital and bill Medicaid. Programs of greater than 16 beds or those on the grounds of a state hospital may **not** bill claims to Medicaid and should submit a MICP request for the individual Crisis Stabilization Unit service and submit encounters as instructed in the CSU service definition.

Providers that are eligible to bill Medicaid for services provided in a CSU may bill for the unbundled services listed in the package, up to the daily maximum for each service, and should also submit encounters for the CSU service as instructed in the service definition. Although not all services provided in a CSU are individually billable, the program expectations for services to be provided within CSUs have not changed. Providers of C&A CSU services may not bill **unbundled** service encounters through the C&A fee-for-service system for services provided within any Crisis Stabilization Unit due to the fact that this is a state-contracted service. Only CSU service encounters may be submitted for non-Medicaid eligible children in CSUs.

The following table lists the services, maximum daily unit limits, and maximum units currently available during the 20-day authorization period:

Package Code	Package Name	Service Groups Included	Service Group Name	Auth Period in Days	Max Auth Units	Max Daily Units
P0003	Crisis Stabilization Program	20101	Crisis Stabilization Program	20	20	1
		10101	Beh Health Assmt & Serv Plan Development	20	32	24
		10103	Diagnostic Assessment	20	2	2
		10110	Crisis Intervention	20	32	8
		10120	Psychiatric Treatment	20	20	1
		10130	Nursing Assessment & Care	20	80	5
		10140	Medication Administration	20	20	1
		10170	Group Outpatient Services	20	80	4

D. MH Intensive Outpatient (C&A)

This Intensive Outpatient package was designed to support agencies that provide services at an intensity that would be consistent with a C&A Mental Health day treatment model. Since the DBHDD was required by CMS to discontinue reimbursement for bundled day treatment services, providers have had to bill for the individual services provided within their programs.

The C&A package differs from the Adult package only in that it includes the state-funded Structured Activity Supports service. The following table lists the services, maximum daily unit limits, and maximum units currently available during the 180-day authorization period:

Service Group Code	Package Name	Service Groups Included	Service Name	Auth Period in Days	Max Auth Units	Max Daily Units
P0004	MH Intensive Outpatient (C&A)	10101	Beh Health Assmt & Serv Plan Development	180	32	24
		10102	Psychological Testing	180	10	5
		10103	Diagnostic Assessment	180	4	2
		10110	Crisis Intervention	180	24	16
		10120	Psychiatric Treatment	180	24	1
		10130	Nursing Assessment & Care	180	24	16
		10140	Medication Administration	180	40	1
		10150	Community Support	180	600	96
		10160	Individual Outpatient Services	180	36	1
		10170	Group Outpatient Services	180	1170	16
		10180	Family Outpatient Services	180	100	8
		20902	Structured Activity Supports	180	320	8

E. MH Intensive Outpatient (Adult)

The Intensive Outpatient package was designed to support agencies that provide services at an intensity that would be consistent with a day treatment model. Since the DBHDD was required by CMS to discontinue reimbursement for bundled day treatment services, providers have had to bill for the individual services provided within their programs.

The following table lists the services, maximum daily unit limits, and maximum units currently available during the 180-day authorization period:

Service Group Code	Package Name	Service Groups Included	Service Name	Auth Period in Days	Max Auth Units	Max Daily Units
P0005	MH Intensive Outpatient (Adults)	10101	Beh Health Assmt & Serv Plan Development	180	32	24
		10102	Psychological Testing	180	10	5
		10103	Diagnostic Assessment	180	4	2
		10110	Crisis Intervention	180	24	16
		10120	Psychiatric Treatment	180	24	1
		10130	Nursing Assessment & Care	180	24	16
		10140	Medication Administration	180	40	1
		10150	Community Support	180	600	96
		10160	Individual Outpatient Services	180	36	1
		10170	Group Outpatient Services	180	1170	16
		10180	Family Outpatient Services	180	100	8

F. SA Intensive Outpatient (Adolescent)

This Intensive Outpatient package was designed to support agencies that provide services at an intensity that would be consistent with a SA Adolescent day treatment model. Since the DBHDD was required by CMS to discontinue reimbursement for bundled day treatment services, providers have had to bill for the individual services provided within their programs.

The SA Adolescent package differs from the Adult package only in that it includes the state-funded Structured Activity Supports service. The following table lists the services, maximum daily unit limits, and maximum units currently available during the 180-day authorization period:

Service Group Code	Package Name	Service Groups Included	Service Name	Auth Period in Days	Max Auth Units	Max Daily Units
P0006	SA Intensive Outpatient (Adolescent)	10101	Beh Health Assmt & Serv Plan Development	180	32	24
		10103	Diagnostic Assessment	180	4	2
		10120	Psychiatric Treatment	180	12	1
		10130	Nursing Assessment & Care	180	48	16
		10150	Community Support	180	600	96
		10160	Individual Outpatient Services	180	36	1
		10170	Group Outpatient Services	180	1170	20
		10180	Family Outpatient Services	180	100	8
		20902	Structured Activity Supports	180	320	8

G. SA Intensive Outpatient (Adult)

The SA Intensive Outpatient package is designed to support agencies that provide services at an intensity that would be consistent with a day treatment model. Since the DBHDD was required by CMS to discontinue reimbursement for bundled day treatment services, providers have had to bill for the individual services provided within their programs.

The following table lists the services, maximum daily unit limits, and maximum units currently available during the 180-day authorization period:

Service Group Code	Package Name	Service Groups Included	Service Name	Auth Period in Days	Max Auth Units	Max Daily Units
P0007	SA Intensive Outpatient (Adults)	10101	Beh Health Assmt & Serv Plan Development	180	32	24
		10103	Diagnostic Assessment	180	4	2
		10120	Psychiatric Treatment	180	12	1
		10130	Nursing Assessment & Care	180	48	16
		10150	Community Support	180	600	96
		10160	Individual Outpatient Services	180	36	1
		10170	Group Outpatient Services	180	1170	20
		10180	Family Outpatient Services	180	100	8

H. Assertive Community Treatment

The Assertive Community Treatment package was constructed in FY11 to allow Assertive Community Treatment teams the opportunity to provide curriculum-based group supports to individuals who are enrolled recipients of the ACT team services/supports. The package format allows the DBHDD to track and monitor services for this specific set of services.

Package Code	Package Name	Service Groups Included	Service Group Name	Auth Period in Days	Max Auth Units	Max Daily Units
P0011	Assertive Community Treatment	20601	Assertive Community Treatment	90	240	60
		20603	ACT- Group Outpatient Services	90	96	8

I. Ready For Work (RFW) Services and Supports (Adult)

The Ready for Work packages are designed to allow RFW agencies to select a group of services specified in their contracts to support a very specific population (See Part I, Section V). The package format allows the DBHDD to track and monitor services for this specific set of services in an unbundled environment.

Service Group Code	Package Name	Service Groups Included	Service Name	Auth Period in Days	Max Auth Units	Max Daily Units	Medicaid/ State
P0008	RFW Intensive Outpatient	10101	Beh Health Assmt & Serv Plan Development	180	32	24	Both
		10103	Diagnostic Assessment	180	4	2	Both
		10120	Psychiatric Treatment	180	12	1	Both
		10130	Nursing Assessment & Care	180	48	16	Both
		10150	Community Support	180	600	48	Both
		10160	Individual Outpatient Services	180	36	1	Both
		10170	Group Outpatient Services	180	1170	20	Both
		10180	Family Outpatient Services	180	100	8	Both

Service Group Code	Package Name	Service Groups Included	Service Name	Auth Period in Days	Max Auth Units	Max Daily Units	Medicaid/ State
P0009	RFW Intensive Residential	20510	Structured Residential- RFW/TANF	180	180	1	State ¹
		10101	Beh Health Assmt & Serv Plan Development	180	32	24	Both
		10103	Diagnostic Assessment	180	4	2	Both
		10120	Psychiatric Treatment	180	24	1	Both
		10130	Nursing Assessment & Care	180	48	16	Both
		10140	Medication Administration	180	40	1	Both

¹ These services cannot be billed to Medicaid and should be billed as State Contracted Services or Fee for Service

Overview of Modifiers:

Certain services in the Service Guidelines contain specific modifiers. The following is a list of the modifiers included herein and their specific description:

MODIFIER DESCRIPTIONS

GT = Via Interactive audio and video telecommunication systems
HA = Child/Adolescent Program
HQ = Group Setting
HR = Family/Couple with client present
HS = Family/Couple without client present
HT = Multidisciplinary team
U1 = Practitioner Level 1
U2 = Practitioner Level 2
U3 = Practitioner Level 3
U4 = Practitioner Level 4
U5 = Practitioner Level 5
U6 = In-Clinic
U7 = Out-of-Clinic
UK = Collateral Contact

The following modifiers are State created and used on state services only:

H9 = Court-ordered
R1 = Residential Level 1 (State Code)
R2 = Residential Level 2 (State Code)
R3 = Residential Level 3 (State Code)
TB = Transitional Bed (State Code)
U2 = Crisis Stabilization Unit High Intensity (State Code)
ZH = From State Hospital (State Code)
ZC = From Crisis Stabilization Unit (State Code)
ZP = From PRTF - Psychiatric Residential Treatment Facility (State Code)
ZJ = From Jail / YDC / RYDC (State Code)
ZO = From Other Institutional Setting (State Code)

Mental Health and Addictive Disease

***Children and Adolescents'
CORE Benefit Package***

Behavioral Health Assessment

HIPAA Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Mental Health Assessment by a non-Physician	Practitioner Level 2, In-Clinic	H0031	U2	U6			\$38.97
	Practitioner Level 3, In-Clinic	H0031	U3	U6			\$30.01
	Practitioner Level 4, In-Clinic	H0031	U4	U6			\$20.30
	Practitioner Level 5, In-Clinic	H0031	U5	U6			\$15.13
	Practitioner Level 2, Out-of-Clinic	H0031	U2	U7			\$46.76
	Practitioner Level 3, Out-of-Clinic	H0031	U3	U7			\$36.68
	Practitioner Level 4, Out-of-Clinic	H0031	U4	U7			\$24.36
	Practitioner Level 5, Out-of-Clinic	H0031	U5	U7			\$18.15

Definition of Service: The Behavioral Health Assessment process consists of a face-to-face comprehensive clinical assessment with the individual, which must include the youth's perspective, and should include family/responsible caregiver(s) and others significant in the youth's life as well as collateral agencies/treatment providers.

The purpose of the Behavioral Health Assessment process is to gather all information needed in to determine the youth's problems, symptoms, strengths, needs, abilities and preferences, to develop a social (extent of natural supports and community integration) and medical history, to determine functional level and degree of ability versus disability, and to engage with collateral contacts for other assessment information. An age-sensitive suicide risk assessment shall also be completed. The information gathered should support the determination of a differential diagnosis and assist in screening for/ruling-out potential co-occurring disorders.

As indicated, information from medical, nursing, school, nutritional, etc. staff should serve as the basis for the comprehensive assessment and the resulting IRP.

The entire process should involve the child/youth as a full partner and should include assessment of strengths and resources as identified by the youth and his/her family.

Target Population

Children & Adolescents with a known or suspected mental health diagnosis and/or Substance-Related Disorder

Benefit Information	Available to all known or suspected Core Customers. Requires a MICP Registration or a MICP New Episode.
Utilization Criteria	<u>Available to those with CAFAS scores:</u> 10-50: Resiliency Maintenance 60-90: Low Intensity Community-Based Services 100-130: High Intensity Community-Based Services 140-180: Medically Monitored Community Residential 190-240: Medically Managed Community Residential 190-240: Medically Managed Inpatient Residential
Ordering Practitioner	Physician, Psychologist, Physician's Assistant, Advanced Practice Registered Nurse (Clinical Nurse Specialist or Nurse Practitioner), LPC, LMFT, LCSW
Unit Value	15 minutes
Initial Authorization*	32 units (Combined with H0032 – Service Plan Development)
Re-Authorization*	32 units (Combined with H0032 – Service Plan Development)
Maximum Daily Units*	24 units (Combined with H0032 – Service Plan Development)
Authorization Period*	180 days
UAS: Budget and Expense Categories	<u>Core Services Provider</u> 231 – C&A Mental Health 831 – C&A Addictive Diseases
Admission Criteria	1. A known or suspected mental illness or substance-related disorder; and 2. Initial screening/intake information indicates a need for further assessment; and 3. At least a preliminary indication that youth meets Core Customer eligibility.
Continuing Stay Criteria	The youth's situation/functioning has changed in such a way that previous assessments are outdated.
Discharge Criteria	1. An adequate continuing care plan has been established; and one or more of the following: 2. Individual has withdrawn or been discharged from service; or 3. Individual no longer demonstrates need for additional assessment.
Service Exclusions	None
Clinical Exclusions	None

**(unless authorized as a part of a specific "package" which changes the authorization parameters)*

Additional Service Criteria:

A. Required Components

1. Any diagnosis given to an individual must come from persons identified in O.C.G.A Practice Acts as qualified to provide a diagnosis. These practitioners include a licensed psychologist, a physician or a PA or APRN (NP and CNS-PMH) working in conjunction with a physician with an approved job description or protocol.
2. As indicated, medical, nursing, peer, school, nutritional, etc. staff can provide information from records, and various multi-disciplinary resources to complete the comprehensive nature of the assessment and time spent gathering this information may be billed as long as the detailed documentation justifies the time and need for capturing said information.
3. An initial Behavioral Health Assessment is required within the first 30 days of service, with ongoing assessments completed as demanded by changes with an individual.
4. "Out-of-Clinic" may only be billed when:

- Travel by the practitioner is to a non-contiguous location; and/or
 - Travel by the practitioner is to a facility not owned, leased, controlled or named as a service site by the agency who is billing the service(excepting visits to Shelter Plus sites); and/or
 - Travel is to a facility owned, leased or controlled by the agency billing the service, but no more than 6 individuals are being served in the course of that day by a single practitioner in non-group services; and/or
 - Travel is to a facility owned, leased, controlled or named as a service site by the agency, but no more than 24 individuals are being served in groups at that site in the course of a day.
- If the service does not qualify to be billed as "out of clinic," then the "in-clinic" rate may still be billed.

B. Staffing Requirements

1. The following practitioners may provide Behavioral Health Assessment services:

- Practitioner Level 2: Psychologist, APRN, PA
- Practitioner Level 3: LCSW, LPC, LMFT, RN
- Practitioner Level 4: LMSW; LAPC; LAMFT; Psychologist/LCSW/LPC/LMFT's supervisee/trainee with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology, functioning within the scope of the practice acts of the state; MAC, CAC-II, CADC, CCADC, GCADC (II, III); CAC-I or Addiction Counselor Trainees with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology (addictions counselors may only perform these functions related to treatment of addictive diseases).
- Practitioner Level 5: Certified Addiction Counselor-I, Registered Alcohol and Drug Technician (I, II, or III), Addiction Counselor Trainee with high school diploma/equivalent (practitioners at this level may only perform these functions related to treatment of addictive diseases).

C. Clinical Operations

1. The individual consumer (and caregiver/responsible family members, etc., as appropriate) should actively participate in the assessment processes.

D. Service Access

1. Children/Families access this service when it has been determined through an initial screening that the youth has mental health or addictive disease concerns.
2. Behavioral Health Assessment may **not** be provided in an Institution for Mental Diseases (IMD, e.g. state or private psychiatric hospital, psychiatric residential treatment facility or Crisis Stabilization Unit with greater than 16 beds), jail, youth development center (YDC) or prison system. This service may not be provided or billed via this code for youth who are involuntarily detained in Regional Youth Detention Centers (RYDCs) awaiting criminal proceedings, penal dispositions, or other involuntary detainment proceedings. Any exception to this requires supporting documentation from the DJJ partners. The provider holds the risk for assuring the youth's eligibility.

E. Additional Medicaid Requirements

1. The daily maximum within a CSU for combined Behavioral Health Assessment and Service Plan Development is 24 units/day.

F. Reporting & Billing Requirements

1. All other applicable Medicaid, MICP, ERO, and other DBHDD reporting requirements must be followed.

G. Documentation Requirements

1. Providers must document services in accordance with the specifications for documentation requirements specified in Part II, Section V of the Provider Manual
2. In addition to the authorization produced through this service, documentation of clinical assessment findings from this service must also be completed and placed in the individual's chart as a Comprehensive Assessment.

Community Support							
HIPAA Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Community Support	Practitioner Level 4, In-Clinic	H2015	U4	U6			\$20.30
	Practitioner Level 5, In-Clinic	H2015	U5	U6			\$15.13
	Practitioner Level 4, Out-of-Clinic	H2015	U4	U7			\$24.36
	Practitioner Level 5, Out-of-Clinic	H2015	U5	U7			\$18.15
	Practitioner Level 4, In-Clinic, Collateral Contact	H2015	UK	U4	U6		\$20.30
	Practitioner Level 5, In-Clinic, Collateral Contact	H2015	UK	U5	U6		\$15.13
	Practitioner Level 4, Out-of-Clinic, Collateral Contact	H2015	UK	U4	U7		\$24.36
	Practitioner Level 5, Out-of-Clinic, Collateral Contact	H2015	UK	U5	U7		\$18.15

Definition of Service: Community Support services consist of rehabilitative, environmental support and resources coordination considered essential to assist a youth and family in gaining access to necessary services and in creating environments that promote resiliency and support the emotional and functional growth and development of the youth. The service activities of Community Support include:

- Assistance to the youth and family/responsible caregivers in the facilitation and coordination of the Individual Resiliency Plan (IRP) including providing skills support in the youth/family's self-articulation of personal goals and objectives;
- Planning in a proactive manner to assist the youth and family in managing or preventing crisis situations;
- Individualized interventions, which shall have as objectives:
 - 1) Identification, with the youth, of strengths which may aid him/her in achieving resilience, as well as barriers that impede the development of skills necessary for age-appropriate functioning in school, with peers, and with family;
 - 2) Support to facilitate enhanced natural and age-appropriate supports (including support/assistance with defining what wellness means to the youth in order to assist them with resiliency-based goal setting and attainment);
 - 3) Assistance in the development of interpersonal, community coping and functional skills (including adaptation to home, school and healthy social environments);
 - 4) Encouraging the development and eventual succession of natural supports in living, learning, working, other social environments;
 - 5) Assistance in the acquisition of skills for the youth to self-recognize emotional triggers and to self-manage behaviors related to the youth's identified emotional disturbance;
 - 6) Assistance with personal development, school performance, work performance, and functioning in social and family environment through teaching skills/strategies to ameliorate the effect of behavioral health symptoms;
 - 7) Assistance in enhancing social and coping skills that ameliorate life stresses resulting from the youth's emotional disturbance;

- 8) Service and resource coordination to assist the youth and family in gaining access to necessary rehabilitative, medical, social and other services and supports;
- 9) Assistance to youth and other supporting natural resources with illness understanding and self-management;
- 10) Any necessary monitoring and follow-up to determine if the services accessed have adequately met the youth's needs;
- 11) Identification, with the youth/family, of risk indicators related to substance related disorder relapse, and strategies to prevent relapse.

This service is provided to youth in order to promote stability and build towards age-appropriate functioning in their daily environment. Stability is measured by a decreased number of hospitalizations, by decreased frequency and duration of crisis episodes and by increased and/or stable participation in school and community activities. Supports based on the youth's needs are used to promote resiliency while understanding the effects of the emotional disturbance and/or substance use/abuse and to promote functioning at an age-appropriate level. The Community Support staff will serve as the primary coordinator of behavioral health services and will provide linkage to community; general entitlements; and psychiatric, substance use/abuse, medical services, crisis prevention and intervention services.

Target Population	Children and Adolescents with one of the following: Mental Health Diagnosis Substance-Related Disorder Co-Occurring Substance-Related Disorder and Mental Health Diagnosis Co-Occurring Mental Health Diagnosis and Mental Retardation/Developmental Disabilities Co-Occurring Substance-Related Disorder and Mental Retardation/Developmental Disabilities
Benefit Information	Available to Core Customers. Requires a MICP Registration or a MICP New Episode.
Utilization Criteria	<u>Available to those with CAFAS scores:</u> 10-50: Resiliency Maintenance 60-90: Low Intensity Community-Based Services 100-130: High Intensity Community-Based Services 140-180: Medically Monitored Community Residential 190-240: Medically Managed Community Residential 190-240: Medically Managed Inpatient Residential
Ordering Practitioner	Physician, Psychologist, Physician's Assistant, Advanced Practice Registered Nurse (Clinical Nurse Specialist or Nurse Practitioner), LPC, LMFT, LCSW
Unit Value	15 minutes
Initial Authorization*	600 units
Re-Authorization*	600 units
Maximum Daily Units*	48 units
Authorization Period*	180 days
UAS: Budget and Expense Categories	<u>Core Services Provider</u> 226 – C&A Mental Health 826 – C&A Addictive Diseases

Admission Criteria	<ol style="list-style-type: none"> 1. Individual must meet target population criteria as indicated above; and one or more of the following: 2. Individual may need assistance with developing, maintaining, or enhancing social supports or other community coping skills; or 3. Individual may need assistance with daily living skills including coordination to gain access to necessary rehabilitative and medical services
Continuing Stay Criteria	<ol style="list-style-type: none"> 1. Individual continues to meet admission criteria; and 2. Individual demonstrates documented progress or maintenance of community skills relative to goals identified in the Individualized Resiliency Plan.
Discharge Criteria	<ol style="list-style-type: none"> 1. An adequate continuing care plan has been established; and one or more of the following: 2. Goals of Individualized Resiliency Plan have been substantially met; or 3. Individual/family requests discharge and the individual is not imminently in danger of harm to self or others; or 4. Transfer to another service is warranted by change in the individual's condition.
Service Exclusions	<ol style="list-style-type: none"> 1. Intensive Family Intervention and CSI may be provided concurrently during transition between these services for support and continuity of care for a maximum of four units of CSI per month. If services are provided concurrently, CSI should not be duplication of IFI services. This service must be adequately justified in the Individualized Resiliency Plan. 2. Assistance to the youth and family/responsible caregivers in the facilitation and coordination of the Individual Resiliency Plan (IRP) including providing skills support in the youth/family's self-articulation of personal goals and objectives can be billed as CSI; however, the actual plan development must be billed and provided in accordance with the service guideline for Service Plan Development. 3. The billable activities of Community Support do not include: <ul style="list-style-type: none"> • Transportation • Observation/Monitoring • Tutoring/Homework Completion • Diversionary Activities (i.e. activities/time during which a therapeutic intervention tied to a goal on the individual's treatment plan is not occurring)
Clinical Exclusions	<ol style="list-style-type: none"> 1. There is a significant lack of community coping skills such that a more intensive service is needed. 2. Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of a psychiatric condition overlaying the primary diagnosis: <ul style="list-style-type: none"> • mental retardation • autism • organic mental disorder, or • traumatic brain injury

**(unless authorized as a part of a specific "package" which changes the authorization parameters)*

Additional Service Criteria:

A. Required Components

1. Community Support services must include a variety of interventions in order to assist the consumer in developing:
 - Symptom self-monitoring and self-management of symptoms
 - Strategies and supportive interventions for avoiding out-of-home placement for youth and building stronger family support skills and knowledge of the youth or youth's strengths and limitations
 - Relapse prevention strategies and plans
2. Community Support services focus on building and maintaining a therapeutic relationship with the youth and facilitating treatment and resiliency goals.
3. The organization must have policies and procedures for protecting the safety of staff that engage in these community-based service delivery activities.
4. Contact must be made with youth receiving Community Support services a minimum of twice each month. At least one of these contacts must be face-to-face and the second may be either face-to-face or telephone contact (denoted by the UK modifier) depending on the youth's support needs and documented preferences of the family.
5. At least 50% of CSI service units must be delivered face-to-face with the identified youth receiving the service and at least 80% of all face-to-face service units must be delivered in non-clinic settings over the authorization period (these units are specific to single individual consumer records and are not aggregate across an agency/program or multiple payors).
6. In the absence of the required monthly face-to-face contact **and** if at least two unsuccessful attempts to make face-to-face contact have been tried and documented, the provider may bill for a maximum of two telephone contacts in that specified month (denoted by the UK modifier).
7. Unsuccessful attempts to make contact with the consumer are not billable.
8. When this service is provided to youth and their families, the child/adolescent consumer of service must clearly remain the target of service.
9. Any diagnosis given to a youth must come from persons identified in O.C.G.A Practice Acts as qualified to provide a diagnosis. These practitioners include a licensed psychologist, a physician or a PA or APRN (NP and CNS-PMH) working in conjunction with a physician with an approved job description or protocol.
10. When the primary focus of Community Support services for youth is medication maintenance, the following allowances apply:
 - a. These youth are not counted in the offsite service requirement or the consumer-to-staff ratio; and
 - b. These youth are not counted in the monthly face-to-face contact requirement; however, face-to-face contact is required every 3 months and monthly calls are an allowed billable service.
11. CSI is an individual intervention and may **not** be provided or billed for more than one consumer during the same time period.
12. "Out-of-Clinic" may only be billed when:
 - Travel by the practitioner is to a non-contiguous location; and/or
 - Travel by the practitioner is to a facility not owned, leased, controlled or named as a service site by the agency who is billing the service(excepting visits to Shelter Plus sites); and/or

- Travel is to a facility owned, leased or controlled by the agency billing the service, but no more than 6 individuals are being served in the course of that day by a single practitioner in non-group services; and/or
 - Travel is to a facility owned, leased, controlled or named as a service site by the agency, but no more than 24 individuals are being served in groups at that site in the course of a day.
- If the service does not qualify to be billed as "out of clinic," then the "in-clinic" rate may still be billed.

B. Staffing Requirements

1. The following practitioners may provide Community Support services:
 - Practitioner Level 1: Physician/Psychiatrist (reimbursed at Level 4 rate)
 - Practitioner Level 2: Psychologist, APRN, PA (reimbursed at Level 4 rate)
 - Practitioner Level 3: LCSW, LPC, LMFT, RN (reimbursed at Level 4 rate)
 - Practitioner Level 4: LMSW; LAPC; LAMFT; Psychologist/LCSW/LPC/LMFT's supervisee/trainee with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology, functioning within the scope of the practice acts of the state; MAC, CAC-II, CADC, CCADC, GCADC (II, III); PP, CPRP, CAC-I or Addiction Counselor Trainees with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology
2. Under the documented supervision (organizational charts, supervisory notation, etc.) of one of the licensed/credentialed professionals above, the following staff may also provide Community Support:
 - Certified Peer Specialists
 - Paraprofessional staff
 - Certified Psychiatric Rehabilitation Professional
 - Certified Addiction Counselor-I
 - Registered Alcohol and Drug Technician (I,II, or III)
 - Addiction Counselor Trainee
3. Community Support practitioners may have the recommended consumer-to-staff ratio of 30 consumers per staff member and must maintain a maximum ratio of 50 consumers per staff member. Youth who receive only medication maintenance are not counted in the staff ratio calculation.

C. Clinical Operations

1. Community Support services provided to youth must include coordination with family and significant others and with other systems of care such as the school system, juvenile justice system, and child welfare and child protective services when appropriate to treatment and educational needs. This coordination is an essential component of Community Support and can be billed for up to 70 percent of the contacts when directly related to the support and enhancement of the youth's resilience. When this type of intervention is delivered, it shall be designated with a UK modifier.

2. Community Support providers must have the ability to deliver services in various environments, such as homes, schools, homeless shelters, or street locations. The provider should keep in mind that families may prefer to meet staff at a community location other than their homes or other conspicuous locations (e.g. their school), especially if staff drive a vehicle that is clearly marked as a state or agency vehicle, or if staff must identify themselves and their purpose to gain access to the youth in a way that may potentially embarrass the individual or breach the youth's privacy/confidentiality. Staff should be sensitive to and respectful of youth and family privacy/confidentiality rights and preferences in this regard to the greatest extent possible (e.g. if staff must meet with a youth during their school time, choosing inconspicuous times and locations to promote privacy).
3. If services are performed in school setting during school hours:
 - a. Documentation must indicate that intervention is most effective when provided during school hours.
 - b. IRP should indicate how the intervention has been coordinated among family system, school, and provider.
4. The organization must have policies that govern the provision of services in natural settings and can document that it respects youth and/or families' right to privacy and confidentiality when services are provided in these settings.
5. The organization must have established procedures/protocols for handling emergency and crisis situations that describe methods for supporting youth as they transition to and from psychiatric hospitalization.
6. Each provider must have policies and procedures for the provision of individual-specific outreach services, including means by which these services and youth are targeted for such efforts.
7. The organization must have a Community Support Organizational Plan that addresses the following:
 - a. Description of the particular rehabilitation, resiliency and natural support development models utilized, types of intervention practiced, and typical daily schedule for staff
 - b. Description of the staffing pattern and how staff are deployed to assure that the required staff-to-consumer ratios are maintained, including how unplanned staff absences, illnesses, or emergencies are accommodated, how case mix is managed, access, etc.
 - c. Description of the hours of operations as related to access and availability to the youth served; and
 - d. Description of how the plan for services is modified or adjusted to meet the needs specified in every Individualized Resiliency Plan
8. Utilization (frequency and intensity) of CSI should be directly related to the CAFAS and to the other functional elements of the youth's assessment. In addition, when clinical/functional needs are great, there should be complementary therapeutic services by licensed/credential professionals paired with the provision of CSI (individual, group, family, etc.).

D. Service Accessibility

1. Specific to the "Medication Maintenance Track," consumers who require more than 4 contacts per quarter for two consecutive quarters (as based upon clinical need) are expected to be re-evaluated with the CAFAS for enhanced access to CSI and/or other services. The designation of the CSI "medication maintenance track" should be lifted and exceptions stated above in A.10. are no longer applied.

2. Community Support may **not** be provided in an Institution for Mental Diseases (IMD, e.g. state or private psychiatric hospital, psychiatric residential treatment facility or Crisis Stabilization Unit with greater than 16 beds), jail, youth development center (YDC) or prison system.
3. This service may not be provided and billed for youth who are involuntarily detained in Regional Youth Detention Centers (RYDCs) awaiting criminal proceedings, penal dispositions, or other involuntary detention proceedings. Any exception to this requires supporting documentation from the DJJ partners. The provider holds the risk for assuring the youth's eligibility

E. Additional Medicaid Requirements

Currently, there are no additional Medicaid requirements to be added to the requirements above when billing Medicaid for this service.

F. Reporting & Billing Requirements

1. When a billable collateral contact is provided, the H2015UK reporting mechanism shall be utilized. A collateral contact is classified as any contact that is not face-to-face with the individual.
2. All other applicable Medicaid, MICP, ERO, and other DBHDD reporting requirements must be followed.

G. Documentation Requirements

Providers must document services in accordance with the specifications for documentation requirements specified in Part II, Section V of the Provider Manual.

Community Transition Planning							
Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Community Transition Planning	Community Transition Planning (State Hospital)	T2038	ZH				\$20.92
	Community Transition Planning (Crisis Stabilization Unit)	T2038	ZC				\$20.92
	Community Transition Planning (PRTF)	T2038	ZP				\$20.92
	Community Transition Planning (Jail / Youth Detention Center)	T2038	ZJ				\$20.92
	Community Transition Planning(Other)	T2038	ZO				\$20.92

Definition of Service: Community Transition Planning is a service provided by Core and IFI providers to address the care, service, and support needs of children and adolescents with serious emotional disturbance and/or co-occurring disorders to ensure a coordinated plan of transition from a qualifying facility to the community. Each episode of Community Transition Planning must include contact with the consumer, family, or caregiver with a minimum of one (1) face-to-face contact with the consumer prior to release from a facility. Additional Transition Planning activities include: educating the consumer, family, and/or caregiver on service options offered by the chosen primary service agency; participating in facility treatment team meetings to develop a transition plan.

In partnership between other community service providers and the hospital/facility staff, the community service agency maintains responsibility for carrying out transitional activities either by the consumer's chosen primary service coordinator or by the service coordinator's designated Community Transition Liaison. Community Transition Planning may also be used for Community Support staff, ACT team members and Certified Peer Specialists who work with the consumer in the community or will work with the consumer in the future to maintain or establish contact with the consumer.

Community Transition Planning consists of the following interventions to ensure the youth, family, and/or caregiver transitions successfully from the facility to their local community:

- Establishing a connection or reconnection with the youth/parent/caregiver through supportive contacts while in the qualifying facility. By engaging with the youth, this helps to develop and strengthen a relationship. Educate the youth/parent/caregiver about local community resources and service options available to meet their needs upon transition into the community. This allows the youth/parent/caregiver to make self-directed, educated choices on those service options that they feel will best meet their needs.
- Participating in qualifying facility team meetings especially in person centered planning for those in an out-of-home treatment facility for longer than 60 days, to share hospital and community information related to estimated length of stay, present problems related to admission, discharge/release criteria, progress toward treatment goals, personal strengths, available supports and assets, medical condition, medication issues, and community treatment needs
- Linking the youth with community services including visits between the youth and the Community Support staff, or IFI team members who will be working with the youth/parent/caregiver in the community which improves the likelihood of the youth accepting services and working toward change

Target Population	Children and Adolescents with one of the following: Mental Health Diagnosis Substance Related Disorder Co-Occurring Substance-Related and Mental Health Diagnosis
Benefit Information	Available to Core Customers in need of Brief Stabilization or Ongoing Services. Requires a MICP Registration or MICP New Episode.
Utilization Criteria	Available to those currently in qualifying facilities who meet Core Customer Eligibility Definition
Unit Value	15 minutes
Reimbursement Rate	\$20.92 /unit
Initial Authorization	10 units
Re-Authorization	10 units
Authorization Period	90 days (Registration) 180 days (New Episode)
UAS: Budget and Expense Categories	262 – C&A Mental Health 862 – C&A Addictive Diseases (This is a FFS service and thus providers will not submit MIERS)
Admission Criteria	Individual who meet Core Customer Eligibility while in one of the following qualifying facilities: <ol style="list-style-type: none"> 1. State Operated Hospital 2. Crisis Stabilization Unit (CSU) 3. Psychiatric Residential Treatment Facility (PRTF) 4. Jail/Youth Development Center (YDC) 5. Other (ex: Community Psychiatric Hospital) <p>Note: Modifier on Procedure Code indicates setting in which the consumer is transitioning from.</p>
Continuing Stay Criteria	Same as above.
Discharge Criteria	<ol style="list-style-type: none"> 1. Individual/family requests discharge; or 2. Individual no longer meets Core Customer Eligibility; or 3. Individual is discharged from a qualifying facility.
Service Exclusions	None
Clinical Exclusions	Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of a co-occurring Behavioral Health condition: <ol style="list-style-type: none"> a. Developmental Disability without a co-occurring mental illness or addictive disease diagnosis b. Autism c. Organic Mental Disorder d. Traumatic Brain Injury

Additional Service Criteria:

A. Required Components

Prior to Release from a Qualifying Facility:

When the youth has had (a) a length of stay of 60 days or longer in a facility or (b) youth is readmitted to a facility within 30 days of discharge, a community transition plan in partnership with the facility is required. Evidence of planning shall be recorded and a copy of the Plan shall be included in both the youth's hospital and community record.

B. Staffing Requirements

1. A Master's/Bachelor's degree in behavioral or social science that is primarily psychological in nature under the supervision of a licensed practitioner; or
2. A Georgia Certified Peer Specialist or trained Paraprofessional under the supervision of a licensed practitioner; or
3. An LPN practicing under supervision in accordance with the Georgia Practice Acts.

C. Clinical Operations

Community Transition Planning activities shall include:

1. Telephone and Face-to-face contacts with youth/family/caregiver;
2. Participating in youth's clinical staffing(s) prior to their discharge from the facility;
3. Applications for youth resources and services prior to discharge from the facility including
 - a. Healthcare
 - b. Entitlements for which they are eligible
 - c. Education
 - d. Consumer Support Services
 - e. Applicable waivers, i.e., PRTF, and/or MRDD

D. Service Access

1. This service must be available 7 days a week (if the qualifying facility discharges or releases 7 days a week).
2. This service may be delivered via telemedicine technology or via telephone conferencing.

E. Reporting & Billing Requirements

1. There must be a minimum of one face-to-face with the youth prior to release from hospital or qualifying facility in order to bill for any telephone contacts.
2. Complete the Multipurpose Information Consumer Profile (MICP) information.
3. Providers must document services in accordance with the specifications for documentation requirements specified in PART II, Section V of the Provider Manual.

F. Documentation Requirements

1. A documented Community Transition Plan for:
 - a. Individuals with a length of stay greater than 60 days; or
 - b. Individuals readmitted within 30 days of discharge.
2. Documentation of all face-to-face and telephone contacts and a description of progress with Community Transition Plan implementation and outcomes.

Crisis Intervention							
HIPAA Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Crisis Intervention	Practitioner Level 1, In-Clinic	H2011	U1	U6			\$58.21
	Practitioner Level 2, In-Clinic	H2011	U2	U6			\$38.97
	Practitioner Level 3, In-Clinic	H2011	U3	U6			\$30.01
	Practitioner Level 4, In-Clinic	H2011	U4	U6			\$20.30
	Practitioner Level 1, Out-of-Clinic	H2011	U1	U7			\$74.09
	Practitioner Level 2, Out-of-Clinic	H2011	U2	U7			\$46.76
	Practitioner Level 3, Out-of-Clinic	H2011	U3	U7			\$36.68
	Practitioner Level 4, Out-of-Clinic	H2011	U4	U7			\$24.36

Definition of Service: Services directed toward the support of a child who is experiencing an abrupt and substantial change in behavior which is usually associated with a precipitating situation and which is in the direction of severe impairment of functioning or a marked increase in personal distress. Crisis Intervention is designed to prevent out of home placement or hospitalization. Often, a crisis exists at such time as a child and/or his or her family/responsible caregiver(s) decide to seek help and/or the individual, family/responsible caregiver(s), or practitioner identifies the situation as a crisis. Crisis services are time-limited and present-focused in order to address the immediate crisis and develop appropriate links to alternate services. Services may involve the youth and his/her family/responsible caregiver(s) and/or significant other, as well as other service providers.

The current family-owned safety plan, if existing, should be utilized to help manage the crisis. Interventions provided should honor and be respectful of the child and family's wishes/choices by following the plan as closely as possible in line with appropriate clinical judgment. Plans/advanced directives developed during the Assessment/IRP process should be reviewed and updated (or developed if the individual is a new consumer) as part of this service to help prevent or manage future crisis situations.

Some examples of interventions that may be used to de-escalate a crisis situation could include: a situational assessment; active listening and empathic responses to help relieve emotional distress; effective verbal and behavioral responses to warning signs of crisis related behavior; assistance to, and involvement/participation of the individual (to the extent he or she is capable) in active problem solving planning and interventions; facilitation of access to a myriad of crisis stabilization and other services deemed necessary to effectively manage the crisis; mobilization of natural support systems; and other crisis interventions as appropriate to the individual and issues to be addressed.

Target Population	Children/Adolescents with known or suspected Mental Health issues and/or Substance Related Disorders Children/Adolescents experiencing a severe situational crisis
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Benefit Information	Available to all known or suspected Core Customers. Requires a MICP Registration or a MICP New Episode.
Utilization Criteria	<u>Available to those with CAFAS scores:</u> 10-50: Resiliency Maintenance 60-90: Low Intensity Community-Based Services 100-130: High Intensity Community-Based Services 140-180: Medically Monitored Community Residential 190-240: Medically Managed Community Residential 190-240: Medically Managed Inpatient Residential
Ordering Practitioner	Physician, Psychologist, Physician's Assistant, Advanced Practice Registered Nurse (Clinical Nurse Specialist or Nurse Practitioner), LPC, LMFT, LCSW
Unit Value	15 minutes
Initial Authorization*	48 units
Re-Authorization*	48 units
Maximum Daily Units*	16 units
Authorization Period*	180 days
UAS: Budget and Expense Categories	<u>Core Services Provider</u> 221 – C&A Mental Health 821 – C&A Addictive Diseases
Admission Criteria	1. Treatment at a lower intensity has been attempted or given serious consideration; and #2 and/or #3 are met: 2. Youth has a known or suspected mental health diagnosis or substance related disorder; or 3. Youth is at risk of harm to self, others and/or property. Risk may range from mild to imminent; and one or both of the following: a. Youth has insufficient or severely limited resources or skills necessary to cope with the immediate crisis; or b. Youth demonstrates lack of judgment and/or impulse control and/or cognitive/perceptual abilities.
Continuing Stay Criteria	This service may be utilized at various points in the child's course of treatment and recovery, however, each intervention is intended to be a discrete time-limited service that stabilizes the individual and moves him/her to the appropriate level of care.
Discharge Criteria	1. Individual no longer meets continued stay guidelines; and 2. Crisis situation is resolved and an adequate continuing care plan has been established.
Service Exclusions	
Clinical Exclusions	Severity of clinical issues precludes provision of services at this level of care.

**(unless authorized as a part of a specific "package" which changes the authorization parameters)*

Additional Service Criteria:

A. Required Components

1. H2011 U6 is provided in clinic-based settings.
2. H2011 U7 is provided in out-of-clinic settings.

3. Any diagnosis given to an individual must come from persons identified in O.C.G.A Practice Acts as qualified to provide a diagnosis. These practitioners include a licensed psychologist, a physician or a PA or APRN (NP and CNS-PMH) working in conjunction with a physician with an approved job description or protocol.
4. "Out-of-Clinic" may only be billed when:
 - Travel by the practitioner is to a non-contiguous location; and/or
 - Travel by the practitioner is to a facility not owned, leased, controlled or named as a service site by the agency who is billing the service(excepting visits to Shelter Plus sites); and/or
 - Travel is to a facility owned, leased or controlled by the agency billing the service, but no more than 6 individuals are being served in the course of that day by a single practitioner in non-group services; and/or
 - Travel is to a facility owned, leased, controlled or named as a service site by the agency, but no more than 24 individuals are being served in groups at that site in the course of a day.If the service does not qualify to be billed as "out of clinic," then the "in-clinic" rate may still be billed.

B. Staffing Requirements

1. The following practitioners may provide Crisis Intervention services:
 - Practitioner Level 1: Physician/Psychiatrist
 - Practitioner Level 2: Psychologist, APRN, PA
 - Practitioner Level 3: LCSW, LPC, LMFT, RN
 - Practitioner Level 4: LMSW; LAPC; LAMFT; Psychologist/LCSW/LPC/LMFT's supervisee/trainee with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology, functioning within the scope of the practice acts of the state.

C. Clinical Operations

1. In any review of clinical appropriateness of this service, the mix of services offered to the individual is important. The use of crisis units will be looked at by the External Review Organization in combination with other supporting services. For example, if an individual presents in crisis and the crisis is alleviated within an hour but ongoing support continues, it is expected that 4 units of crisis will be billed and then some supporting service such as individual counseling will be utilized to support the individual during that interval of service.

D. Service Access

1. All crisis service response times for this service must be within 2 hours of the consumer or other constituent contact to the provider agency.
2. Services are available 24-hours per day, 7 days per week, and may be offered by telephone and/or face-to-face in most settings (e.g. home, school, community, clinic etc).
3. Crisis Intervention may **not** be provided in an Institution for Mental Diseases (IMD, e.g. state or private psychiatric hospital, psychiatric residential treatment facility or Crisis Stabilization Unit with greater than 16 beds), jail, youth development center (YDC) or prison system.

4. This service may not be provided and billed for youth who are involuntarily detained in Regional Youth Detention Centers (RYDCs) awaiting criminal proceedings, penal dispositions, or other involuntary detention proceedings. Any exception to this requires supporting documentation from the DJJ partners. The provider holds the risk for assuring the youth's eligibility.

E. Additional Medicaid Requirements

1. This service must be billed as either In-Clinic or Out-of-Clinic Crisis Management/ Intervention for Medicaid recipients in accordance with A. above.
2. The daily maximum within a CSU for Crisis Intervention is 8 units/day.

F. Reporting & Billing Requirements

All other applicable Medicaid, MICP, ERO, and other DBHDD reporting requirements must be followed.

G. Documentation Requirements

Providers must document services in accordance with the specifications for documentation requirements specified in Part II, Section V of the Provider Manual.

Diagnostic Assessment

HIPAA Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Psychiatric Diagnostic Examination	Practitioner Level 1, In-Clinic, Child Program	90801	HA	U1	U6		\$174.63
	Practitioner Level 1, Out-of-Clinic, Child Program	90801	HA	U1	U7		\$222.26
	Practitioner Level 1, Via interactive audio and video telecommunication systems, Child Program	90801	GT	HA	U1		\$174.63
	Practitioner Level 2, In-Clinic, Child Program	90801	HA	U2	U6		\$116.90
	Practitioner Level 2, Out-of-Clinic, Child Program	90801	HA	U2	U7		\$140.28
	Practitioner Level 2, Via interactive audio and video telecommunication systems, Child Program	90801	GT	HA	U2		\$116.90
Psychiatric Diagnostic Examination, Interactive	Practitioner Level 1, In-Clinic, Child Program	90802	HA	U1	U6		\$174.63
	Practitioner Level 1, Out-of-Clinic, Child Program	90802	HA	U1	U7		\$222.26
	Practitioner Level 1, Via interactive audio and video telecommunication systems, Child Program	90802	GT	HA	U1		\$174.63
	Practitioner Level 2, In-Clinic, Child Program	90802	HA	U2	U6		\$116.90
	Practitioner Level 2, Out-of-Clinic, Child Program	90802	HA	U2	U7		\$140.28
	Practitioner Level 2, Via interactive audio and video telecommunication systems, Child Program	90802	GT	HA	U2		\$116.90

Definition of Service: Psychiatric diagnostic interview examination includes a history; mental status exam; evaluation and assessment of physiological phenomena (including co-morbidity between behavioral and physical health care issues); psychiatric diagnostic evaluation (including assessing for co-occurring disorders and the development of a differential diagnosis); screening and/or assessment of any withdrawal symptoms for youth with substance related diagnoses; assessment of the appropriateness of initiating or continuing services; and a disposition. These are completed by face-to-face evaluation of the youth (which may include the use of telemedicine) and may include communication with family and other sources and the ordering and medical interpretation of laboratory or

other medical diagnostic studies.

Interactive diagnostic interview examinations are typically furnished to children and involve the use of physical aids and non-verbal communication to overcome barriers to therapeutic interaction between the clinician and a patient as a result of expressive or receptive language deficits. Interactive diagnostic interview examinations are also used when a sign language interpreter or other language interpreter is utilized order to facilitate communication between the clinician and a consumer with a hearing impairment or with limited English proficiency.

Target Population	Youth with known or suspected Mental Illness or Substance Related Disorders
Benefit Information	Available to all known or suspected Core Customers. Requires a MICP Registration or a MICP New Episode.
Utilization Criteria	<u>Available to those with CAFAS scores:</u> 10-50: Resiliency Maintenance 60-90: Low Intensity Community-Based Services 100-130: High Intensity Community-Based Services 140-180: Medically Monitored Community Residential 190-240: Medically Managed Community Residential 190-240: Medically Managed Inpatient Residential
Ordering Practitioner	Physician, Physician's Assistant, Advanced Practice Registered Nurse (Clinical Nurse Specialist or Nurse Practitioner)
Unit Value	1 encounter
Initial Authorization*	2 units
Re-Authorization*	2 units
Maximum Daily Units*	1 unit per procedure code
Authorization Period*	180 days
UAS: Budget and Expense Categories	<u>Core Services Provider</u> 220 – C&A Mental Health 820 – C&A Addictive Diseases
Admission Criteria	1. Youth has a known or suspected mental illness or a substance-related disorder and has recently entered the service system; or 2. Youth is in need of annual assessment and re-authorization of service array; or 3. Youth has need of an assessment due to a change in clinical/functional status.
Continuing Stay Criteria	Individual's situation/functioning has changed in such a way that previous assessments are outdated.
Discharge Criteria	1. An adequate continuing care plan has been established; and one or more of the following: 2. Individual has withdrawn or been discharged from service; or 3. Individual no longer demonstrates need for continued diagnostic assessment.
Service Exclusions	None
Clinical Exclusions	None

**(unless authorized as a part of a specific "package" which changes the authorization parameters)*

Additional Service Criteria:

A. Required Components

1. Telemedicine may be utilized for an initial Psychiatric Diagnostic Examination as well as for ongoing Psychiatric Diagnostic Examination via the use of appropriate procedure codes with the GT modifier.
2. Any diagnosis given to an individual must come from persons identified in O.C.G.A Practice Acts as qualified to provide a diagnosis. These practitioners include a licensed psychologist, a physician or a PA or APRN (NP and CNS-PMH) working in conjunction with a physician with an approved job description or protocol.
3. "Out-of-Clinic" may only be billed when:
 - Travel by the practitioner is to a non-contiguous location; and/or
 - Travel by the practitioner is to a facility not owned, leased, controlled or named as a service site by the agency who is billing the service(excepting visits to Shelter Plus sites); and/or
 - Travel is to a facility owned, leased or controlled by the agency billing the service, but no more than 6 individuals are being served in the course of that day by a single practitioner in non-group services; and/or
 - Travel is to a facility owned, leased, controlled or named as a service site by the agency, but no more than 24 individuals are being served in groups at that site in the course of a day. If the service does not qualify to be billed as "out of clinic," then the "in-clinic" rate may still be billed.

B. Staffing Requirements

1. The following practitioners can provide a Psychiatric Diagnostic Examination:
 - Practitioner Level 1: Physician/Psychiatrist
 - Practitioner Level 2: Psychologist, APRN, PA

C. Clinical Operations

1. It is expected that youth and families will be treated as full partners in the treatment regimen/services planned and received. As such, it is expected that practitioners will fully discuss treatment options with youth and families and allow for individual choice when possible. Discussion of treatment options should include a full disclosure of the pros and cons of each option (e.g. full disclosure of medication/treatment regimen potential side effects, potential adverse reactions--including potential adverse reaction from not taking medication as prescribed, and expected benefits). If such full discussion/disclosure to the youth is not possible or advisable according to the clinical judgment of the practitioner, this should be documented in the youth's chart (including the specific information that was not discussed and a compelling rationale for lack of discussion/disclosure). The family/caregiver's role is an essential component of this dialogue.

D. Service Access

1. Diagnostic Assessment may **not** be provided in an Institution for Mental Diseases (IMD, e.g. state or private psychiatric hospital, psychiatric residential treatment facility or Crisis Stabilization Unit with greater than 16 beds), jail, youth development center (YDC) or prison system.
2. This service may not be provided and billed for youth who are involuntarily detained in Regional Youth Detention Centers (RYDCs) awaiting criminal proceedings, penal dispositions, or other

involuntary detainment proceedings. Any exception to this requires supporting documentation from the DJJ partners. The provider holds the risk for assuring the youth's eligibility

E. Additional Medicaid Requirements

The daily maximum within a CSU for Diagnostic Assessment (Psychiatric Diagnostic Interview) for children and adolescents is 2 units, Two units should be utilized only if it is necessary in a complex diagnostic case for the physician extender (PA or APRN) to call in the physician for an assessment of the child to corroborate or verify the correct diagnosis.

F. Reporting & Billing Requirements

All applicable Medicaid, MICP, ERO, and other DBHDD reporting requirements must be adhered to.

G. Documentation Requirements

Providers must document services in accordance with the specifications for documentation requirements specified in Part II, Section V of the Provider Manual.

Family Outpatient Services: Family Counseling

HIPAA Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Family – Behavioral health counseling and therapy (without client present)	Practitioner Level 2, In-Clinic	H0004	HS	U2	U6		\$38.97
	Practitioner Level 3, In-Clinic	H0004	HS	U3	U6		\$30.01
	Practitioner Level 4, In-Clinic	H0004	HS	U4	U6		\$20.30
	Practitioner Level 5, In-Clinic	H0004	HS	U5	U6		\$15.13
	Practitioner Level 2, Out-of-Clinic	H0004	HS	U2	U7		\$46.76
	Practitioner Level 3, Out-of-Clinic	H0004	HS	U3	U7		\$36.68
	Practitioner Level 4, Out-of-Clinic	H0004	HS	U4	U7		\$24.36
	Practitioner Level 5, Out-of-Clinic	H0004	HS	U5	U7		\$18.15
Family -- Behavioral health counseling and therapy (with client present)	Practitioner Level 2, In-Clinic	H0004	HR	U2	U6		\$38.97
	Practitioner Level 3, In-Clinic	H0004	HR	U3	U6		\$30.01
	Practitioner Level 4, In-Clinic	H0004	HR	U4	U6		\$20.30
	Practitioner Level 5, In-Clinic	H0004	HR	U5	U6		\$15.13
	Practitioner Level 2, Out-of-Clinic	H0004	HR	U2	U7		\$46.76
	Practitioner Level 3, Out-of-Clinic	H0004	HR	U3	U7		\$36.68
	Practitioner Level 4, Out-of-Clinic	H0004	HR	U4	U7		\$24.36
	Practitioner Level 5, Out-of-Clinic	H0004	HR	U5	U7		\$18.15
Family Psychotherapy without the patient present (appropriate license required)	Practitioner Level 2, In-Clinic	90846	U2	U6			\$38.97
	Practitioner Level 3, In-Clinic	90846	U3	U6			\$30.01
	Practitioner Level 4, In-Clinic	90846	U4	U6			\$20.30
	Practitioner Level 5, In-Clinic	90846	U5	U6			\$15.13
	Practitioner Level 2, Out-of-Clinic	90846	U2	U7			\$46.76
	Practitioner Level 3, Out-of-Clinic	90846	U3	U7			\$36.68
	Practitioner Level 4, Out-of-Clinic	90846	U4	U7			\$24.36
	Practitioner Level 5, Out-of-Clinic	90846	U5	U7			\$18.15
	Practitioner Level 2, In-Clinic	90847	U2	U6			\$38.97

Conjoint Family Psychotherapy with the patient present (appropriate license required)	Practitioner Level 3, In-Clinic	90847	U3	U6	\$30.01
	Practitioner Level 4, In-Clinic	90847	U4	U6	\$20.30
	Practitioner Level 5, In-Clinic	90847	U5	U6	\$15.13
	Practitioner Level 2, Out-of-Clinic	90847	U2	U7	\$46.76
	Practitioner Level 3, Out-of-Clinic	90847	U3	U7	\$36.68
	Practitioner Level 4, Out-of-Clinic	90847	U4	U7	\$24.36
	Practitioner Level 5, Out-of-Clinic	90847	U5	U7	\$18.15

Definition of Service: A counseling service shown to be successful with identified family populations, diagnoses and service needs, provided by a licensed/credentialed therapist. Services are directed toward achievement of specific goals defined by the individual youth and by the parent(s)/responsible caregiver(s) and specified in the Individualized Resiliency Plan (**Note:** Although interventions may involve the family, the focus or primary beneficiary of intervention must always be the individual consumer). Family counseling provides systematic interactions between the identified individual consumer, staff and the individual's family members directed toward the restoration, development, enhancement or maintenance of functioning of the identified consumer/family unit. This may include specific clinical interventions/activities to enhance family roles; relationships, communication and functioning that promote the resiliency of the individual/family unit. Specific goals/issues to be addressed though these services may include the restoration, development, enhancement or maintenance of:

- 1) cognitive processing skills;
- 2) healthy coping mechanisms;
- 3) adaptive behaviors and skills;
- 4) interpersonal skills;
- 5) family roles and relationships;
- 6) the family's understanding of the person's mental illness and substance-related disorders and methods of intervention, interaction and mutual support the family can use to assist their family member therapeutic goals.

Best practices such as Multi-systemic Family Therapy, Multidimensional Family Therapy, Behavioral Family Therapy, Functional Family Therapy or others appropriate for the family and issues to be addressed should be utilized in the provision of this service.

Target Population	Children & Adolescents with Mental Illness and/or Substance-Related Disorders
Benefit Information	Available to all Core Customers. Requires a MICP Registration or a MICP New Episode.

Utilization Criteria	<u>Available to those with CAFAS scores:</u> 10-50: Resiliency Maintenance 60-90: Low Intensity Community-Based Services 100-130: High Intensity Community-Based Services 140-180: Medically Monitored Community Residential 190-240: Medically Managed Community Residential 190-240: Medically Managed Inpatient Residential
Ordering Practitioner	Physician, Psychologist, Physician's Assistant, Advanced Practice Registered Nurse (Clinical Nurse Specialist or Nurse Practitioner), LPC, LMFT, LCSW
Unit Value	15 minutes
Initial Authorization*	If a MICP Registration is submitted - 32 units (combined with Family Training) If a MICP New Episode is submitted - 60 units (combined with Family Training)
Reauthorization*	60 units (Family Training and Family Counseling combined)
Maximum Daily Units*	16 units (Family Training and Family Counseling combined)
Authorization Period*	180 days
UAS: Budget and Expense Categories	<u>Core Services Provider</u> 230 – C&A Mental Health 830 – C&A Addictive Diseases
Admission Criteria	1. Individual must have an emotional disturbance and/or substance-related disorder diagnosis that is at least destabilizing (markedly interferes with the ability to carry out activities of daily living or places others in danger) or distressing (causes mental anguish or suffering); and 2. Individual's level of functioning does not preclude the provision of services in an outpatient milieu; and 3. Individual's assessment indicates needs that may be supported by a therapeutic intervention shown to be successful with identified family populations and individual's diagnoses.
Continuing Stay Criteria	1. Individual continues to meet Admission Criteria as articulated above; and 2. Progress notes document progress relative to goals identified in the Individualized Resiliency Plan, but all treatment/support goals have not yet been achieved.
Discharge Criteria	1. An adequate continuing care plan has been established; and one or more of the following: 2. Goals of the Individualized Resiliency Plan have been substantially met; or 3. Individual/family requests discharge and individual is not in imminent danger of harm to self or others; or 4. Transfer to another service is warranted by change in individual's condition; or 5. Individual requires more intensive services.
Service Exclusions	Intensive Family Intervention

Clinical Exclusions	<ol style="list-style-type: none"> 1. Severity of behavioral health impairment precludes provision of services. 2. Severity of cognitive impairment precludes provision of services in this level of care. 3. There is a lack of social support systems such that a more intensive level of service is needed. 4. There is no outlook for improvement with this particular service 5. This service is not intended to supplant other services such as MR/DD Personal and Family Support or any day services where the individual may more appropriately receive these services with staff in various community settings. 6. Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of a qualifying psychiatric condition overlaying the primary diagnosis: mental retardation, autism, organic mental disorder, and traumatic brain injury.
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**(unless authorized as a part of a specific "package" which changes the authorization parameters)*

Additional Service Criteria:

A. Required Components

1. The treatment orientation, modality, and goals must be specified and agreed upon by the youth/family/caregiver.
2. The Individualized Resiliency Plan for the individual includes goals and objectives specific to the family for whom the service is being provided.
3. Any diagnosis given to an individual must come from persons identified in O.C.G.A Practice Acts as qualified to provide a diagnosis. These practitioners include a licensed psychologist, a physician or a PA or APRN (NP and CNS-PMH) working in conjunction with a physician with an approved job description or protocol.
4. "Out-of-Clinic" may only be billed when:
 - Travel by the practitioner is to a non-contiguous location; and/or
 - Travel by the practitioner is to a facility not owned, leased, controlled or named as a service site by the agency who is billing the service(excepting visits to Shelter Plus sites); and/or
 - Travel is to a facility owned, leased or controlled by the agency billing the service, but no more than 6 individuals are being served in the course of that day by a single practitioner in non-group services; and/or
 - Travel is to a facility owned, leased, controlled or named as a service site by the agency, but no more than 24 individuals are being served in groups at that site in the course of a day.
 If the service does not qualify to be billed as "out of clinic," then the "in-clinic" rate may still be billed.

B. Staffing Requirements

1. The following individuals can provide behavioral health counseling and psychotherapy to families:
 - Practitioner Level 1: Physician/Psychiatrist (reimbursed at Level 2 rate)
 - Practitioner Level 2: Psychologist, CNS-PMH

- Practitioner Level 3: LCSW, LPC, LMFT, RN
- Practitioner Level 4: LMSW; LAPC; LAMFT; Psychologist/LCSW/LPC/LMFT's supervisee/trainee with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology, functioning within the scope of the practice acts of the state; MAC, CAC-II, CADC, CCADC, GCADC (II, III); CAC-I or Addiction Counselor Trainees with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology (addiction counselors may only perform these functions related to treatment of addictive diseases).
- Practitioner Level 5: CAC-I, RADT (I, II, or III), Addiction Counselor Trainees with high school diploma/equivalent (practitioners at this level may only perform these functions related to treatment of addictive diseases).

C. Clinical Operations

1. Models of best practice delivery may include (as clinically appropriate) Multidimensional Family Therapy, Behavioral Family Therapy, Functional Family Therapy, and others as appropriate the family and issues to be addressed.

D. Service Access

1. Services may not exceed 16 Billable units (combined Family Counseling and Family Therapy) in a single day. If clinical need indicates this level of intensity, other services may need to be considered for authorization.
2. Family Counseling may **not** be provided in an Institution for Mental Diseases (IMD, e.g. state or private psychiatric hospital, psychiatric residential treatment facility or Crisis Stabilization Unit with greater than 16 beds), jail, youth development center (YDC) or prison system.
3. This service may not be provided and billed for youth who are involuntarily detained in Regional Youth Detention Centers (RYDCs) awaiting criminal proceedings, penal dispositions, or other involuntary detainment proceedings. Any exception to this requires supporting documentation from the DJJ partners. The provider holds the risk for assuring the youth's eligibility
4. For the purposes of this specific service, the definition of family **excludes** employees of Child Caring Institution, employees of DJJ or employees of DFCS as recipients of service.

E. Additional Medicaid Requirements

Currently, there are no additional Medicaid requirements to be added to the requirements above when billing Medicaid for this service.

F. Reporting & Billing Requirements

All applicable Medicaid, MICP, ERO, and other DBHDD reporting requirements must be followed.

G. Documentation Requirements

1. Providers must document services in accordance with the specifications for documentation requirements specified in Part II, Section V of the Provider Manual.
2. If there are multiple family members in the Family Counseling session who are enrolled consumers for whom the focus of treatment is related to goals on their treatment plans, we recommend the following:

- a. Document the family session in the charts of each individual consumer for whom the treatment is related to a specific goal on the individual's IRP
- b. Charge the Family Counseling session units to one of the consumers.
- c. Indicate "NC" (No Charge) on the documentation for the other consumer(s) in the family session and have the note reflect that the charges for the session are assigned to another family member in the session.

Family Outpatient Services: Family Training

HIPAA Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Family Skills Training and Development	Practitioner Level 4, In-Clinic, without client present	H2014	HS	U4	U6		\$20.30
	Practitioner Level 5, In-Clinic, without client present	H2014	HS	U5	U6		\$15.13
	Practitioner Level 4, Out-of-Clinic, without client present	H2014	HS	U4	U7		\$24.36
	Practitioner Level 5, Out-of-Clinic, without client present	H2014	HS	U5	U7		\$18.15
	Practitioner Level 4, In-Clinic, with client present	H2014	HR	U4	U6		\$20.30
	Practitioner Level 5, In-Clinic, with client present	H2014	HR	U5	U6		\$15.13
	Practitioner Level 4, Out-of-Clinic, with client present	H2014	HR	U4	U7		\$24.36
	Practitioner Level 5, Out-of-Clinic, with client present	H2014	HR	U5	U7		\$18.15

Definition of Service: A therapeutic interaction shown to be successful with identified family populations, diagnoses and service needs, provided by qualified staff. Services are directed toward achievement of specific goals defined by the individual youth and by the parent(s)/responsible caregiver(s) and specified in the Individualized Resiliency Plan (note: although interventions may involve the family, the focus or primary beneficiary of intervention must always be the individual consumer).

Family training provides systematic interactions between the identified individual consumer, staff and the individual's family members directed toward the restoration, development, enhancement or maintenance of functioning of the identified consumer/family unit. This may include support of the family, as well as training and specific activities to enhance family roles; relationships, communication and functioning that promote the resiliency of the individual/family unit.

Specific goals/issues to be addressed through these services may include the restoration, development, enhancement or maintenance of:

- 1) illness and medication self-management knowledge and skills (e.g. symptom management, behavioral management, relapse prevention skills, knowledge of medications and side effects, and motivational/skill development in taking medication as prescribed/helping a family member to take medication as prescribed);
- 2) problem solving and practicing functional support;
- 3) healthy coping mechanisms;
- 4) adaptive behaviors and skills;
- 5) interpersonal skills;

- 6) daily living skills;
- 7) resource access and management skills; and
- 8) the family's understanding of mental illness and substance related disorders, the steps necessary to facilitate recovery/resiliency, and methods of intervention, interaction and mutual support the family can use to assist their family member.

Target Population	Children & Adolescents with Mental Illness and/or Substance-Related Disorders
Benefit Information	Available to all Core Customers. Requires a MICP Registration or a MICP New Episode.
Utilization Criteria	<u>Available to those with CAFAS scores:</u> 10-50: Resiliency Maintenance 60-90: Low Intensity Community-Based Services 100-130: High Intensity Community-Based Services 140-180: Medically Monitored Community Residential 190-240: Medically Managed Community Residential 190-240: Medically Managed Inpatient Residential
Ordering Practitioner	Physician, Psychologist, Physician's Assistant, Advanced Practice Registered Nurse (Clinical Nurse Specialist or Nurse Practitioner), LPC, LMFT, LCSW
Unit Value	15 minutes
Initial Authorization*	If a MICP Registration is submitted - 32 units (combined with Family Counseling) If a MICP New Episode is submitted - 60 units (combined with Family Counseling)
Reauthorization *	60 units (Family Training and Family Counseling combined)
Authorization Period*	180 days
Maximum Daily Units*	16 units (Family Training and Family Counseling combined)
UAS: Budget and Expense Categories	<u>Core Services Provider</u> 230 – C&A Mental Health 830 – C&A Addictive Diseases
Admission Criteria	<ol style="list-style-type: none"> 1. Individual must have an emotional disturbance and/or substance-related disorder diagnosis that is at least destabilizing (markedly interferes with the ability to carry out activities of daily living or places others in danger) or distressing (causes mental anguish or suffering); and 2. Individual's level of functioning does not preclude the provision of services in an outpatient milieu; and 3. Individual's assessment indicates needs that may be supported by a therapeutic intervention shown to be successful with identified family populations and individual's diagnoses.
Continuing Stay Criteria	<ol style="list-style-type: none"> 1. Individual continues to meet Admission Criteria as articulated above; and 2. Progress notes document progress relative to goals identified in the Individualized Resiliency Plan, but all treatment/support goals have not yet been achieved.

Discharge Criteria	<ol style="list-style-type: none"> 1. An adequate continuing care plan has been established; and one or more of the following: 2. Goals of the Individualized Resiliency Plan have been substantially met; or 3. Individual/family requests discharge and individual is not in imminent danger of harm to self or others; or 4. Transfer to another service is warranted by change in individual's condition; or 5. Individual requires more intensive services.
Service Exclusions	Designated Crisis Stabilization Unit services and Intensive Family Intervention
Clinical Exclusions	<ol style="list-style-type: none"> 1. Severity of behavioral health impairment precludes provision of services. 2. Severity of cognitive impairment precludes provision of services in this level of care. 3. There is a lack of social support systems such that a more intensive level of service is needed. 4. There is no outlook for improvement with this particular service 5. This service is not intended to supplant other services such as Personal and Family Support or any day services where the individual may more appropriately receive these services with staff in various community settings. 6. Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of a psychiatric condition overlaying the primary diagnosis: mental retardation, autism, organic mental disorder, and traumatic brain injury.

**(unless authorized as a part of a specific "package" which changes the authorization parameters)*

Additional Service Criteria:

A. Required Components

1. The treatment orientation, modality and goals must be specified and agreed upon by the youth/family/caregiver.
2. The Individualized Resiliency Plan for the individual includes goals and objectives specific to the youth and family for whom the service is being provided.
3. Any diagnosis given to an individual must come from persons identified in O.C.G.A Practice Acts as qualified to provide a diagnosis. These practitioners include a licensed psychologist, a physician or a PA or APRN (NP and CNS-PMH) working in conjunction with a physician with an approved job description or protocol.
4. "Out-of-Clinic" may only be billed when:
 - Travel by the practitioner is to a non-contiguous location; and/or
 - Travel by the practitioner is to a facility not owned, leased, controlled or named as a service site by the agency who is billing the service(excepting visits to Shelter Plus sites); and/or
 - Travel is to a facility owned, leased or controlled by the agency billing the service, but no more than 6 individuals are being served in the course of that day by a single practitioner in non-group services; and/or

- Travel is to a facility owned, leased, controlled or named as a service site by the agency, but no more than 24 individuals are being served in groups at that site in the course of a day. If the service does not qualify to be billed as "out of clinic," then the "in-clinic" rate may still be billed.

B. Staffing Requirements

1. The following individuals can provide skills training and development to families:

- Practitioner Level 1: Physician/Psychiatrist (reimbursed at Level 4 rate)
- Practitioner Level 2: Psychologist, APRN, PA (reimbursed at Level 4 rate)
- Practitioner Level 3: LCSW, LPC, LMFT, RN (reimbursed at Level 4 rate)
- Practitioner Level 4: LMSW; LAPC; LAMFT; Psychologist's supervisee/trainee with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology functioning within the scope of the practice acts of the state; MAC, CAC-II, CADC, CCADC, GCADC (II, III); PP, CPRP, CAC-I or Addiction Counselor Trainees with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology
- Practitioner Level 5: CPS, PP, CPRP, CAC-I, RADT (I, II, or III), Addiction Counselor Trainees with high school diploma/equivalent under supervision of one of the licensed/credentialed professionals above

C. Clinical Operations

D. Service Access

1. Services may not exceed 16 Billable units (combined Family Counseling and Family Therapy) in a single day. If clinical need indicates this level of intensity, other services may need to be considered for authorization.
2. Family Training may **not** be provided in an Institution for Mental Diseases (IMD, e.g. state or private psychiatric hospital, psychiatric residential treatment facility or Crisis Stabilization Unit with greater than 16 beds), jail, youth development center (YDC) or prison system.
3. This service may not be provided and billed for youth who are involuntarily detained in Regional Youth Detention Centers (RYDCs) awaiting criminal proceedings, penal dispositions, or other involuntary detainment proceedings. Any exception to this requires supporting documentation from the DJJ partners. The provider holds the risk for assuring the youth's eligibility
4. For the purposes of this specific service, the definition of family **excludes** employees of Child Caring Institution, employees of DJJ or employees of DFCS as recipients of service.

E. Additional Medicaid Requirements

Currently, there are no additional Medicaid requirements to be added to the requirements above when billing Medicaid for this service.

F. Reporting & Billing Requirements

All applicable Medicaid, MICP, ERO, and other DBHDD reporting requirements must be followed.

G. Documentation Requirements

1. Providers must document services in accordance with the specifications for documentation requirements specified in Part II, Section V of the Provider Manual
2. If there are multiple family members in the Family Training session who are enrolled consumers for whom the focus of treatment in the group is related to goals on their treatment plans, we recommend the following:
 - a. Document the family session in the charts of each individual consumer for whom the treatment is related to a specific goal on the individual's IRP
 - b. Charge the Family Training session units to one of the consumers.
 - c. Indicate "NC" (No Charge) on the documentation for the other consumer(s) in the family session and have the note reflect that the charges for the session are assigned to another family member in the session.

Group Outpatient Services: Group Counseling

HIPAA Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Group – Behavioral health counseling and therapy	Practitioner Level 2, In-Clinic	H0004	HQ	U2	U6		\$8.50
	Practitioner Level 3, In-Clinic	H0004	HQ	U3	U6		\$6.60
	Practitioner Level 4, In-Clinic	H0004	HQ	U4	U6		\$4.43
	Practitioner Level 5, In-Clinic	H0004	HQ	U5	U6		\$3.30
	Practitioner Level 2, Out-of-Clinic	H0004	HQ	U2	U7		\$10.39
	Practitioner Level 3, Out-of-Clinic	H0004	HQ	U3	U7		\$8.25
	Practitioner Level 4, Out-of-Clinic	H0004	HQ	U4	U7		\$5.41
	Practitioner Level 5, Out-of-Clinic	H0004	HQ	U5	U7		\$4.03
	Practitioner Level 2, In-Clinic, Multi-family group, with client present	H0004	HQ	HR	U2	U6	\$8.50
	Practitioner Level 3, In-Clinic, Multi-family group, with client present	H0004	HQ	HR	U3	U6	\$6.60
	Practitioner Level 4, In-Clinic, Multi-family group, with client present	H0004	HQ	HR	U4	U6	\$4.43
	Practitioner Level 5, In-Clinic, Multi-family group, with client present	H0004	HQ	HR	U5	U6	\$3.30
	Practitioner Level 2, Out-of-Clinic, Multi-family group, with client present	H0004	HQ	HR	U2	U7	\$10.39
	Practitioner Level 3, Out-of-Clinic, Multi-family group, with client present	H0004	HQ	HR	U3	U7	\$8.25
	Practitioner Level 4, Out-of-Clinic, Multi-family group, with client present	H0004	HQ	HR	U4	U7	\$5.41
	Practitioner Level 5, Out-of-Clinic, Multi-family group, with client present	H0004	HQ	HR	U5	U7	\$4.03
	Practitioner Level 2, In-Clinic, Multi-family group, without client present	H0004	HQ	HS	U2	U6	\$8.50

	Practitioner Level 3, In-Clinic, Multi-family group, without client present	H0004	HQ	HS	U3	U6	\$6.60
	Practitioner Level 4, In-Clinic, Multi-family group, without client present	H0004	HQ	HS	U4	U6	\$4.43
	Practitioner Level 5, In-Clinic, Multi-family group, without client present	H0004	HQ	HS	U5	U6	\$3.30
	Practitioner Level 2, Out-of-Clinic, Multi-family group, without client present	H0004	HQ	HS	U2	U7	\$10.39
	Practitioner Level 3, Out-of-Clinic, Multi-family group, without client present	H0004	HQ	HS	U3	U7	\$8.25
	Practitioner Level 4, Out-of-Clinic, Multi-family group, without client present	H0004	HQ	HS	U4	U7	\$5.41
	Practitioner Level 5, Out-of-Clinic, Multi-family group, without client present	H0004	HQ	HS	U5	U7	\$4.03
Group Psychotherapy other than of a multiple family group (appropriate license required)	Practitioner Level 2, In-Clinic	90853	U2	U6			\$8.50
	Practitioner Level 3, In-Clinic	90853	U3	U6			\$6.60
	Practitioner Level 4, In-Clinic	90853	U4	U6			\$4.43
	Practitioner Level 5, In-Clinic	90853	U5	U6			\$3.30
	Practitioner Level 2, Out-of-Clinic	90853	U2	U7			\$10.39
	Practitioner Level 3, Out-of-Clinic	90853	U3	U7			\$8.25
	Practitioner Level 4, Out-of-Clinic	90853	U4	U7			\$5.41
	Practitioner Level 5, Out-of-Clinic	90853	U5	U7			\$4.03

Definition of Service: A therapeutic intervention or counseling service shown to be successful with identified populations, diagnoses and service needs. Services are directed toward achievement of specific goals defined by the youth and by the parent(s)/responsible caregiver(s) and specified in the Individualized Resiliency Plan. Services may address goals/issues such as promoting resiliency, and the restoration, development, enhancement or maintenance of:

- 1)cognitive skills;
- 2)healthy coping mechanisms;
- 3)adaptive behaviors and skills;
- 4)interpersonal skills
- 5)identifying and resolving personal, social, intrapersonal and interpersonal concerns.

Target Population	Individuals with Mental Illness and/or Substance-Related Disorders
Benefit Information	Available to all Core Customers. Requires a MICP Registration or a MICP

	New Episode.
Utilization Criteria	<u>Available to those with CAFAS scores:</u> 10-50: Resiliency Maintenance 60-90: Low Intensity Community-Based Services 100-130: High Intensity Community-Based Services 140-180: Medically Monitored Community Residential 190-240: Medically Managed Community Residential 190-240: Medically Managed Inpatient Residential
Ordering Practitioner	Physician, Psychologist, Physician's Assistant, Advanced Practice Registered Nurse (Clinical Nurse Specialist or Nurse Practitioner), LPC, LMFT, LCSW
Unit Value	15 minutes
Initial Authorization*	If a MICP Registration is submitted - 32 units If a MICP New Episode is submitted - 200 units
Re-Authorization*	200 units
Authorization Period*	180 days
Maximum Daily Units *	16 units for Brief Registration 20 units for Ongoing MICP
UAS: Budget and Expense Categories	<u>Core Services Provider</u> 229 – C&A Mental Health 829 – C&A Addictive Diseases
Admission Criteria	1. Youth must have a primary emotional disturbance/substance-related disorder diagnosis that is at least destabilizing (markedly interferes with the ability to carry out activities of daily living or places others in danger) or distressing (causes mental anguish or suffering); and 2. The youth's level of functioning does not preclude the provision of services in an outpatient milieu; and 3. The individual's resiliency goal/s that are to be addressed by this service must be conducive to response by a group milieu.
Continuing Stay Criteria	1. Youth continues to meet admission criteria; and 2. Youth demonstrates documented progress relative to goals identified in the Individualized Resiliency Plan, but treatment goals have not yet been achieved.
Discharge Criteria	1. An adequate continuing care plan has been established; and one or more of the following: 2. Goals of the Individualized Resiliency Plan have been substantially met; or 3. Youth and family requests discharge and the youth is not in imminent danger of harm to self or others; or 4. Transfer to another service/level of care is warranted by change in youth's condition; or 5. Youth requires more intensive services.
Service Exclusions	See also below, Item A.2.

Clinical Exclusions	<ol style="list-style-type: none"> 1. Severity of behavioral health issue precludes provision of services. 2. Severity of cognitive impairment precludes provision of services in this level of care. 3. There is a lack of social support systems such that a more intensive level of service is needed. 4. This service is not intended to supplant other services such as MR/DD Personal and Family Support or any day services where the individual may more appropriately receive these services with staff in various community settings. 5. Youth with the following conditions are excluded from admission unless there is clearly documented evidence of a psychiatric condition overlaying the primary diagnosis: mental retardation, autism, organic mental disorder, and traumatic brain injury.
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**(unless authorized as a part of a specific “package” which changes the authorization parameters)*

Additional Service Criteria:

A. Required Components

1. The treatment orientation, modality and goals must be specified and agreed upon by the youth/family/caregiver. If there are disparate goals between the youth and family, this is addressed clinically as part of the resiliency building plans and interventions.
2. When billed concurrently with IFI services, this service must be curriculum based and/or targeted to a very specific clinical issue (e.g. incest survivor groups, perpetrator groups, sexual abuse survivor groups).
3. Any diagnosis given to an individual must come from persons identified in O.C.G.A Practice Acts as qualified to provide a diagnosis. These practitioners include a licensed psychologist, a physician or a PA or APRN (NP and CNS-PMH) working in conjunction with a physician with an approved job description or protocol.
4. “Out-of-Clinic” may only be billed when:
 - Travel by the practitioner is to a non-contiguous location; and/or
 - Travel by the practitioner is to a facility not owned, leased, controlled or named as a service site by the agency who is billing the service(excepting visits to Shelter Plus sites); and/or
 - Travel is to a facility owned, leased or controlled by the agency billing the service, but no more than 6 individuals are being served in the course of that day by a single practitioner in non-group services; and/or
 - Travel is to a facility owned, leased, controlled or named as a service site by the agency, but no more than 24 individuals are being served in groups at that site in the course of a day.

If the service does not qualify to be billed as "out of clinic," then the "in-clinic" rate may still be billed.

B. Staffing Requirements

1. The following individuals can provide group counseling:
 - Practitioner Level 1: Physician/Psychiatrist (reimbursed at Level 2 rate)
 - Practitioner Level 2: Psychologist, CNS-PMH
 - Practitioner Level 3: LCSW, LPC, LMFT, RN
 - Practitioner Level 4: LMSW; LAPC; LAMFT; Psychologist/LCSW/LPC/LMFT’s supervisee/trainee with at least a Bachelor’s degree in one of the helping professions such

as social work, community counseling, counseling, psychology, or criminology, functioning within the scope of the practice acts of the state; MAC, CAC-II, CADC, CCADC, GCADC (II, III); CAC-I or Addiction Counselor Trainees with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology (may only perform these functions related to treatment of addictive diseases).

- Practitioner Level 5: CAC-I, RADT (I, II, or III), Addiction Counselor Trainees with high school diploma/equivalent (practitioners at this level may only perform these functions related to treatment of addictive diseases).
2. Students and individuals working toward licensure as a professional counselor, social worker, or marriage and family therapist must work under direction and documented clinical supervision of a licensed professional in accordance with the rules of the Georgia Composite Board of Professional Counselors, Social Workers and Marriage and Family Therapists. Agencies should refer to O.C.G.A. 43-10A-3 for the definitions of "direction" and "supervision" and the Documentation Guidelines included in this Provider Manual.
 3. The three specialties governed by the board referenced in B.2. above have different supervision requirements for individuals working toward licensure and it is the responsibility of the agency to ensure that the supervision requirements specified by the Board for the specialty (professional counseling, social work or marriage and family therapy) for which the individual is working toward licensure are met (also reference Documentation Guidelines included in this manual).
 4. Addiction counselor trainees may perform counseling as a trainee for a period of up to 3 years if they meet the requirements in O.C.G.A. 43-10A. This is limited to the provision of chemical dependency treatment under direction and supervision of a clinical supervisor approved by the certification body under which the trainee is seeking certification. Agencies should refer to O.C.G.A. 43-10A-3 for the definitions of "direction" and "supervision" and to the Documentation Guidelines set forth in this Provider Manual.
 5. The status of students, trainees, and individuals working toward licensure must be disclosed to the individuals receiving services from trainees and interns and signatures/titles of these practitioners must also include "S/T."
 6. Maximum face-to-face ratio cannot be more than 10 consumers to 1 direct service staff based on average group attendance

C. Clinical Operations

1. The membership of a multiple family group (H0004 HQ) consists of multiple family units such as a group of two or more parent(s) from different families either with (HR) or without (HS) participation of their child/children.
2. Practitioners and supervisors of those providing this service are expected to maintain knowledge and skills regarding group practice such as selecting appropriate participants for a particular group, working with the group to establish necessary group norms and goals, and understanding and managing group dynamics and processes.

D. Service Access

1. Group Counseling may **not** be provided in an Institution for Mental Diseases (IMD, e.g. state or private psychiatric hospital, psychiatric residential treatment facility or Crisis Stabilization Unit with greater than 16 beds), jail, youth development center (YDC) or prison system.
2. This service may not be provided and billed for individuals who are involuntarily detained in Regional Youth Detention Centers (RYDCs) awaiting criminal proceedings, penal dispositions, or

- other involuntary detainment proceedings. Any exception to this requires supporting documentation from the DJJ partners. The provider holds the risk for assuring the youth's eligibility
3. For the purposes of this specific service, when this service is provided to multi-family groups, the definition of family **excludes** employees of Child Caring Institution, employees of DJJ or employees of DFCS as recipients of service.

E. Additional Medicaid Requirements

The daily maximum within a CSU for combined Group Training/Counseling is 4 units/day.

F. Reporting & Billing Requirements

All applicable Medicaid, MICP, ERO, and other DBHDD reporting requirements must be followed.

G. Documentation Requirements

Providers must document services in accordance with the specifications for documentation requirements specified in Part II, Section V of the Provider Manual.

Group Outpatient Services: Group Training

HIPAA Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Group Skills Training & Development	Practitioner Level 4, In-Clinic	H2014	HQ	U4	U6		\$4.43
	Practitioner Level 5, In-Clinic	H2014	HQ	U5	U6		\$3.30
	Practitioner Level 4, Out-of-Clinic	H2014	HQ	U4	U7		\$5.41
	Practitioner Level 5, Out-of-Clinic	H2014	HQ	U5	U7		\$4.03
	Practitioner Level 4, In-Clinic, with client present	H2014	HQ	HR	U4	U6	\$4.43
	Practitioner Level 5, In-Clinic, with client present	H2014	HQ	HR	U5	U6	\$3.30
	Practitioner Level 4, Out-of-Clinic, with client present	H2014	HQ	HR	U4	U7	\$5.41
	Practitioner Level 5, Out-of-Clinic, with client present	H2014	HQ	HR	U5	U7	\$4.03
	Practitioner Level 4, In-Clinic, without client present	H2014	HQ	HS	U4	U6	\$4.43
	Practitioner Level 5, In-Clinic, without client present	H2014	HQ	HS	U5	U6	\$3.30
	Practitioner Level 4, Out-of-Clinic, without client present	H2014	HQ	HS	U4	U7	\$5.41
	Practitioner Level 5, Out-of-Clinic, without client present	H2014	HQ	HS	U5	U7	\$4.03

Definition of Service: A therapeutic interaction shown to be successful with identified populations, diagnoses and service needs. Services are directed toward achievement of specific goals defined by the youth and by the parent(s)/responsible caregiver(s) and specified in the Individualized Resiliency Plan. Services may address goals/issues such as promoting resiliency, and the restoration, development, enhancement or maintenance of:

- 1) illness and medication self-management knowledge and skills (e.g. symptom management, behavioral management, relapse prevention skills, knowledge of medications and side effects, and motivational/skill development in taking medication as prescribed);
- 2) problem solving skills;
- 3) healthy coping mechanisms;
- 4) adaptive skills;
- 5) interpersonal skills;
- 6) daily living skills;
- 7) resource management skills;
- 8) knowledge regarding emotional disturbance, substance related disorders and other relevant topics

that assist in meeting the youth's and family's needs; and 9) skills necessary to access and build community resources and natural support systems.	
Target Population	Individuals with Mental Illness and/or Substance-Related Disorders
Benefit Information	Available to all Core Customers. Requires a MICP Registration or a MICP New Episode.
Utilization Criteria	<u>Available to those with CAFAS scores:</u> 10-50: Resiliency Maintenance 60-90: Low Intensity Community-Based Services 100-130: High Intensity Community-Based Services 140-180: Medically Monitored Community Residential 190-240: Medically Managed Community Residential 190-240: Medically Managed Inpatient Residential
Ordering Practitioner	Physician, Psychologist, Physician's Assistant, Advanced Practice Registered Nurse (Clinical Nurse Specialist or Nurse Practitioner), LPC, LMFT, LCSW
Unit Value	15 minutes
Initial Authorization*	If a MICP Registration is submitted - 32 units If a MICP New Episode is submitted - 200 units
Re-Authorization*	200 units
Maximum Daily Units*	16 units
Authorization Period*	180 days
UAS: Budget and Expense Categories	<u>Core Services Provider</u> 229 – C&A Mental Health 829 – C&A Addictive Diseases
Admission Criteria	1. Youth must have a primary emotional disturbance/substance-related disorder diagnosis that is at least destabilizing (markedly interferes with the ability to carry out activities of daily living or places others in danger) or distressing (causes mental anguish or suffering); and 2. The youth's level of functioning does not preclude the provision of services in an outpatient milieu; and 3. The individual's resiliency goal/s that are to be addressed by this service must be conducive to response by a group milieu.
Continuing Stay Criteria	1. Youth continues to meet admission criteria; and 2. Youth demonstrates documented progress relative to goals identified in the Individualized Resiliency Plan, but treatment goals have not yet been achieved.
Discharge Criteria	1. An adequate continuing care plan has been established; and one or more of the following: 2. Goals of the Individualized Resiliency Plan have been substantially met; or 3. Youth and family requests discharge and the youth is not in imminent danger of harm to self or others; or 4. Transfer to another service/level of care is warranted by change in youth's condition; or 5. Youth requires more intensive services.
Service Exclusions	See also below, Item A.2.

Clinical Exclusions	<ol style="list-style-type: none"> 1. Severity of behavioral health issue precludes provision of services. 2. Severity of cognitive impairment precludes provision of services in this level of care. 3. There is a lack of social support systems such that a more intensive level of service is needed. 4. This service is not intended to supplant other services such as MR/DD Personal and Family Support or any day services where the individual may more appropriately receive these services with staff in various community settings. 5. Youth with the following conditions are excluded from admission unless there is clearly documented evidence of a psychiatric condition overlaying the primary diagnosis: mental retardation, autism, organic mental disorder, and traumatic brain injury.
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**(unless authorized as a part of a specific “package” which changes the authorization parameters)*

Additional Service Criteria:

A. Required Components

1. The functional goals addressed through this service must be specified and agreed upon by the youth/family/caregiver. If there are disparate goals between the youth and family, this is addressed clinically as part of the resiliency building plans and interventions.
2. When billed concurrently with IFI services, this service must be curriculum based and/or targeted to a very specific clinical issue (e.g. incest survivor groups, perpetrator groups, sexual abuse survivor groups).
3. Any diagnosis given to an individual must come from persons identified in O.C.G.A Practice Acts as qualified to provide a diagnosis. These practitioners include a licensed psychologist, a physician or a PA or APRN (NP and CNS-PMH) working in conjunction with a physician with an approved job description or protocol.
4. “Out-of-Clinic” may only be billed when:
 - Travel by the practitioner is to a non-contiguous location; and/or
 - Travel by the practitioner is to a facility not owned, leased, controlled or named as a service site by the agency who is billing the service(excepting visits to Shelter Plus sites); and/or
 - Travel is to a facility owned, leased or controlled by the agency billing the service, but no more than 6 individuals are being served in the course of that day by a single practitioner in non-group services; and/or
 - Travel is to a facility owned, leased, controlled or named as a service site by the agency, but no more than 24 individuals are being served in groups at that site in the course of a day.
 If the service does not qualify to be billed as "out of clinic," then the "in-clinic" rate may still be billed.

B. Staffing Requirements

1. The following individuals can provide group training:
 - Practitioner Level 1: Physician/Psychiatrist (reimbursed at Level 4 rate)
 - Practitioner Level 2: Psychologist, APRN, PA (reimbursed at Level 4 rate)

- Practitioner Level 3: LCSW, LPC, LMFT, RN (reimbursed at Level 4 rate)
 - Practitioner Level 4: LMSW; LAPC; LAMFT; Psychologist/LCSW/LPC/LMFT's supervisee/trainee with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology, functioning within the scope of the practice acts of the state; MAC, CAC-II, CADC, CCADC, GCADC (II, III); PP, CPRP, CAC-I or Addiction Counselor Trainees with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology
 - Practitioner Level 5: CPS, PP, CPRP, CAC-I, RADT (I, II, or III), Addiction Counselor Trainees with high school diploma/equivalent under supervision of one of the licensed/credentialed professionals above
2. Maximum face-to-face ratio cannot be more than 10 consumers to 1 direct service staff based on average group attendance

C. Clinical Operations

1. Out-of-clinic group skills training is allowable and clinically valuable for some consumers; therefore, this option should be explored to the benefit of the consumer. In this event, staff must be able to assess and address the individual needs and progress of each consumer consistently throughout the intervention/activity (e.g. in an example of teaching 2-3 consumers to access public transportation in the community, group training may be given to help each consumer individually to understand the bus schedule in a way that makes sense to them, to address questions/concerns each may have about how to use the bus, perhaps to spend time riding the bus with the consumers and assisting each to understand and become comfortable with riding the bus in accordance with *individual* goals, etc).
2. The membership of a multiple family Group Training session (H2014 HQ) consists of multiple family units such as a group of two or more parent(s) from different families either with (HR) or without (HS) participation of their child/children.

D. Service Access

1. Group Training may **not** be provided in an Institution for Mental Diseases (IMD, e.g. state or private psychiatric hospital, psychiatric residential treatment facility or Crisis Stabilization Unit with greater than 16 beds), jail, youth development center (YDC) or prison system.
2. This service may not be provided and billed for youth who are involuntarily detained in Regional Youth Detention Centers (RYDCs) awaiting criminal proceedings, penal dispositions, or other involuntary detainment proceedings. Any exception to this requires supporting documentation from the DJJ partners. The provider holds the risk for assuring the youth's eligibility

E. Additional Medicaid Requirements

The daily maximum within a CSU for combined Group Training/Counseling is 4 units/day.

F. Reporting & Billing Requirements

1. All applicable Medicaid, MICP, ERO, and other DBHDD reporting requirements must be followed.
2. Out-of-clinic group skills training is denoted by the U7 modifier.

G. Documentation Requirements

Providers must document services in accordance with the specifications for documentation requirements specified in Part II, Section V of the Provider Manual

Individual Counseling

HIPAA Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Individual Psychotherapy, insight oriented, behavior-modifying and/or supportive in an office or outpatient facility, approximately <u>20-30 minutes</u> face-to-face with patient	Practitioner Level 2, In-Clinic	90804	U2	U6			64.95
	Practitioner Level 3, In-Clinic	90804	U3	U6			50.02
	Practitioner Level 4, In-Clinic	90804	U4	U6			33.83
	Practitioner Level 5, In-Clinic	90804	U5	U6			25.21.
	Practitioner Level 2, Out-of-Clinic	90804	U2	U7			77.93
	Practitioner Level 3, Out-of-Clinic	90804	U3	U7			61.13
	Practitioner Level 4, Out-of-Clinic	90804	U4	U7			40.59
	Practitioner Level 5, Out-of-Clinic	90804	U5	U7			30.25
Individual Psychotherapy, insight oriented, behavior-modifying and/or supportive in an office or outpatient facility, approximately <u>45-50 minutes</u> face-to-face with patient	Practitioner Level 2, In-Clinic	90806	U2	U6			116.90
	Practitioner Level 3, In-Clinic	90806	U3	U6			90.03
	Practitioner Level 4, In-Clinic	90806	U4	U6			60.89
	Practitioner Level 5, In-Clinic	90806	U5	U6			45.38
	Practitioner Level 2, Out-of-Clinic	90806	U2	U7			140.28
	Practitioner Level 3, Out-of-Clinic	90806	U3	U7			110.04
	Practitioner Level 4, Out-of-Clinic	90806	U4	U7			73.07
	Practitioner Level 5, Out-of-Clinic	90806	U5	U7			54.46
Individual Psychotherapy, insight oriented, behavior-modifying and/or supportive in an office or outpatient facility, approximately <u>75-80 minutes</u> face-to-face with patient	Practitioner Level 2, In-Clinic	90808	U2	U6			194.84
	Practitioner Level 3, In-Clinic	90808	U3	U6			150.05
	Practitioner Level 4, In-Clinic	90808	U4	U6			101.48
	Practitioner Level 5, In-Clinic	90808	U5	U6			75.64
	Practitioner Level 2, Out-of-Clinic	90808	U2	U7			233.80
	Practitioner Level 3, Out-of-Clinic	90808	U3	U7			183.39
	Practitioner Level 4, Out-of-Clinic	90808	U4	U7			121.78
	Practitioner Level 5, Out-of-Clinic	90808	U5	U7			90.76
Individual psychotherapy,	Practitioner Level 2, In-Clinic	90810	U2	U6			64.95

interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately <u>20-30 minutes</u> face-to-face with patient	Practitioner Level 3, In-Clinic	90810	U3	U6	50.02
	Practitioner Level 4, In-Clinic	90810	U4	U6	33.83
	Practitioner Level 5, In-Clinic	90810	U5	U6	25.21
	Practitioner Level 2, Out-of-Clinic	90810	U2	U7	77.93
	Practitioner Level 3, Out-of-Clinic	90810	U3	U7	61.13
	Practitioner Level 4, Out-of-Clinic	90810	U4	U7	40.59
	Practitioner Level 5, Out-of-Clinic	90810	U5	U7	30.25
Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately <u>45-50 minutes</u> face-to-face with patient	Practitioner Level 2, In-Clinic	90812	U2	U6	116.90
	Practitioner Level 3, In-Clinic	90812	U3	U6	90.03
	Practitioner Level 4, In-Clinic	90812	U4	U6	60.89
	Practitioner Level 5, In-Clinic	90812	U5	U6	45.38
	Practitioner Level 2, Out-of-Clinic	90812	U2	U7	140.28
	Practitioner Level 3, Out-of-Clinic	90812	U3	U7	110.04
	Practitioner Level 4, Out-of-Clinic	90812	U4	U7	73.07
Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal	Practitioner Level 5, Out-of-Clinic	90812	U5	U7	54.46
	Practitioner Level 2, In-Clinic	90814	U2	U6	194.84
	Practitioner Level 3, In-Clinic	90814	U3	U6	150.05
	Practitioner Level 4, In-Clinic	90814	U4	U6	101.48
	Practitioner Level 5, In-Clinic	90814	U5	U6	75.64
Practitioner Level 2, Out-of-Clinic	90814	U2	U7	233.80	

communication, in an office or outpatient facility, approximately 75-80 minutes face-to-face with patient	Practitioner Level 3, Out-of-Clinic	90814	U3	U7	183.39
	Practitioner Level 4, Out-of-Clinic	90814	U4	U7	121.78
	Practitioner Level 5, Out-of-Clinic	90814	U5	U7	90.76

Definition of Service: A therapeutic intervention or counseling service shown to be successful with identified youth populations, diagnoses and service needs, provided by a qualified clinician. Techniques employed involve the principles, methods and procedures of counseling that assist the youth in identifying and resolving personal, social, vocational, intrapersonal and interpersonal concerns. Services are directed toward achievement of specific goals defined by the youth and by the parent(s)/responsible caregiver(s) and specified in the Individualized Resiliency Plan. These services address goals/issues such as promoting resiliency, and the restoration, development, enhancement or maintenance of:

- 1) the illness/emotional disturbance and medication self-management knowledge and skills (e.g. symptom management, behavioral management, relapse prevention skills, knowledge of medications and side effects, and motivational/skill development in taking medication as prescribed);
- 2) problem solving and cognitive skills;
- 3) healthy coping mechanisms;
- 4) adaptive behaviors and skills;
- 5) interpersonal skills; and
- 6) knowledge regarding the emotional disturbance, substance related disorders and other relevant topics that assist in meeting the youth's needs.

Best/evidence based practice modalities may include (as clinically appropriate): Motivational Interviewing/Enhancement Therapy, Cognitive Behavioral Therapy, Behavioral Modification, Behavioral Management, Rational Behavioral Therapy, Dialectical Behavioral Therapy, Interactive Play Therapy, and others as appropriate to the individual and clinical issues to be addressed.

Target Population	Children/Adolescents with a Mental Illness/Emotional Disturbance and/or Substance-Related Disorders
Benefit Information	Available to all Core Customers. Requires a MICP Registration or a MICP New Episode.
Utilization Criteria	<u>Available to those with CAFAS scores:</u> 10-50: Resiliency Maintenance 60-90: Low Intensity Community-Based Services 100-130: High Intensity Community-Based Services 140-180: Medically Monitored Community Residential 190-240: Medically Managed Community Residential 190-240: Medically Managed Inpatient Residential
Ordering Practitioner	Physician, Psychologist, Physician's Assistant, Advanced Practice Registered Nurse (Clinical Nurse Specialist or Nurse Practitioner), LPC, LMFT, LCSW
Unit Value	1 encounter
Initial Authorization*	24 units

Re-Authorization*	24 units
Maximum Daily Units*	1 unit
Authorization Period*	180 days
UAS: Budget and Expense Categories	<u>Core Services Provider</u> 228 – C&A Mental Health 828 – C&A Addictive Diseases
Admission Criteria	1. Youth must have a primary emotional disturbance/substance-related disorder diagnosis that is at least destabilizing (markedly interferes with the ability to carry out activities of daily living or places others in danger) or distressing (causes mental anguish or suffering); and 2. The youth's level of functioning does not preclude the provision of services in an outpatient milieu; and
Continuing Stay Criteria	1. Individual continues to meet admission criteria; and 2. Individual demonstrates documented progress relative to goals identified in the Individualized Resiliency Plan, but treatment goals have not yet been achieved.
Discharge Criteria	1. Adequate continuing care plan has been established; and one or more of the following: 2. Goals of the Individualized Resiliency Plan have been substantially met; or 3. Individual/family requests discharge and individual is not in imminent danger of harm to self or others; or 4. Transfer to another service is warranted by change in individual's condition; or 5. Individual requires a service approach which supports less or more intensive need.
Service Exclusions	Designated Crisis Stabilization Unit services and Intensive Family Intervention
Clinical Exclusions	1. Severity of behavioral health disturbance precludes provision of services. 2. Severity of cognitive impairment precludes provision of services in this level of care. 3. There is a lack of social support systems such that a more intensive level of service is needed. 4. There is no outlook for improvement with this particular service 5. Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of a psychiatric condition overlaying the primary diagnosis: mental retardation, autism, organic mental disorder and traumatic brain injury.

**(unless authorized as a part of a specific "package" which changes the authorization parameters)*

Additional Service Criteria:

A. Required Components

1. The treatment orientation, modality and goals must be specified and agreed upon by the youth/family/caregiver.
2. Any diagnosis given to an individual must come from persons identified in

O.C.G.A Practice Acts as qualified to provide a diagnosis. These practitioners include a licensed psychologist, a physician or a PA or APRN (NP and CNS-PMH) working in conjunction with a physician with an approved job description or protocol.

3. "Out-of-Clinic" may only be billed when:

- Travel by the practitioner is to a non-contiguous location; and/or
- Travel by the practitioner is to a facility not owned, leased, controlled or named as a service site by the agency who is billing the service(excepting visits to Shelter Plus sites); and/or
- Travel is to a facility owned, leased or controlled by the agency billing the service, but no more than 6 individuals are being served in the course of that day by a single practitioner in non-group services; and/or
- Travel is to a facility owned, leased, controlled or named as a service site by the agency, but no more than 24 individuals are being served in groups at that site in the course of a day.

If the service does not qualify to be billed as "out of clinic," then the "in-clinic" rate may still be billed.

B. Staffing Requirements

1. The following individuals can provide group training:

- Practitioner Level 1: Physician/Psychiatrist (reimbursed at Level 2 rate)
- Practitioner Level 2: Psychologist, CNS-PMH
- Practitioner Level 3: LCSW, LPC, LMFT, RN
- Practitioner Level 4: LMSW; LAPC; LAMFT; Psychologist/LCSW/LPC/LMFT's supervisee/trainee with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology, functioning within the scope of the practice acts of the state; MAC, CAC-II, CADC, CCADC, GCADC (II, III); CAC-I or Addiction Counselor Trainee with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology (addiction counselors may only perform these functions related to treatment of addictive diseases).
- Practitioner Level 5: CAC-I, RADT (I, II, or III), Addiction Counselor Trainees with high school diploma/equivalent (practitioners at this level may only perform these functions related to treatment of addictive diseases).

2. Students and individuals working toward licensure as a professional counselor, social worker, or marriage and family therapist must work under direction and documented clinical supervision of a licensed professional in accordance with the rules of the Georgia Composite Board of Professional Counselors, Social Workers and Marriage and Family Therapists. Agencies should refer to O.C.G.A. 43-10A-3 for the definitions of "direction" and "supervision" and the Documentation Guidelines included in this Provider Manual.

3. The three specialties governed by the board referenced in B.2. above have different supervision requirements for individuals working toward licensure and it is the responsibility of the agency to ensure that the supervision requirements specified by the Board for the specialty (professional

counseling, social work or marriage and family therapy) for which the individual is working toward licensure are met.

4. Addiction counselor trainees may perform counseling as a trainee for a period of up to 3 years if they meet the requirements in O.C.G.A. 43-10A. This is limited to the provision of chemical dependency treatment under direction and supervision of a clinical supervisor approved by the certification body under which the trainee is seeking certification. Agencies should refer to O.C.G.A. 43-10A-3 and to the Documentation Guidelines included in this Provider Manual for the definitions of "direction" and "supervision".
5. The status of students, trainees, and individuals working toward licensure must be disclosed to the individuals receiving services from trainees and interns and signatures/titles of these practitioners must also include "S/T."

C. Clinical Operations

Practitioners and supervisors of those providing this service are expected to maintain knowledge and skills regarding current research trends in best/evidence based counseling practices.

D. Service Access

1. Individual Counseling may **not** be provided in an Institution for Mental Diseases (IMD, e.g. state or private psychiatric hospital, psychiatric residential treatment facility or Crisis Stabilization Unit with greater than 16 beds), jail, youth development center (YDC) or prison system.
2. This service may not be provided and billed for youth who are involuntarily detained in Regional Youth Detention Centers (RYDCs) awaiting criminal proceedings, penal dispositions, or other involuntary detention proceedings. Any exception to this requires supporting documentation from the DJJ partners. The provider holds the risk for assuring the youth's eligibility

E. Additional Medicaid Requirements

Currently, there are no additional Medicaid requirements to be added to the requirements above when billing Medicaid for this service.

F. Reporting & Billing Requirements

All applicable Medicaid, MICP, ERO, and other DBHDD reporting requirements must be followed.

G. Documentation Requirements

Providers must document services in accordance with the specifications for documentation requirements specified in Part II, Section V of the Provider Manual.

Medication Administration							
HIPAA Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Comprehensive Medication Services	Practitioner Level 2, In-Clinic	H2010	U2	U6			\$33.40
	Practitioner Level 3, In-Clinic	H2010	U3	U6			\$25.39
	Practitioner Level 4, In-Clinic	H2010	U4	U6			\$17.40
	Practitioner Level 5, In-Clinic	H2010	U5	U6			\$12.97
	Practitioner Level 2, Out-of-Clinic	H2010	U2	U7			\$42.51
	Practitioner Level 3, Out-of-Clinic	H2010	U3	U7			\$33.01
	Practitioner Level 4, Out-of-Clinic	H2010	U4	U7			\$22.14
Therapeutic, prophylactic or diagnostic injection	Practitioner Level 2, In-Clinic	96372	U2	U6			\$33.40
	Practitioner Level 3, In-Clinic	96372	U3	U6			\$25.39
	Practitioner Level 4, In-Clinic	96372	U4	U6			\$17.40
	Practitioner Level 2, Out-of-Clinic	96372	U2	U7			\$42.51
	Practitioner Level 3, Out-of-Clinic	96372	U3	U7			\$33.01
	Practitioner Level 4, Out-of-Clinic	96372	U4	U7			\$22.14
Alcohol, and/or drug services, methadone administration and/or service (provision of the drug by a licensed program)	Practitioner Level 2, In-Clinic	H0020	U2	U6			\$33.40
	Practitioner Level 3, In-Clinic	H0020	U3	U6			\$25.39
	Practitioner Level 4, In-Clinic	H0020	U4	U6			\$17.40

Definition of Service: As reimbursed through this service, medication administration includes the act of introducing a drug (any chemical substance that, when absorbed into the body of a living organism, alters normal bodily function) into the body of another person by any number of routes including, but not limited to the following: oral, nasal, inhalant, intramuscular injection, intravenous, topical, suppository or intraocular. Medication administration requires a physician's order and must be administered by licensed or credentialed* medical personnel under the supervision of a physician or registered nurse in accordance with O.C.G.A.

This service does **not** cover the supervision of self-administration of medications (See Clinical Exclusions below).

The service must include:

1. An assessment, by the licensed or credentialed medical personnel administering the medication, of the youth's physical, psychological and behavioral status in order to make a recommendation regarding whether to continue the medication and/or its means of administration, and whether to refer the youth to the physician for a medication review.
2. Education to the youth and/or family/responsible caregiver(s), by appropriate licensed medical personnel, on the proper administration and monitoring of prescribed medication in accordance with the youth's resiliency plan.

For individuals who need opioid maintenance, the Opioid Maintenance service should be requested.

Target Population	Youth with SED Youth with Substance Related Disorders Youth with Co-occurring SED and Substance Related Disorders Youth with Co-occurring SED and MR/DD (if the medications are related to the SED issue) Youth with Co-occurring Substance Related Disorders and MR/DD (if the medications are related to the substance use/abuse issue)
Benefit Information	Available to all Core Customers. Requires a MICP Registration or a MICP New Episode.
Utilization Criteria	<u>Available to those with CAFAS scores:</u> 10-50: Resiliency Maintenance 60-90: Low Intensity Community-Based Services 100-130: High Intensity Community-Based Services 140-180: Medically Monitored Community Residential 190-240: Medically Managed Community Residential 190-240: Medically Managed Inpatient Residential
Ordering Practitioner	Physician, Physician's Assistant, Advanced Practice Registered Nurse (Clinical Nurse Specialist or Nurse Practitioner)
Unit Value	1 encounter
Initial Authorization*	With the submission of MICP Registration - 6 units shared With the submission of MICP New Episode: H2010 & 96372 = 60 units shared
Re-Authorization*	H2010 & 96372 = 60 units shared
Maximum Daily Units*	1 unit
Authorization Period*	180 days
UAS: Budget and Expense Categories	<u>Core Services Provider</u> 224 – C&A Mental Health 824 – C&A Addictive Diseases

<p>Admission Criteria</p>	<ol style="list-style-type: none"> 1. Youth presents symptoms that are likely to respond to pharmacological interventions; and 2. Youth has been prescribed medications as a part of the treatment array; and 3. Youth/family/responsible caregiver is unable to self-administer/administer prescribed medication because: <ol style="list-style-type: none"> a. Although the youth is willing to take the prescribed medication, it is in an injectable form and must be administered by licensed medical personnel; or b. Although youth is willing to take the prescribed medication, it is a Class A controlled substance which must be stored and dispensed by medical personnel in accordance with state law; or c. Administration by licensed/credentialed medical personnel is necessary because an assessment of the youth's physical, psychological and behavioral status is required in order to make a determination regarding whether to continue the medication and/or its means of administration and/or whether to refer the youth to the physician for a medication review. d. Due to the family/caregiver's lack of capacity there is no responsible party to manage/supervise self-administration of medication (refer youth/family for CSI and/or Family or Group Training in order to teach these skills)
<p>Continuing Stay Criteria</p>	<ol style="list-style-type: none"> 1. Youth continues to meet admission criteria.
<p>Discharge Criteria</p>	<ol style="list-style-type: none"> 1. Youth no longer needs medication; or 2. Youth/Family/Caregiver is able to self-administer, administer, or supervise self-administration medication; and 3. Adequate continuing care plan has been established.
<p>Service Exclusions</p>	<ol style="list-style-type: none"> 1. Does not include medication given as a part of Ambulatory Detoxification. Medication administered as part of Ambulatory Detoxification is billed as "Ambulatory Detoxification." 2. Must not be billed in the same day as Nursing Assessment 3. For individuals who need opioid maintenance, the Opioid Maintenance service should be requested.
<p>Clinical Exclusions</p>	<p>This service does not cover the supervision of self-administration of medications. Self-administration of medications can be done by anyone physically and mentally capable of taking or administering medications to himself/herself. Youth and adults with mental health issues, or developmental disabilities are very often capable of self administration of medications even if supervision by others is needed in order to adequately or safely manage self-administration of medication and other activities of daily living.</p>

**(unless authorized as a part of a specific "package" which changes the authorization parameters)*

Additional Service Criteria:

A. Required Components

1. There must be a physician's order for the medication and for the administration of the medication. The order must be in the youth's chart. Telephone orders are acceptable provided they are co-signed by the physician in accordance with DBHDD standards.
2. Documentation must support that the individual is being trained in the risks and benefits of the medications being administered and that symptoms are being monitored by the staff member administering the medication.
3. Documentation must support the medical necessity of administration by licensed/credentialed medical personnel rather than by the youth, family or caregiver.
4. Documentation must support that the youth AND family/caregiver is being trained in the principles of self-administration of medication and supervision of self-administration or that the youth/family/caregiver is physically or mentally unable to self-administer/administer. This documentation will be subject to scrutiny by the External Review Organization in reauthorizing services in this category.
5. This service does **not** include the supervision of self-administration of medication.
6. Any diagnosis given to an individual must come from persons identified in O.C.G.A Practice Acts as qualified to provide a diagnosis. These practitioners include a licensed psychologist, a physician or a PA or APRN (NP and CNS-PMH) working in conjunction with a physician with an approved job description or protocol.
7. "Out-of-Clinic" may only be billed when:
 - Travel by the practitioner is to a non-contiguous location; and/or
 - Travel by the practitioner is to a facility not owned, leased, controlled or named as a service site by the agency who is billing the service(excepting visits to Shelter Plus sites); and/or
 - Travel is to a facility owned, leased or controlled by the agency billing the service, but no more than 6 individuals are being served in the course of that day by a single practitioner in non-group services; and/or
 - Travel is to a facility owned, leased, controlled or named as a service site by the agency, but no more than 24 individuals are being served in groups at that site in the course of a day.If the service does not qualify to be billed as "out of clinic," then the "in-clinic" rate may still be billed.

B. Staffing Requirements

1. The following individuals can provide comprehensive medication services:
 - Practitioner Level 2: Advanced Practice Registered Nurse (APRN), PA, Pharmacist
 - Practitioner Level 3: Registered Nurse (RN)
 - Practitioner Level 4: Licensed Practical Nurse (LPN)
 - Practitioner Level 5: Qualified Medication Aide (QMA) who works in a CLA
2. The following individuals can provide therapeutic, prophylactic or diagnostic injections:
 - Practitioner Level 2: Advanced Practice Registered Nurse (APRN), PA, Pharmacist
 - Practitioner Level 3: Registered Nurse (RN)

- Practitioner Level 4: Licensed Practical Nurse (LPN)
3. The following individuals can provide alcohol to drug services, methadone administration and/or service provision:
 - Practitioner Level 2: Advanced Practice Registered Nurse (APRN), PA, Pharmacist
 - Practitioner Level 3: Registered Nurse (RN)
 - Practitioner Level 4: Licensed Practical Nurse (LPN)
 4. Qualified Medication Aides working in a Community Living Arrangement (CLA) may administer medication only in a CLA.

C. Clinical Operations

1. Medication administration may not be billed for the provision of single or multiple doses of medication that a consumer has the ability to self-administer, either independently or with supervision by a caregiver, either in a clinic or a community setting. In a group home/CCI setting, for example, medications may be managed by the house parents or residential care staff and kept locked up for safety reasons. Staff may hand out medication to the residents but this does not constitute administration of medication for the purposes of this definition and, like other watchful oversight and monitoring functions, are not reimbursable treatment services.
2. If consumer/family requires training in skills needed in order to learn to manage his/her own medications and their safe self-administration and/or supervision of self-administration, this skills training service can be provided via the Community Support or Family/Group Training services in accordance with the person's individualized recovery/resiliency plan.
3. Foster parents are eligible for CSI or Family/Group Training in the supervision of medication self-administration by youth living in their care, but agency employees, including those working in residential settings such as group homes and CCIs, are not eligible for CSI or Family/Group Training in the supervision of medication self-administration by youth in their care.

D. Service Access

1. Medication Administration may **not** be provided in an Institution for Mental Diseases (IMD, e.g. state or private psychiatric hospital, psychiatric residential treatment facility or Crisis Stabilization Unit with greater than 16 beds), jail, youth development center (YDC) or prison system.
2. This service may not be provided and billed for youth who are involuntarily detained in Regional Youth Detention Centers (RYDCs) awaiting criminal proceedings, penal dispositions, or other involuntary detainment proceedings. Any exception to this requires supporting documentation from the DJJ partners. The provider holds the risk for assuring the youth's eligibility.

E. Additional Medicaid Requirements

As in all other settings, the daily maximum within a CSU for Medication Administration is 1 unit/day.

F. Reporting & Billing Requirements

All applicable Medicaid, MICP, ERO, and other DBHDD reporting requirements must be followed.

G. Documentation Requirements

Providers must document services in accordance with the specifications for documentation requirements specified in Part II, Section V of the Provider Manual.

Nursing Assessment and Health Services							
HIPAA Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Nursing Assessment/ Evaluation	Practitioner Level 2, In-Clinic	T1001	U2	U6			\$38.97
	Practitioner Level 3, In-Clinic	T1001	U3	U6			\$30.01
	Practitioner Level 4, In-Clinic	T1001	U4	U6			\$20.30
	Practitioner Level 2, Out-of-Clinic	T1001	U2	U7			\$46.76
	Practitioner Level 3, Out-of-Clinic	T1001	U3	U7			\$36.68
	Practitioner Level 4, Out-of-Clinic	T1001	U4	U7			\$24.36
RN Services, up to 15 minutes	Practitioner Level 2, In-Clinic	T1002	U2	U6			\$38.97
	Practitioner Level 3, In-Clinic	T1002	U3	U6			\$30.01
	Practitioner Level 2, Out-of-Clinic	T1002	U2	U7			\$46.76
	Practitioner Level 3, Out-of-Clinic	T1002	U3	U7			\$36.68
LPN/LVN Services, up to 15 minutes	Practitioner Level 4, In-Clinic	T1003	U4	U6			\$20.30
	Practitioner Level 4, Out-of-Clinic	T1003	U4	U7			\$24.36
Health and Behavior Assessment, Face-to-Face with the Patient, Initial Assessment	Practitioner Level 2, In-Clinic	96150	U2	U6			\$38.97
	Practitioner Level 3, In-Clinic	96150	U3	U6			\$30.01
	Practitioner Level 4, In-Clinic	96150	U4	U6			\$20.30
	Practitioner Level 2, Out-of-Clinic	96150	U2	U7			\$46.76
	Practitioner Level 3, Out-of-Clinic	96150	U3	U7			\$36.68
	Practitioner Level 4, Out-of-Clinic	96150	U4	U7			\$24.36
Health and Behavior Assessment, Face-to-Face with the Patient, Re- assessment	Practitioner Level 2, In-Clinic	96151	U2	U6			\$38.97
	Practitioner Level 3, In-Clinic	96151	U3	U6			\$30.01
	Practitioner Level 4, In-Clinic	96151	U4	U6			\$20.30
	Practitioner Level 2, Out-of-Clinic	96151	U2	U7			\$46.76
	Practitioner Level 3, Out-of-Clinic	96151	U3	U7			\$36.68
	Practitioner Level 4, Out-of-Clinic	96151	U4	U7			\$24.36

Definition of Service: This service requires face-to-face contact with the youth/family/caregiver to monitor, evaluate, assess, and/or carry out a physician's orders regarding the psychological and/or

physical problems and general wellness of the youth. It includes:

- 1) Providing nursing assessments and interventions to observe, monitor and care for the physical, nutritional, behavioral health and related psychosocial issues, problems or crises manifested in the course of the youth's treatment;
- 2) Assessing and monitoring the youth's response to medication(s) to determine the need to continue medication and/or to determine the need to refer the youth to a physician for a medication review;
- 3) Assessing and monitoring a youth's medical and other health issues that are either directly related to the mental health or substance related disorder, or to the treatment of the disorder (e.g. diabetes, cardiac and/or blood pressure issues, substance withdrawal symptoms, weight gain and fluid retention, seizures, etc);
- 4) Consulting with the youth's family/caregiver about medical, nutritional and other health issues related to the individual's mental health or substance related issues;
- 5) Educating the youth and family/responsible caregiver(s) on medications and potential medication side effects (especially those which may adversely affect health such as weight gain or loss, blood pressure changes, cardiac abnormalities, development of diabetes or seizures, etc);
- 6) Consulting with the youth and family/caregiver (s) about the various aspects of informed consent (when prescribing occurs/APRN)
- 7) Training for self-administration of medication; and
- 8) Venipuncture required to monitor and assess mental health, substance disorders or directly related conditions, and to monitor side effects of psychotropic medications, as ordered by a Licensed Physician, Physician Assistant or Advanced Practice Nurse.
- 9) Providing assessment, testing, and referral for infectious diseases.

Target Population	Youth with Mental Health issues/SED and/or Substance Related Disorders Individuals with Mental Health issues/SED and MR/DD Individuals with Substance Related Disorders and MR/DD
Benefit Information	Available to all Core Customers. Requires a MICP Registration or a MICP New Episode.
Utilization Criteria	<u>Available to those with CAFAS scores:</u> 10-50: Resiliency Maintenance 60-90: Low Intensity Community-Based Services 100-130: High Intensity Community-Based Services 140-180: Medically Monitored Community Residential 190-240: Medically Managed Community Residential 190-240: Medically Managed Inpatient Residential
Ordering Practitioner	Physician, Physician's Assistant, Advanced Practice Registered Nurse (Clinical Nurse Specialist or Nurse Practitioner)
Unit Value	15 minutes
Initial Authorization*	With the submission of MICP Registration -12 units With the submission of MICP New Episode - 60 units
Re-Authorization*	60 units
Maximum Daily Units*	16 units (32 for Ambulatory Detox)
Authorization Period*	180 days

UAS: Budget and Expense Categories	<u>Core Services Provider</u> 223 – C&A Mental Health 823 – C&A Addictive Diseases
Admission Criteria	1. Youth presents with symptoms that are likely to respond to medical/nursing interventions; or 2. Youth has been prescribed medications as a part of the treatment array or has a confounding medical condition.
Continuing Stay Criteria	1. Youth continues to demonstrate symptoms that are likely to respond to or are responding to medical interventions; or 2. Youth exhibits acute disabling conditions of sufficient severity to bring about a significant impairment in day-to-day functioning; or 3. Youth demonstrates progress relative to medical/medication goals identified in the Individualized Resiliency Plan, but treatment goals have not yet been achieved.
Discharge Criteria	1. An adequate continuing care plan has been established; and one or more of the following: 2. Youth no longer demonstrates symptoms that are likely to respond to or are responding to medical/nursing interventions; or 3. Goals of the Individualized Resiliency Plan have been substantially met; or 4. Youth/family requests discharge and youth is not in imminent danger of harm to self or others.
Service Exclusions	Medication Administration, Opioid Maintenance
Clinical Exclusions	Routine nursing activities that are included as a part of ambulatory detoxification and medication administration/methadone administration.

**(unless authorized as a part of a specific “package” which changes the authorization parameters)*

Additional Service Criteria:

A. Required Components

1. Nutritional assessments indicated by a youth’s confounding health issues might be billed under this code (96150, 96151). No more than 8 units specific to nutritional assessments can be billed for an individual within a year. This specific assessment must be provided by a Registered Nurse or by a Licensed Dietician (LD).
2. This service does **not** include the supervision of self-administration of medication.
3. Each nursing contact should document the checking of vital signs (Temperature, Pulse, Blood Pressure, Respiratory Rate, and weight, if medically indicated or if related to behavioral health symptom or behavioral health medication side effect) in accordance with general psychiatric nursing practice.
4. Any diagnosis given to an individual must come from persons identified in O.C.G.A Practice Acts as qualified to provide a diagnosis. These practitioners include a licensed psychologist, a physician or a PA or APRN (NP and CNS-PMH) working in conjunction with a physician with an approved job description or protocol.
5. “Out-of-Clinic” may only be billed when:
 - Travel by the practitioner is to a non-contiguous location; and/or
 - Travel by the practitioner is to a facility not owned, leased, controlled or named as a service site by the agency who is billing the service(excepting visits to Shelter Plus sites); and/or

- Travel is to a facility owned, leased or controlled by the agency billing the service, but no more than 6 individuals are being served in the course of that day by a single practitioner in non-group services; and/or
- Travel is to a facility owned, leased, controlled or named as a service site by the agency, but no more than 24 individuals are being served in groups at that site in the course of a day. If the service does not qualify to be billed as "out of clinic," then the "in-clinic" rate may still be billed.

B. Staffing Requirements

1. The following individuals can provide nursing assessment and evaluation services:
 - Practitioner Level 2: Advanced Practice Registered Nurse (APRN)
 - Practitioner Level 3: Registered Nurse (RN)
 - Practitioner Level 4: Licensed Practical Nurse (LPN), Licensed Dietician (LD)
2. The following individuals can provide RN services:
 - Practitioner Level 2: Advanced Practice Registered Nurse (APRN)
 - Practitioner Level 3: Registered Nurse (RN)
3. The following individuals can provide LPN/LVN services:
 - Practitioner Level 4: Licensed Practical Nurse (LPN)
4. The following individuals can provide Health or Behavior Assessment (initial and reassessment) services:
 - Practitioner Level 2: Advanced Practice Registered Nurse (APRN)
 - Practitioner Level 3: Registered Nurse (RN), Licensed Dietician (LD)
 - Practitioner Level 4: Licensed Practical Nurse (LPN)

C. Clinical Operations

1. Venipuncture billed under this service must include documentation that includes canula size utilized, insertion site, number of attempts, location, and consumer tolerance of procedure.
2. All nursing procedures must include relevant consumer-centered, family-oriented education regarding the procedure.

D. Service Access

1. Nursing Assessment and Care may **not** be provided in an Institution for Mental Diseases (IMD, e.g. state or private psychiatric hospital, psychiatric residential treatment facility or Crisis Stabilization Unit with greater than 16 beds), jail, youth development center (YDC) or prison system.

2. This service may not be provided and billed for youth who are involuntarily detained in Regional Youth Detention Centers (RYDCs) awaiting criminal proceedings, penal dispositions, or other involuntary detainment proceedings. Any exception to this requires supporting documentation from the DJJ partners. The provider holds the risk for assuring the youth's eligibility

E. Additional Medicaid Requirements

The daily maximum within a CSU for Nursing Assessment and Health Services is 5 units/day.

F. Reporting & Billing Requirements

All applicable Medicaid, MICP, ERO, and other DBHDD reporting requirements must be followed.

G. Documentation Requirements

Providers must document services in accordance with the specifications for documentation requirements specified in Part II, Section V of the Provider Manual.

Pharmacy & Lab

Definition of Service: Pharmacy and Lab Services include operating or purchasing services to order, package, and distribute prescription medications. It includes provision of assistance to consumers to access indigent medication programs, sample medication programs and payment for necessary medications when no other funding source is available. This service provides for appropriate lab work, such as drug screens and medication levels, to be performed. This service is to ensure that necessary medication and lab services are not withheld or delayed to consumers based on inability to pay.

Target Population	Individuals with Mental Illness or Substance Related Disorders
Benefit Information	Available to all Core Customers with emphasis on priority populations.
Utilization Criteria	<u>Available to those with CAFAS scores:</u> 10-50: Resiliency Maintenance 60-90: Low Intensity Community-Based Services 100-130: High Intensity Community-Based Services 140-180: Medically Monitored Community Residential 190-240: Medically Managed Community Residential 190-240: Medically Managed Inpatient Residential
Unit Value	
Initial Authorization	
Re-Authorization	
Authorization Period	
UAS: Budget and Expense Categories	
Admission Criteria	Individual has been assessed by a prescribing professional to need a psychotropic, anti-cholinergic, addiction specific, or anti-convulsant (as related to behavioral health issue) medication and/or lab work required for persons entering services, and/or monitoring medication levels.
Continuing Stay Criteria	Individual continues to meet the admission criteria as determined by the prescribing professional
Discharge Criteria	1. Individual no longer demonstrates symptoms that are likely to respond to or are responding to pharmacologic interventions; or 2. Individual requests discharge and individual is not imminently dangerous or under court order for this intervention.
Service Exclusions	
Clinical Exclusions	

Additional Service Requirements:

A. Required Components

1. Service must be provided by a licensed pharmacy or through contract with a licensed pharmacy.

2. Agency must participate in any pharmaceutical rebate programs or pharmacy assistance programs that promote consumer access in obtaining medication.
3. Providers shall refer all consumers who have an inability to pay for medications or services to the local county offices of the Department's Division of Family and Children's Services for the purposes of determining Medicaid eligibility.

B. Staffing Requirements

C. Clinical Operations

D. Service Access

E. Additional Medicaid Requirements

Not a Medicaid Rehabilitation Option service. Medicaid recipients may access the general Medicaid pharmacy program as prescribed by the Department of Community Health.

F. Reporting & Billing Requirements

All applicable MICP and other DBHDD reporting requirements must be met.

Psychiatric Treatment

HIPAA Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Individual Psychotherapy, insight oriented, behavior-modifying and/or supportive in an office or outpatient facility, approximately <u>20-30 minutes</u> face-to-face with patient with medical evaluation and management services.	Practitioner Level 1, In-Clinic, Child Program	90805	HA	U1	U6		\$97.02
	Practitioner Level 1, Out-of-Clinic, Child Program	90805	HA	U1	U7		\$123.48
	Practitioner Level 2, In-Clinic, Child Program	90805	HA	U2	U6		\$64.95
	Practitioner Level 2, Out-of-Clinic, Child Program	90805	HA	U2	U7		\$77.93
Individual Psychotherapy, insight oriented, behavior-modifying and/or supportive in an office or outpatient facility, approximately <u>45-50 minutes</u> face-to-face with patient with medical evaluation and management services.	Practitioner Level 1, In-Clinic, Child Program	90807	HA	U1	U6		\$174.63
	Practitioner Level 1, Out-of-Clinic, Child Program	90807	HA	U1	U7		\$222.26
	Practitioner Level 2, In-Clinic, Child Program	90807	HA	U2	U6		\$116.90
	Practitioner Level 2, Out-of-Clinic, Child Program	90807	HA	U2	U7		\$140.28

Pharmaceutical Management	Practitioner Level 1, In-Clinic, Child Program	90862	HA	U1	U6	\$58.21
	Practitioner Level 1, Via interactive audio and video telecommunication systems, Child Program	90862	GT	HA	U1	\$58.21
	Practitioner Level 1, Out-of-Clinic, Child Program	90862	HA	U1	U7	\$74.09
	Practitioner Level 2, In-Clinic, Child Program	90862	HA	U2	U6	\$38.97
	Practitioner Level 2, Via interactive audio and video telecommunication systems, Child Program	90862	GT	HA	U2	\$38.97
	Practitioner Level 2, Out-of-Clinic, Child Program	90862	HA	U2	U7	\$46.76

Definition of Service: The provision of specialized medical and/or psychiatric services that include, but are not limited to:

- a. Psychotherapeutic services with medical evaluation and management including evaluation and assessment of physiological phenomena (including co-morbidity between behavioral and physical health care issues);
- b. Assessment and monitoring of an individual's status in relation to treatment with medication,
- c. Assessment of the appropriateness of initiating or continuing services.

Youth must receive appropriate medical interventions as prescribed and provided by a physician (or physician extender) that shall support the individualized goals of resiliency as identified by the youth/family/caregiver and their Individualized Resiliency Plan (within the parameters of the youth/family's informed consent).

Target Population	Youth with SED or Substance Related Disorders
Benefit Information	Available to all Core Customers. Requires a MICP Registration or a MICP New Episode.
Utilization Criteria	<u>Available to those with CAFAS scores:</u> 10-50: Resiliency Maintenance 60-90: Low Intensity Community-Based Services 100-130: High Intensity Community-Based Services 140-180: Medically Monitored Community Residential 190-240: Medically Managed Community Residential 190-240: Medically Managed Inpatient Residential
Ordering Practitioner	Physician, Physician's Assistant, Advanced Practice Registered Nurse (Clinical Nurse Specialist or Nurse Practitioner)
Unit Value	1 encounter
Initial Authorization*	12 units
Re-Authorization*	12 units
Maximum Daily Units*	1 unit (see Item F.1, and F.2. for exceptions)

Authorization Period*	180 days
UAS: Budget and Expense Categories	<u>Core Services Provider</u> 222 – C&A Mental Health 822 – C&A Addictive Diseases
Admission Criteria	1. Individual is determined to be in need of psychotherapy services and has confounding medical issues which interact with behavioral health diagnosis, requiring medical oversight; or 2. Individual has been prescribed medications as a part of the treatment array
Continuing Stay Criteria	1. Individual continues to meet the admission criteria; or 2. Individual exhibits acute disabling conditions of sufficient severity to bring about a significant impairment in day-to-day functioning; or 3. Individual continues to present symptoms that are likely to respond to pharmacological interventions; or 4. Individual continues to demonstrate symptoms that are likely to respond or are responding to medical interventions; or 5. Individual continues to require management of pharmacological treatment in order to maintain symptom remission.
Discharge Criteria	1. An adequate continuing care plan has been established; and one or more of the following: 2. Individual has withdrawn or been discharged from service; or 3. Individual no longer demonstrates symptoms that need pharmacological interventions.
Service Exclusions	
Clinical Exclusions	

**(unless authorized as a part of a specific “package” which changes the authorization parameters)*

Additional Service Criteria:

A. Required Components

1. Telemedicine may be utilized for an initial Psychiatric Diagnostic Examination as well as for ongoing Psychiatric Diagnostic Examination via the use of appropriate procedure codes with the GT modifier.
2. Any diagnosis given to an individual must come from persons identified in O.C.G.A Practice Acts as qualified to provide a diagnosis. These practitioners include a licensed psychologist, a physician or a Physician’s Assistant (PA) or Advanced Practice Registered Nurse (APRN: Nurse Practitioner or Clinical Nurse Specialist—Psychiatry & Mental Health) working in conjunction with a physician with an approved job description or protocol.
3. “Out-of-Clinic” may only be billed when:
 - Travel by the practitioner is to a non-contiguous location; and/or
 - Travel by the practitioner is to a facility not owned, leased, controlled or named as a service site by the agency who is billing the service(excepting visits to Shelter Plus sites); and/or
 - Travel is to a facility owned, leased or controlled by the agency billing the service, but no more than 6 individuals are being served in the course of that day by a single practitioner in non-group services; and/or
 - Travel is to a facility owned, leased, controlled or named as a service site by the agency, but no more than 24 individuals are being served in groups at that site in the course of a day.

If the service does not qualify to be billed as "out of clinic," then the "in-clinic" rate may still be billed.

B. Staffing Requirements

1. The following individuals can provide individual psychotherapy face to face with medical evaluation and management services:

- Practitioner Level 1: Physician/Psychiatrist
- Practitioner Level 2: CNS-PMH (Clinical Nurse Specialist in Psychiatric/Mental Health)

2. The following individuals can provide pharmacological management:

- Practitioner Level 1: Physician/Psychiatrist
- Practitioner Level 2: PA or APRN (if authority to perform this task is delegated by physician through approved job description or protocol)

C. Clinical Operations

1. It is expected that youth and families will be treated as full partners in the treatment regimen/services planned and received. As such, it is expected that practitioners will fully discuss treatment options with youth and families and allow for individual choice when possible. Discussion of treatment options should include a full disclosure of the pros and cons of each option (e.g. full disclosure of medication/treatment regimen potential side effects, potential adverse reactions-- including potential adverse reaction from not taking medication as prescribed, and expected benefits). If such full discussion/disclosure to the youth is not possible or advisable according to the clinical judgment of the practitioner, this should be documented in the youth's chart (including the specific information that was not discussed and a compelling rationale for lack of discussion/disclosure). The family/caregiver's role is an essential component of this dialogue.

D. Service Access

1. Telemedicine is the use of medical information exchanged from one site to another via electronic communications to improve a patient's health. Electronic communication means the use of interactive telecommunications equipment that includes, at a minimum, audio and video equipment permitting two-way, real time interactive communication between the patient, and the physician or practitioner at the distant site.
2. Psychiatric Treatment may **not** be provided in an Institution for Mental Diseases (IMD, e.g. state or private psychiatric hospital, psychiatric residential treatment facility or Crisis Stabilization Unit with greater than 16 beds), jail, youth development center (YDC) or prison system.
3. This service may not be provided and billed for youth who are involuntarily detained in Regional Youth Detention Centers (RYDCs) awaiting criminal proceedings, penal dispositions, or other involuntary detention proceedings. Any exception to this requires supporting documentation from the DJJ partners. The provider holds the risk for assuring the youth's eligibility

E. Additional Medicaid Requirements

1. The Daily maximum within a CSU for Pharmacologic Management is 1 unit/day.

2. Even if a physician providing behavioral health treatment and care also has his/her own Medicaid number, he/she should bill this code via the approved provider agency's Medicaid number through the Medicaid Category of Service (COS) 440.

F. Reporting & Billing Requirements

1. Within this service group, there is an allowance for when a U2 practitioner conducts an intervention and, because of clinical indicators presenting during this intervention, a U1 practitioner needs to provide another unit due to the concern of the U2 supervisee (e.g. Physician's Assistant provides and bills 90805U2U6 and because of concerns, requests U1 intervention following his/her billing of U2 intervention). The use of this practice should be rare and will be subject to additional utilization review scrutiny.
2. Within this service group, a second unit with a U1 modifier may be used in the event that a Telemedicine Psychiatric Treatment unit is provided and it indicates a need for a face-to-face assessment (e.g. 90862GTU1 is billed and it is clinically indicated that a face-to-face by an on-site physician needs to immediately follow based upon clinical indicators during the first intervention, then 90862U1, can also be billed in the same day).
3. All applicable Medicaid, MICP, ERO, and other DBHDD reporting requirements must be adhered to.

G. Documentation Requirements

Providers must document services in accordance with the specifications for documentation requirements specified in Part II, Section V of the Provider Manual.

Psychological Testing

HIPAA Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Psychological Testing – Psycho-diagnostic assessment of emotionality, intellectual abilities, personality and psycho-pathology e.g. MMP, Rorschach, WAIS (per hour of psychologist's or physician's time, both face-to-face with the patient and time interpreting test results and preparing the report)	Practitioner Level 2, In-Clinic	96101	U2	U6			155.87
	Practitioner Level 2, Out-of-Clinic	96101	U2	U7			187.04
Psychological Testing – Psycho-diagnostic assessment of emotionality, intellectual abilities, personality and psycho-pathology e.g. MMP, Rorschach, WAIS) with qualified healthcare professional interpretation and report, administered by technician, per hour of technician time, face-to-face	Practitioner Level 3, In-Clinic	96102	U3	U6			120.04
	Practitioner Level 3, Out-of-Clinic	96102	U3	U7			146.71
	Practitioner Level 4, In-Clinic	96102	U4	U6			81.18
	Practitioner Level 4, Out-of-Clinic	96102	U4	U7			97.42

Definition of Service: Psychological testing consists of a face-to-face assessment of emotional functioning, personality, cognitive functioning (e.g. thinking, attention, memory) or intellectual abilities using an objective and standardized tool that has uniform procedures for administration and scoring and utilizes normative data upon which interpretation of results is based.

Psychological tests are only administered and interpreted by those who are properly trained in their

selection and application. The practitioner administering the test ensures that the testing environment does not interfere with the performance of the examinee and ensures that the environment affords adequate protections of privacy and confidentiality.

This service covers both the face-to-face administration of the test instrument(s) by a qualified examiner as well as the time spent by a psychologist or physician (with the proper education and training) interpreting the test results and preparing a written report.

Target Population	Children & Adolescents with a known or suspected mental health diagnosis and/or Substance-Related Disorder
Benefit Information	Requires a MICP Registration or MICP New Episode.
Utilization Criteria	<u>Available to those with CAFAS scores:</u> 10-50: Resiliency Maintenance 60-90: Low Intensity Community-Based Services 100-130: High Intensity Community-Based Services 140-180: Medically Monitored Community Residential 190-240: Medically Managed Community Residential 190-240: Medically Managed Inpatient Residential
Ordering Practitioner	Physician, Psychologist, Physician's Assistant, Advanced Practice Registered Nurse (Clinical Nurse Specialist or Nurse Practitioner), LPC, LMFT, LCSW
Unit Value	1 hour
Initial Authorization	5 units
Re-Authorization	5 units
Maximum Daily Units	5 units
Authorization Period	180 days
UAS: Budget and Expense Categories	<u>Core Services Provider</u> 232 – C&A Mental Health 832 – C&A Addictive Diseases
Admission Criteria	1. A known or suspected mental illness or substance-related disorder; and 2. Initial screening/intake information indicates a need for additional undetermined supports and recovery/resiliency planning; and 3. Youth meets Core Customer eligibility.
Continuing Stay Criteria	The youth's situation/functioning has changed in such a way that previous assessments are outdated.
Discharge Criteria	Each intervention is intended to be a discrete time-limited service that modifies treatment/support goals or is indicated due to change in illness/disorder.
Service Exclusions	None
Clinical Exclusions	None

Additional Service Criteria:

A. Required Components

1. There may be no more than one comprehensive battery of 96101 and 96102 provided to one individual within a year.

2. There may be no more than 10 combined hours of 96101 and 96012 provided to one individual within a year.
3. Any diagnosis given to an individual must come from persons identified in O.C.G.A Practice Acts as qualified to provide a diagnosis. These practitioners include a licensed psychologist, a physician or a PA or APRN (NP and CNS-PMH) working in conjunction with a physician with an approved job description or protocol.
4. "Out-of-Clinic" may only be billed when:
 - Travel by the practitioner is to a non-contiguous location; and/or
 - Travel by the practitioner is to a facility not owned, leased, controlled or named as a service site by the agency who is billing the service(excepting visits to Shelter Plus sites); and/or
 - Travel is to a facility owned, leased or controlled by the agency billing the service, but no more than 6 individuals are being served in the course of that day by a single practitioner in non-group services; and/or
 - Travel is to a facility owned, leased, controlled or named as a service site by the agency, but no more than 24 individuals are being served in groups at that site in the course of a day.If the service does not qualify to be billed as "out of clinic," then the "in-clinic" rate may still be billed.

B. Staffing Requirements

The following practitioners can perform Psychological Testing:

- Practitioner Level 2: Psychologist
- Practitioner Level 3: LCSW, LPC, LMFT in conjunction with Psychologist
- Practitioner Level 4: Psychologist's supervisee/trainee with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology, functioning within the scope of the practice acts of the state.

C. Clinical Operations

The individual consumer (and caregiver/responsible family members etc as appropriate) must actively participate in the assessment processes.

D. Service Access

1. Psychological Testing may **not** be provided in an Institution for Mental Diseases (IMD, e.g. state or private psychiatric hospital, psychiatric residential treatment facility or Crisis Stabilization Unit with greater than 16 beds), jail, youth development center (YDC) or prison system.
2. This service may not be provided and billed for individuals who are involuntarily detained in Regional Youth Detention Centers (RYDCs) awaiting criminal proceedings, penal dispositions, or other involuntary detention proceedings. Any exception to this requires supporting documentation from the DJJ partners. The provider holds the risk for assuring the youth's eligibility

E. Additional Medicaid Requirements

These services are performed in accordance with GA Practice Acts.

F. Reporting & Billing Requirements

All other applicable Medicaid, MICP, ERO, and other DBHDD reporting requirements must be followed.

G. Documentation Requirements

1. Providers must document services in accordance with the specifications for documentation requirements specified in Part II, Section V of the Provider Manual
2. In addition to the authorization produced through this service, documentation of clinical assessment findings from this service should also be completed and placed in the individual's chart.

Service Plan Development							
HIPAA Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Service Plan Development	Practitioner Level 2, In-Clinic	H0032	U2	U6			\$38.97
	Practitioner Level 3, In-Clinic	H0032	U3	U6			\$30.01
	Practitioner Level 4, In-Clinic	H0032	U4	U6			\$20.30
	Practitioner Level 5, In-Clinic	H0032	U5	U6			\$15.13
	Practitioner Level 2, Out-of-Clinic	H0032	U2	U7			\$46.76
	Practitioner Level 3, Out-of-Clinic	H0032	U3	U7			\$36.68
	Practitioner Level 4, Out-of-Clinic	H0032	U4	U7			\$24.36
	Practitioner Level 5, Out-of-Clinic	H0032	U5	U7			\$18.15

Definition of Service: Children/Families access this service when it has been determined through an initial screening that the youth has mental health or addictive disease concerns. The Individualized Recovery/Resiliency Plan results from the Diagnostic and Behavioral Health Assessments and is required within the first 30 days of service, with ongoing plans completed as demanded by individual consumer need and/or by service policy.

The Individualized Recovery/Resiliency Planning process includes the individual's perspective, and should include family and/or significant others as well as collateral agencies/treatment providers/relevant individuals.

Information from a comprehensive assessment should ultimately be used to develop, together with the child and/or caretakers an Individualized Resiliency Plan that supports resilience and that is based on goals identified by the individual with parent(s)/responsible caregiver(s) involvement. As indicated, medical, nursing, peer, school, nutritional, etc staff should provide information from records, and various multi-disciplinary assessments for the development of the Individualized Resiliency Plan (IRP).

The cornerstone component of the child and adolescent Individualized Recovery/Resiliency Plan (IRP) involves a discussion with the child/adolescent and parent(s)/responsible caregiver(s) regarding what resiliency means to them personally (e.g. the child having more friends, improvement of behavioral health symptoms, staying in school, improved family relationships etc), and the development of goals (i.e. outcomes) and objectives that are defined by and meaningful to the child/adolescent based upon the individual's articulation of their recovery hopes. Concurrent with the development of the IRP, an individualized safety plan should also be developed, with the individual child and parent(s)/responsible caregiver(s) guiding the process through the free expression of their wishes and through their assessment of the components developed for the safety plan as being realistic for them.

The entire process should involve the child/youth as a full partner and should focus on service and resiliency goals/outcomes as identified by the individual and his/her family.

Recovery/Resiliency planning shall set forth the course of care by:

- Prioritizing problems and needs;
- Stating goals which will honor achievement of stated hopes, choice, preferences and desired outcomes of the youth/family;
- Assuring goals/objectives are related to the assessment;
- Defining goals/objectives that are individualized, specific, and measurable with achievable timeframes;
- Defining discharge criteria and desired changes in levels of functioning and quality of life to objectively measure progress;
- Transition planning at onset of service delivery;
- Selecting services and interventions of the right duration, intensity, and frequency to best accomplish these objectives;
- Assuring there is a goal/objective that is consistent with the service intent; and
- Identifying qualified staff who are responsible and designated for the provision of services.

Target Population	Children & Adolescents with a known or suspected mental health diagnosis and/or Substance-Related Disorder
Benefit Information	Available to all known or suspected Core Customers. Requires a MICP Registration or a MICP New Episode.
Utilization Criteria	<u>Available to those with CAFAS scores:</u> 10-50: Resiliency Maintenance 60-90: Low Intensity Community-Based Services 100-130: High Intensity Community-Based Services 140-180: Medically Monitored Community Residential 190-240: Medically Managed Community Residential 190-240: Medically Managed Inpatient Residential
Ordering Practitioner	Physician, Psychologist, Physician's Assistant, Advanced Practice Registered Nurse (Clinical Nurse Specialist or Nurse Practitioner), LPC, LMFT, LCSW
Unit Value	15 minutes
Initial Authorization*	32 units (Combined with H0031 – Behavioral Health Assessment)
Re-Authorization*	32 units (Combined with H0031 – Behavioral Health Assessment)
Maximum Daily Units*	24 units (Combined with H0031 – Behavioral Health Assessment)
Authorization Period*	180 days
UAS: Budget and Expense Categories	<u>Core Services Provider</u> 231 – C&A Mental Health 831 – C&A Addictive Diseases
Admission Criteria	1. A known mental illness or substance-related disorder; and 2. Initial screening/intake information indicates a need for additional undetermined supports and recovery/resiliency planning; and 3. Youth meets Core Customer eligibility.
Continuing Stay Criteria	The youth's situation/functioning has changed in such a way that previous assessments are outdated.
Discharge Criteria	Each intervention is intended to be a discrete time-limited service that

	modifies treatment/support goals or is indicated due to change in illness/disorder.
Service Exclusions	None
Clinical Exclusions	None

**(unless authorized as a part of a specific “package” which changes the authorization parameters)*

Additional Service Criteria:

A. Required Components

1. The service plan must include elements articulated in the Documentation Guideline chapter in this Provider Manual.
2. “Out-of-Clinic” may only be billed when:
 - Travel by the practitioner is to a non-contiguous location; and/or
 - Travel by the practitioner is to a facility not owned, leased, controlled or named as a service site by the agency who is billing the service(excepting visits to Shelter Plus sites); and/or
 - Travel is to a facility owned, leased or controlled by the agency billing the service, but no more than 6 individuals are being served in the course of that day by a single practitioner in non-group services; and/or
 - Travel is to a facility owned, leased, controlled or named as a service site by the agency, but no more than 24 individuals are being served in groups at that site in the course of a day. If the service does not qualify to be billed as “out of clinic,” then the “in-clinic” rate may still be billed.

B. Staffing Requirements

1. The following practitioners can perform Service Planning:
 - Practitioner Level 2: Psychologist, APRN, PA
 - Practitioner Level 3: LCSW, LPC, LMFT, RN
 - Practitioner Level 4: LMSW; LAPC; LAMFT; Psychologist/LCSW/LPC/LMFT’s supervisee/trainee with at least a Bachelor’s degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology, functioning within the scope of the practice acts of the state; MAC, CAC-II, CADC, CCADC, GCADC(II, III); CAC-I or Addiction Counselor Trainee with at least a Bachelor’s degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology (addictions counselors may only perform these functions related to treatment of addictive diseases).
 - Practitioner Level 5: CAC-I, RADT (I, II, or III), Addiction Counselor Trainees with high school diploma/equivalent (practitioners at this level may only perform these functions related to treatment of addictive diseases).

C. Clinical Operations

1. The individual consumer (and caregiver/responsible family members etc as appropriate) should actively participate in planning processes.

2. The Individualized Resiliency Plan should be directed by the individual's/family's personal resiliency goals as defined by them.
3. Safety/crisis planning should be directed by the youth/family and their needs/wishes to the extent possible and clinically appropriate. Plans should not contain elements/components that are not agreeable to, meaningful for, or realistic for the youth/family and that the youth/family is therefore not likely to follow through with.
4. The Multipurpose Informational Consumer Profile (MICP) format for treatment planning does not meet the requirements for a comprehensive Individualized Recovery/Resiliency Plan and should not be used as such. Guidelines for treatment planning are contained in the "Documentation Guidelines" referenced above and in the DBHDD Standards contained in this Provider Manual.
5. For youth at or above age 17 who may need long-term behavioral health supports, plan elements should include transitional elements related to post-primary education, adult services, employment (supported or otherwise), and other transitional approaches to adulthood.

D. Service Access

1. Service Plan Development may not be provided in an Institution for Mental Diseases (IMD, e.g. state or private psychiatric hospital, psychiatric residential treatment facility or Crisis Stabilization Unit with greater than 16 beds), jail, youth development center (YDC) or prison system.
2. This service may not be provided and billed for youth who are involuntarily detained in Regional Youth Detention Centers (RYDCs) awaiting criminal proceedings, penal dispositions, or other involuntary detainment proceedings. Any exception to this requires supporting documentation from the DJJ partners. The provider holds the risk for assuring the youth's eligibility

E. Additional Medicaid Requirements

The daily maximum within a CSU for combined Behavioral Health Assessment and Service Plan Development is 24 units/day.

F. Reporting & Billing Requirements

All other applicable Medicaid, MICP, ERO, and other DBHDD reporting requirements must be followed.

G. Documentation Requirements

1. Providers must document services in accordance with the specifications for documentation requirements specified in Part II, Section V of the Provider Manual
2. The initial authorization/IRP and each subsequent authorization/IRP must be completed within the time-period specified by DBHDD.
3. Every record must contain an IRP in accordance with these Service Guidelines and with the DBHDD Standards contained in this Provider Manual.

Mental Health and Addictive Disease

***Children and Adolescents'
SPECIALTY Benefit Package***

Behavioral Assistance							
HIPAA Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Behavioral Assistance	Therapeutic Behavioral Services, Per 15 minutes	H2019					\$11.31
	Therapeutic Behavioral Services, Per 15 minutes, Group	H2019	HQ				\$2.83
	Therapeutic Behavioral Services, Per 15 minutes, In School	H2019	IS				\$11.31

Definition of Service: Behavioral Assistance provided by Core or IFI providers and is designed to support youth and their families in meeting behavioral goals in various community settings. Behavioral Assistance is targeted for children and adolescents who are at risk of out-of-home placement or who have returned home from residential placement and need flexible wrap-around supports to ensure safety and to support community integration. Behavioral Assistants aid the family in implementing safety plans and behavior management plans when youth are at risk for offending behaviors, aggression, and oppositional defiance. The service must be tied to specific treatment goals and be developed in coordination with the youth and family.

Behavioral Assistants provide support to youth and their families during periods when behaviors have been typically problematic, such as during morning preparation for school, at bedtime, after school or other times when there is evidence of a pattern of an escalation of problem behaviors. Behavior Assistance can be provided during times when a youth is transitioning from a PRTF, residential program, hospital or CSU and the family needs hands on support. It may be provided in school classrooms or on school busses for short periods of time to help a youth's transition from hospitals and residential settings but is not intended as a permanent solution to problem behaviors at school.

Behavioral Assistance provides the youth and family support in a variety of environments, i.e., the home, community, and after school recreation programs. The Behavioral Assistants have flexible schedules in response to individualized consumer and family needs. The service cannot be utilized to supplant parental supervision or as a substitute for routine child-care. The service is available during the day, evenings, on weekends, and on holidays. It may include time spent transporting a youth to an activity but will not allow for reimbursement for staff members to travel when the youth is not in the vehicle.

Behavioral Assistance may not be used to supplant other services, such as Community Support or Intensive Family Intervention. The service may be used as an adjunct to CSI or IFI when a clear and distinct behavioral challenge has been identified that threatens to disrupt the child's ability to live in the community or participate in school and community life. This service may be utilized in conjunction with CSI or IFI when the need for supervision, support and positive role modeling has been demonstrated in addition to the skills training offered by CSI or the clinical services and family training provided by IFI teams. IFI services require a specific team composition dedicated to the IFI team; therefore, a staff member who provides IFI services may not also provide Behavioral Assistance. CSI and Behavioral Assistance may be provided by a single staff member at different times, according to the type of service that is provided. For example, when a CSI staff member is training a child to follow a reward system as

part of a behavior plan, CSI would be billed. However, if a child's behavior is being monitored as part of a behavioral plan and no direct skills training occurs, Behavioral Assistance would be billed.

Behavioral Assistants work closely with the treatment team, attending clinical and supervision meetings, and work in a collaborative way with family members. This service cannot be used to supplant services provided through other funding mechanisms or through other agencies.

Target Population	C&A with SED C&A with AD Issues C&A with Co-occurring SED/AD
Benefit Information	Available to Youth identified as core customers who are: -enrolled in "regular" Medicaid due to disability and are receiving core and/or specialty services; or -are covered by the DBHDD's Fee-For-Service Core and/or IFI via contract or Provider Agreement with the DBHDD. This service is not available to consumers whose benefits are managed through CMOs or other insurance plans.
Utilization Criteria	<u>Available to those with CAFAS scores:</u> 100-130: High Intensity Community-Based Services
Ordering Practitioner	Physician, Psychologist, Physician's Assistant, Advanced Practice Registered Nurse (Clinical Nurse Specialist or Nurse Practitioner), LPC, LMFT, LCSW
Unit Value	15 minutes
Initial Authorization	320 units
Re-Authorization	320 units
Maximum Daily Units	96 units (32 units if receiving this service in a group setting/HQ or in a school setting/IS)
Authorization Period	180 days
UAS: Budget and Expense Categories	<u>Core Services Providers</u> 258-C&A Mental Health 858-C&A Addictive Diseases
Admission Criteria	<ol style="list-style-type: none"> 1. Children and adolescents who meet the target population and core services definition; and 2. Children and adolescents with multi-agency involvement; or 3. Children and adolescents at risk of going into residential support or detention; or 4. Children and adolescents and family need support and assistance in implementing a community safety plan; or 5. Children and adolescents and family need additional supports during a crisis period in order to be safely maintained in the home during periods of stabilization; or 6. Children and adolescents have behavioral challenges that require direct supervision in order to access community activities; or 5. Children and adolescents who are transitioning from hospitals, residential settings, PRTFs, or CSUs.
Continuing Stay Criteria	1. Individual continues to meet the admission criteria.

Discharge Criteria	<ol style="list-style-type: none"> 1. No longer meets admission criteria, and 2. Consumer is no longer at risk for out of home placement, and/or 3. Family has skills to support the child without assistance, or 4. Consumer or family/guardian requests discharge from service, or; 5. Consumer requires a more intensive level of supports than are available through this service
Service Exclusions	PRTF Individuals served through CMOs or other insurance plans
Clinical Exclusions	None

Additional Service Criteria:

A. Required Components

1. In any review of this service, the mix of services to support the consumer will be important. A combination of other therapeutic services such as CSI, individual, group, or family therapy or training is allowed. Services, interventions, and schedules must be planned with the consumer and family.
2. Behavioral Assistance is typically provided one-to-one; however, small groups up to 4 consumers to 1 staff member may occasionally participate together in community events, such as a special recreational event or an outing to a restaurant, museum, or park.
3. Collaboration between family, Behavioral Assistants and other members of the treatment team regarding activities, interventions, and service components is an on-going process.
4. The family's cultural, religious, and social preferences are considered in the development and implementation of any service plan.
5. The family's scheduling needs are emphatically considered in the provision of this service.
6. Behavioral Assistants respect the privacy, routines, and authority of the parent/caregiver, unless there is a suspicion of abuse, or neglect which must be reported as defined by agency policy.
7. Only Core or IFI providers may deliver this service.

B. Staffing Requirements

1. Bachelor's degree in a related field; or
2. Associate's degree with 1 year direct experience working with children or adolescents in a behavioral health setting; or
3. High School Diploma and 3 years direct experience working with children or adolescents in a behavioral health setting; and
4. Ability to communicate effectively with the family and consumer according to the intervention plan; and
5. Ability to communicate effectively in writing to prepare correspondence, reports, and progress notes.

C. Clinical Operations

1. Individualized behavioral support services must be related to the goals and objectives on the IRP. The Behavioral Assistant must engage in purposeful, goal related visits in the consumer's home or other community setting.
2. Behavioral Assistants must be supervised by a LCSW, LMSW, LPC, LAPC, LMFT, LAMFT, or Licensed Clinical Psychologist.
3. Behavioral Assistants must attend clinical meetings related to a consumer's treatment needs.

4. Parents/caregivers are partners with the Behavioral Assistant. The Behavioral Assistant does not relieve the family of parental responsibility or decision-making.
5. Children and Adolescents receiving this service are also enrolled in Core Services and/or IFI services.

D. Service Access

Behavioral Assistance is available during the day, evening, weekends, and holidays. Hours are determined by the specific needs of the consumer and family.

E. Additional Medicaid Requirements

This is not a Medicaid reimbursable service; ABD Medicaid recipients may receive this service, if medically necessary, but it shall be billed via encounter to the DBHDD.

F. Reporting & Billing Requirements

1. See Item E. above.
2. All applicable MICP and other required DBHDD reporting must be followed.

G. Documentation Requirements

1. As with all interventions, this intervention must be documented on the IRP and must be tied to a treatment goal. There must be a weekly summary note indicating progress towards IRP goals. In addition, a daily attendance log that captures the amount of time each consumer spent in the program and supports billing must be maintained. Any unusual or significant events must be documented and communicated to the program supervisor on the day of the occurrence. A current schedule of activities must be posted. All collateral contacts should be documented in the consumer's medical record.
2. Providers must document services in accordance with the specifications for documentation requirements specified in Part II, Section V of the Provider Manual.

Community Based Inpatient Psychiatric and Substance Detoxification Services

HIPAA Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Psychiatric Health Facility Service, Per Diem		H2013					

Definition of Service: A short-term stay in a licensed and accredited community-based hospital for the treatment or rehabilitation of a psychiatric and/or substance related disorder. Services are of short duration and provide treatment for an acute psychiatric or behavioral episode. This service may also include Medically Managed Inpatient Detoxification at ASAM Level IV-D.

Target Population	Children and Adolescents with a SED Children and Adolescents with a Substance Related Disorder Children and Adolescents with Co-occurring SMI and a Substance Related Disorder
Benefit Information	Available to Core Customers in need of Ongoing Services and requires MICP New Episode Request or Update Request (to add as a single service to an existing authorization).
Utilization Criteria	<u>Available to those with CAFAS scores:</u> 190-240: Medically Managed Inpatient Residential (transition)
Ordering Practitioner	
Unit Value	Per Diem
Reimbursement Rate	Per negotiation
Initial Authorization	5 days
Maximum Daily Units	1 unit
Re-Authorization	3 days
Authorization Period	5 days
UAS: Budget and Expense Categories	C&A Crisis Services Provider 235 – C&A Mental Health 835 – C&A Addictive Diseases
Admission Criteria	<ol style="list-style-type: none"> 1. Youth with SED that is experiencing serious impairment; persistent, recurrent, severe, or major symptoms (such as psychoses); or who is experiencing major suicidal, homicidal or high risk tendencies as a result of the mental illness; or 2. Youth's need is assessed for 24/7 supports which must be one-on-one and may not be met by any service array which is available in the community; or 3. Youth is assessed as meeting diagnostic criteria for a Substance Related Disorder according to the latest version of the DSM; and one or more of the following: <ol style="list-style-type: none"> A. Youth is experiencing signs of severe withdrawal, or there is evidence (based on history of substance intake, age, gender,

	<p>previous withdrawal history, present symptoms, physical condition, and/or emotional/behavioral condition) that severe withdrawal syndrome is imminent; or</p> <p>B. Level IV-D is the only available level of service that can provide the medical support and comfort needed by the youth, as evidenced by:</p> <p>i. A detoxification regimen or Youth's response to that regimen that requires monitoring or intervention more frequently than hourly, or</p> <p>ii. The youth's need for detoxification or stabilization while pregnant, until she can be safely treated in a less intensive service.</p>
Continuing Stay Criteria	<ol style="list-style-type: none"> 1. Youth continues to meet admission criteria; and 2. Youth's withdrawal signs and symptoms are not sufficiently resolved to the extent that they can be safely managed in less intensive services;
Discharge Criteria	<ol style="list-style-type: none"> 1. An adequate continuing care plan has been established; and one or more of the following; 2. Youth no longer meets admission and continued stay criteria; or 3. Family requests discharge and youth is not imminently dangerous to self or others; or 4. Transfer to another service/level of care is warranted by change in the individual's condition; or 5. Individual requires services not available in this level of care.
Service Exclusions	<p>This service may not be provided simultaneously to any other service in the service array excepting short-term access to services that provide continuity of care or support planning for discharge from this service.</p>
Clinical Exclusions	<p>Youths with any of the following unless there is clearly documented evidence of an acute psychiatric/addiction episode overlaying the primary diagnosis:</p> <ol style="list-style-type: none"> a. Autism b. Mental Retardation/Developmental Disabilities c. Organic Mental Disorder; or d. Traumatic Brain Injury

Additional Service Criteria:

A. Required Components

1. This service must be licensed by DCH/HFR under the Rules and Regulations for Drug Abuse Treatment Programs, 290-4-2
2. A physician's order in the individual's record is required to initiate detoxification services. Verbal orders or those initiated by a Physician's Assistant or Clinical Nurse Specialist are acceptable provided they are signed by the physician within 24 hours or the next working day.

B. Staffing Requirements

Only nursing or other licensed medical staff under supervision of a physician may provide detoxification services.

C. Clinical Operations

Individuals receiving this service must have a qualifying diagnosis present in the medical record prior to the initiation of services. The diagnosis must be given by persons identified in O.C.G.A Practice Acts as qualified to provide a diagnosis. These practitioners include a licensed psychologist, a physician or a PA or APRN (NP and CNS-PMH) working in conjunction with a physician with an approved job description or protocol.

D. Service Access

E. Additional Medicaid Requirements

Not applicable. This is not a Medicaid billable service.

F. Reporting & Billing Requirements

All applicable MICP and other DBHDD reporting requirements must be followed.

G. Documentation Requirements

Providers must document services in accordance with the specifications for documentation requirements specified in Part II, Section V of the Provider Manual.

Community Transition Planning							
Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Community Transition Planning	Community Transition Planning (State Hospital)	T2038	ZH				\$20.92
	Community Transition Planning (Crisis Stabilization Unit)	T2038	ZC				\$20.92
	Community Transition Planning (PRTF)	T2038	ZP				\$20.92
	Community Transition Planning (Jail / Youth Detention Center)	T2038	ZJ				\$20.92
	Community Transition Planning (Other)	T2038	ZO				\$20.92

If you are an IFI provider, you may provide this service to those youth who are working towards transition into the community (as defined in the CTP guideline) and are expected to receive services from the IFI team. Please refer to the Core Guidelines for the detail.

Crisis Stabilization Unit Services							
HIPAA Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Behavioral Health; Short-term Residential (Non-Hospital Residential Treatment Program Without Room & Board, Per Diem)		H0018	HA	U2			209.22
Behavioral Health; Short-term Residential (Non-Hospital Residential Treatment Program Without Room & Board, Per Diem)		H0018	HA	TB	U2		

Definition of Service: This is a residential alternative to or diversion from inpatient hospitalization, offering psychiatric stabilization and detoxification services. The program provides medically monitored residential services for the purpose of providing psychiatric stabilization and substance detoxification services on a short-term basis. Specific services may include:

- 1) Psychiatric medical assessment;
- 2) Crisis assessment, support and intervention;
- 3) Medically Monitored Residential Substance Detoxification (at ASAM Level III.7-D).
- 4) Medication administration, management and monitoring;
- 5) Brief individual, group and/or family counseling; and
- 6) Linkage to other services as needed.

Services must be provided in a facility designated and certified by the DBHDD as an emergency receiving and evaluation facility

Target Population	Children and Adolescents experiencing: Severe situational crisis SED Substance-Related Disorders Co-Occurring Substance-Related Disorders and Mental Illness Co-Occurring Mental Illness and Mental Retardation Co-Occurring Substance-Related Disorders and Mental Retardation
Benefit Information	Available to Core Customers in need of Ongoing Services. Requires a MICP New Episode Request or Update Request (to add as a single service to an existing authorization).
Utilization Criteria	<u>Available to those with CAFAS scores:</u> 140-180: Medically Monitored Community Residential 190-240: Medically Managed Community Residential OR "clinical information to justify the service provided in the "justification text" on the MICP if CAFAS scores are higher/lower.
Ordering Practitioner	Physician, Physician's Assistant, Advanced Practice Registered Nurse (Clinical Nurse Specialist or Nurse Practitioner)

Unit Value	1 day
Initial Authorization	20 units
Re-Authorization	
Maximum Daily Units	1 unit
Authorization Period	20 days
UAS: Budget and Expense Categories	<u>Crisis Services Provider</u> 234 – C&A Mental Health 834 – C&A Addictive Diseases
Admission Criteria	<ol style="list-style-type: none"> 1. Treatment at a lower level of care has been attempted or given serious consideration; and #2 and/or #3 are met: 2. Child/Youth has a known or suspected illness/disorder in keeping with target populations listed above; or 3. Child/Youth is experiencing a severe situational crisis which has significantly compromised safety and/or functioning; and one or more of the following: <ol style="list-style-type: none"> a. Child/Youth presents a substantial risk of harm or risk to self, others, and/or property or is so unable to care for his or her own physical health and safety as to create a life-endangering crisis. Risk may range from mild to imminent; or b. Child/Youth has insufficient or severely limited resources or skills necessary to cope with the immediate crisis; or c. Child/youth demonstrates lack of judgment and/or impulse control and/or cognitive/perceptual abilities to manage the crisis; or d. For detoxification services, individual meets admission criteria for Medically Monitored Residential Detoxification.
Continuing Stay Criteria	This service may be utilized at various points in the child's course of treatment and recovery; however, each intervention is intended to be a discrete time-limited service that stabilizes the individual.
Discharge Criteria	<ol style="list-style-type: none"> 1. Child/youth no longer meets admission guidelines requirements; or 2. Crisis situation is resolved and an adequate continuing care plan has been established; or 3. Child/youth does not stabilize within the evaluation period and must be transferred to a higher intensity service.
Service Exclusions	None
Clinical Exclusions	<ol style="list-style-type: none"> 1. Youth is not in crisis. 2. Youth does not present a risk of harm to self or others or is able to care for his/her physical health and safety. 3. Severity of clinical issues precludes provision of services at this level of intensity.

Additional Service Criteria:

A. Required Components

1. Crisis Stabilization Units (CSU) providing medically monitored short-term residential psychiatric stabilization and detoxification services shall be designated by the Department as both an emergency receiving facility and an evaluation facility and must be surveyed and certified by the DBHDD.

2. In addition to all service qualifications specified in this document, providers of this service must adhere to and be certified under the *Provider Manual for Community Mental Health, Developmental Disability and Addictive Disorders "Core Requirements for All Providers"* and DBHDD "Core Requirements for Crisis Stabilization Programs Operated by Community Service Boards."
3. The maximum length of stay in a crisis bed is 14 adjusted days (excluding Saturdays, Sundays and state holidays) for children and adolescents.
4. The maximum length of stay in crisis AND transitional beds combined is 29 adjusted calendar days (excluding Saturdays, Sundays and state holidays).
5. Youth occupying transitional beds must receive services from outside the CSU (i.e. community-based services) on a daily basis.
6. Services must be provided in a facility designated as an emergency receiving and evaluation facility that is not also an inpatient hospital, a freestanding Institute for Mental Disease (IMD), or a licensed substance abuse detoxification facility.
7. A CSU must have documented operating agreements and referral mechanisms for psychiatric disorders, addictive disorders, and physical healthcare needs that are beyond the scope of the CSU and that require inpatient treatment. Operating agreements must delineate the type and level of service to be provided by the private or public inpatient hospital or treatment facility. These agreements must specifically address the criteria and procedures for transferring the youth to a designated treatment facility when the CPS is unable to stabilize the youth.

B. Staffing Requirements

1. A physician or a staff member under the supervision of a physician, practicing within the scope of State law, must provide Crisis Stabilization Unit (CSU) Services.
2. All services provided within the CPS must be delivered under the direction of a physician. A physician must conduct an assessment of new admissions, address issues of care, and write orders as required.
3. A CSU must employ a fulltime Nursing Administrator who is a Registered Nurse.
4. A CSU must have a Registered Nurse present at the facility at all times.
5. Staff-to-client ratios must be established based on the stabilization needs of clients being served and in accordance with the "Core Requirements for Crisis Stabilization Programs Operated by Community Service Boards."
6. Functions performed by Physician Assistants, Nurse Practitioners, Clinical Nurse Specialists, Registered Nurses, and Licensed Practical Nurses must be performed within the scope of practice allowed by State law and Professional Practice Acts.

C. Clinical Operations

1. A physician must evaluate a child/youth referred to a CSU within 24 hours of the referral.
2. A CSU must follow the seclusion and restraint procedures included in the Department's "Core Requirements for Crisis Stabilization Programs operated by Community Service Boards."
3. For youth with co-occurring diagnoses including mental retardation/developmental disabilities, this service must target the symptoms, manifestations, and skills-development related to the identified behavioral health issue.
4. Youth served in transitional beds may access an array of community-based services in preparation for their transition out of the CSU, and are expected to engage in community-based services daily while in a transitional bed.

D. Service Access

E. Additional Medicaid Requirements

1. Effective July 1, 2007, Medicaid stopped paying a bundled daily rate for these services. Crisis Stabilization Units with 16 beds or less should bill individual services for Medicaid recipients.
2. The individual services listed below may be billed up to the daily maximum listed for services provided in a Crisis Stabilization Unit. Billable services and daily limits within CSUs are as follows:

Service	Daily Maximum Billable Units
Crisis Intervention	8 units
Diagnostic Assessment	2 units
Psychiatric Treatment	1 unit (Pharmacological Mgmt only)
Nursing Assessment and Care	5 units
Medication Administration	1 unit
Group Training/Counseling	4 units
Beh Health Assmnt & Serv. Plan Devel.	24 units
Medication Administration	1 unit

3. Medicaid claims for the services in E.2. above may **not** be billed for any service provided to Medicaid-eligible individuals in CSUs with greater than 16 beds.

F. Reporting & Billing Requirements

1. Providers must report information on all consumers served in CSUs no matter the funding source:
 - a. The CSU shall submit MICPs for all individuals served (state-funded, Medicaid funded, private pay, other third party payor, etc);
 - b. The CSU shall submit per diem encounters (H0018HAU2 or H0018HATBU2) for all individuals served (state-funded, Medicaid funded, private pay, other third party payor, etc) even if sub-parts cited in E.2 above are also billed as a claim to Medicaid;
 - c. Providers must designate either CSU bed use or transitional bed use in encounter submissions through the absence of or use of the TB modifier. TB represents "Transitional Bed."
2. Unlike all other DBHDD residential services, the start date of a CSU span encounter submission may be in one month and the end date may be in the next. The span of reporting must cover continuous days of service and the number of units must equal the days in the span.
3. All other applicable Medicaid, MICP, ERO, and other DBHDD reporting requirements must be followed.

G. Documentation Requirements

1. In order to report a per diem encounter, the consumer must have participated in the program for a minimum of 8 hours in the identified 12:00AM to 11:59PM day.
2. For individuals transferred to transitional beds, the date of transfer must be documented in a progress note and filed in the individual's chart.
3. Daily engagement in community-based services must also be documented in progress notes for those occupying transitional beds.

4. Specific to item E.2. above, the notes for the program must have documentation to support the per diem AND, if the program bills sub-parts to Medicaid (in accordance with E. above), each discrete service delivered must have documentation to support that sub-billable code (e.g. Group is provided for 1 hour, Group is billed for 1 hour, Group note is for 4 units at the 15 minute rate and meets all the necessary components of documentation for that sub-code).
5. Providers must document services in accordance with the specifications for documentation requirements specified in Part II, Section V of the Provider Manual.

Intensive Family Intervention							
HIPAA Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Intensive Family Intervention	Practitioner Level 3, In-Clinic	H0036	U3	U6			\$30.01
	Practitioner Level 4, In-Clinic	H0036	U4	U6			\$22.14
	Practitioner Level 5, In-Clinic	H0036	U5	U6			\$16.50
	Practitioner Level 3, Out-of-Clinic	H0036	U3	U7			\$41.26
	Practitioner Level 4, Out-of-Clinic	H0036	U4	U7			\$27.06
	Practitioner Level 5, Out-of-Clinic	H0036	U5	U7			\$20.17

Definition of Service: A service intended to improve family functioning by clinically stabilizing the living arrangement, promoting reunification or preventing the utilization of out of home therapeutic venues (i.e. psychiatric hospital, therapeutic foster care, psychiatric residential treatment facilities, or therapeutic residential intervention services) for the identified youth. Services are delivered utilizing a team approach and are provided primarily to youth in their living arrangement and within the family system. Services promote a family-based focus in order to:

- Defuse the current behavioral health crisis, evaluate its nature and intervene to reduce the likelihood of a recurrence;
- Ensure linkage to needed community services and resources; and
- Improve the individual child's/adolescent's ability to self-recognize and self-manage behavioral health issues, as well as the parents'/responsible caregivers' capacity to care for their children.

Services should include crisis intervention, intensive supporting resources management, individual and/or family counseling/training, and other rehabilitative supports to prevent the need for out-of-home placement or other more intensive/restrictive services. Services are based upon a comprehensive, individualized assessment and are directed towards the identified youth and his or her behavioral health needs/strengths and goals as identified in the Individualized Resiliency Plan.

Services shall also include resource coordination/acquisition to achieve the youth's and their family's goals and aspirations of self-sufficiency, resiliency, permanency, and community integration.

Target Population	Children and Adolescents with SED and/or Substance Related Disorders.
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Benefit Information	Available to Core Customers in need of Ongoing Services and requires a MICP New Episode Request or Update Request (to add as a single service to an existing authorization).
Utilization Criteria	<u>Available to those with CAFAS scores:</u> 100-130: High Intensity Community-Based Services 140-180: Medically Monitored Community Residential (transition) 190-240: Medically Managed Community Residential (transition) 190-240: Medically Managed Inpatient Residential (transition)
Ordering Practitioner	Physician, Psychologist, Physician's Assistant, Advanced Practice Registered Nurse (Clinical Nurse Specialist or Nurse Practitioner), LPC, LMFT, LCSW
Unit Value	15 minutes
Initial Authorization	288 units
Re-Authorization	288 units
Maximum Daily Units	48 Units is the standard maximum
Authorization Period	90 days
UAS: Budget and Expense Categories	<u>Intensive Treatment Services Provider</u> 253 – C&A Mental Health 853 – C&A Addictive Diseases
Admission Criteria	<p>1. Youth has a diagnosis and duration of symptoms which classify the illness as SED (youth with SED have a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet DSM diagnostic criteria and results in a functional impairment which substantially interferes with or limits the child's role or functioning in the family, school, or community activities) and/or is diagnosed with a Substance Related Disorder;</p> <p>and one or more of the following:</p> <p>2. Youth has received documented services through other services such as Core Services and exhausted less intensive out-patient programs. Treatment at a lower intensity has been attempted or given serious consideration, but the risk factors for out-of-home placement are compelling (see item G.1. below); The less intensive services previously provided must be documented in the clinical record (even if it via by self-report of the youth and family). or</p> <p>3. Youth and/or family has insufficient or severely limited resources or skills necessary to cope with an immediate behavioral health crisis; or</p> <p>4. Youth and/or family behavioral health issues are unmanageable in traditional outpatient treatment and require intensive, coordinated clinical and supportive intervention; or</p> <p>5. Because of behavioral health issues, the youth is at immediate risk of out-of-home placement or is currently in out-of-home placement (non-institutional-See D.3. and D.4. below) and reunification is imminent (therefore, intensive work needs to begin with the youth and family regarding the youth's treatment goals); or</p> <p>6. Because of behavioral health issues, the youth is at immediate risk of</p>

	legal system intervention or is currently involved with DJJ for behaviors/issues related to SED and/or the Substance-related disorder.
Continuing Stay Criteria	1. Same as above.
Discharge Criteria	<ol style="list-style-type: none"> 1. An adequate continuing care plan has been established; and one or more of the following: 2. Youth no longer meets the admission criteria; or 3. Goals of the Individualized Resiliency Plan have been substantially met; or 4. Individual and family request discharge, and the individual is not imminently dangerous; or 5. Transfer to another service is warranted by change in the individual's condition; or 6. Individual requires services not available within this service.
Service Exclusions	<p>Not offered in conjunction with Individual Counseling, Family Counseling/Training, Crisis Intervention Services, and/or Crisis Stabilization Unit, PRTF, or inpatient hospitalization.</p> <p>May utilize Community Support for continuity of care.</p> <p>This service may not be provided to youth who reside in a congregate setting in which the caregivers are paid (such as group homes, child caring institutions, intensive residential treatment facilities, or any other living environment that is not comprised of family, guardians, or other more permanent caregivers). A short-term exception would be if the youth were preparing for transition back to a single-family unit, the family member is present during the intervention, and the service is directed to supporting the unification/reunification of the youth and his/her identified family/caregiver and takes place in that home and community.</p> <p>The billable activities of IFI do not include:</p> <ol style="list-style-type: none"> 1) Transportation 2) Observation/Monitoring 3) Tutoring/Homework Completion 4) Diversionary Activities (i.e. activities without therapeutic value)
Clinical Exclusions	<ol style="list-style-type: none"> 1. Youth with any of the following unless there is clearly documented evidence of an acute psychiatric/addiction episode overlaying the primary diagnosis: <ol style="list-style-type: none"> a. Autism Spectrum Disorders including Asperger's Disorder (any youth currently enrolled June 30, 2010 shall remain eligible throughout current authorization. b. Mental Retardation/Developmental Disabilities c. Organic Mental Disorder; or d. Traumatic Brain Injury 2. Youth can effectively and safely be treated at a lower intensity of service. This service may not be used in lieu of family preservation and post-adoption services for youth who do not meet the admission criteria for IFI.

Additional Service Criteria: (Elements below which are different from the FY10 version of this definition will be effective 8/1/2010)

A. Required Components:

1. The organization has established procedures/protocols for handling emergency and crisis situations that describe methods for intervention with youth who require psychiatric hospitalization.
2. Each Intensive Family Intervention (IFI) provider must have policies and procedures governing the provision of outreach services, including methods for protecting the safety of staff that engage in outreach activities.
3. The organization must have an Intensive Family Intervention Organizational Plan that addresses the description of:
 - Particular evidence-based family preservation, resource coordination, crisis intervention and wraparound service models utilized (MST, DBT, MDFT, etc), types of intervention practiced. The organization must show documentation that each staff member is trained in the model for in-home treatment (i.e., certification, ongoing supervision provided by the training entity, documentation of annual training in the model).
 - The organization must have demonstrable evidence that they are working towards fidelity to the model that they have chosen (via internal Quality Assurance documentation, staff training documentation, etc). There should not be an eclectic approach to utilizing models. Fidelity to the chosen model is the expectation for each IFI team. If an agency chooses to develop a plan which incorporates more than one evidenced-based model within the organization, there must be a particular evidenced-based model chosen for each IFI team (e.g. an agency administers 3 teams, 2 which will adhere to one model, one to another model). Documentation of training for each staff person on the evidenced-based in-home model they will be utilizing in the provision of services should exist in their personnel files. Some models do not have the stringent staffing requirements that this service requires. The expectation is that staffing patterns in accordance with the specific model used are in compliance with staffing requirements noted in this service definition
 - Hours of operation, the staff assigned, and types of services provided to consumers, families, parents, and/or guardians,
 - How the plan for services is modified or adjusted to meet the needs specified in each Individualized Resiliency Plan, and
4. At least 60% of service units must be provided face-to-face with children and their families, and 80% of all face-to-face service units must be delivered in non-clinic settings over the authorization period.
5. At least 50% of IFI face-to-face units must include the child (identified consumer). However, when the child is not included in the face-to-face contacts, the focus of the contacts must remain on the child and their goals as identified on their IRP.
6. Documentation of how the team works with the family and other agencies/support systems (such as LIPTs, provider agencies, etc) to build a clinically oriented transition and discharge plan is required and should be documented in the clinical record of the consumer.
7. IFI is an individual intervention and may not be provided or billed for more than 1 youth at the same time (including siblings); however, youth participating in an IFI program may receive group skills training and/or group counseling in keeping with his/her individual recovery plan. Siblings who are each authorized to receive IFI must receive individualized services, but family interventions can be

done jointly, with only one bill being submitted to the payor (For example, Sibling 1 and Sibling 2 are being seen for 2 units with the parents. Sibling 1 and Sibling 2 each have the documentation in both records, but only one claim for 2 units of reimbursement may be submitted to the payor source.)

8. IFI is intended to be provided to youth/families in their living arrangement. Services provided in school settings are allowable up to 3 hours/week as a general rule and the clinical record shall include documentation of partnership with the school. Exceptions to this 3 hours/week should be documented to include approval by the IFI Team Leader of clinical need (CAFAS scores, recent discharge from inpatient hospitalization, PRTF, CSU, etc.). The record should indicate why a specific intervention took place in the school during school hours instead of after school in the home or community. Youth receiving this service must never be taken out of the classroom for the convenience of the service provider. IFI should not supplant what schools must provide for support of a child based on the IEP.
9. "Out-of-Clinic" may only be billed when:
 - Travel by the practitioner is to a non-contiguous location; and/or
 - Travel by the practitioner is to a facility not owned, leased, controlled or named as a service site by the agency who is billing the service(excepting visits to Shelter Plus sites); and/or
 - Travel is to a facility owned, leased or controlled by the agency billing the service, but no more than 6 individuals are being served in the course of that day by a single practitioner in non-group services; and/or
 - Travel is to a facility owned, leased, controlled or named as a service site by the agency, but no more than 24 individuals are being served in groups at that site in the course of a day.If the service does not qualify to be billed as "out of clinic," then the "in-clinic" rate may still be billed.

B. Staffing Requirements

1. The following practitioners can provide Intensive Family Intervention within the scope of the team definition which is defined in this Section:
 - Practitioner Level 2: Psychologist, CNS-PMH (reimbursed at Level 3 rate)
 - Practitioner Level 3: LCSW, LPC, LMFT, RN
 - Practitioner Level 4: LMSW; LAPC; LAMFT; Psychologist/LCSW/LPC/LMFT's supervisee/trainee with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology, functioning within the scope of the practice acts of the state; MAC, CAC-II, CADC, CCADC, GCADC (II, III); PP, CPRP, CAC-I or Addiction Counselor Trainees with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology (addictions counselors may only perform counseling functions related to treatment of addictive diseases).
 - Practitioner Level 5: CPS, PP, CPRP, CAC-I, RADT (I, II, or III), Addiction Counselor Trainees with high school diploma/equivalent under supervision of one of the licensed/credentialed professionals above

2. Intensive Family Intervention is provided by a team consisting of the family and the following practitioners:
 - One fulltime Team Leader who is licensed (and/or certified as a CAC II if the target population is solely diagnosed with substance related disorders) by the State of Georgia under the Practice Acts and has at least 3 years of experience working with children with serious emotional disturbances. LAMFT, LMSW, LAPC staff do not qualify for this position. The team leader must be actively engaged in the provision of the IFI service in the following manner:
 - (a) convene, at least weekly, team meetings that serve as the way to staff a child with the team, perform case reviews, team planning, and to provide for the team supervision and coordination of treatment/supports between and among team members. When a specific plan for a specific youth results from this meeting, there shall be an administrative note made in the youth's clinical record. In addition, there should exist a log of meeting minutes from this weekly team meeting that documents team supervision. In essence, there should be two documentation processes for these meetings; one child specific in the clinical record, and the other a log of meeting minutes for each team meeting that summarizes the team supervision process. This supervision and team meeting process is not a separately-billable activity, but the cost is accounted for within the rate methodology and supports the team approach to treatment. Weekly time for group supervision and case review is scheduled and protected.
 - (b) meet at least twice a month with families face-to-face or more often as clinically indicated.
 - (c) provide weekly, individual, clinical supervision to each IFI team member (outside of the weekly team meeting) for all services provided by that member of the IFI team. The individual supervision process is to be one-on-one supervision, documented in a log, with appropriate precautions for consumer confidentiality and indicating date/time of supervision, issues addressed, and placed in the personnel file for the identified IFI team staff.
 - (d) be dedicated to a single IFI team ("Dedicated" means that the team leader works with only one team at least 32 hours/week [up to 40 hours/week] and is a full-time employee of the agency [not a subcontractor/1099 employee]). The Team Leader will be available 24/7 to IFI staff for emergency consultation and supervision as needed.
 - Two to three fulltime equivalent paraprofessionals who work under the supervision of the Team Leader.
 - The team may also include an additional mental health professional, substance abuse professional or paraprofessional. The additional staff may be used .25 percent between 4 teams.
3. To facilitate access for those families who require it, the specialty IFI providers must have access to psychiatric and psychological services, as provided by a Physician, Psychiatrist or a Licensed Psychologist (via contract or referral agreement). These contracts or agreements must be kept in the agency's administrative files and be available for review.
4. Practitioners providing this service are expected to maintain knowledge and skills regarding current research trends in best/evidence based practices. Some examples of best/evidence based practice components/models are multi-systemic therapy, multidimensional family therapy, dialectic behavioral therapy and others as appropriate to the child, family and issues to be addressed. Their personnel files must indicate documentation of training and/or certification in the evidenced-based model chosen by the organization. There shall be training documentation indicating the evidenced-

based in-home practice model each particular staff person will be utilizing in the provision of services.

5. The IFI Team's family-to-staff ratio must not exceed 12 families for teams with two paraprofessional, and 16 families for teams with three paraprofessionals (which is the maximum limit which shall not be exceeded at any given time). The staff-to-family ratio takes into consideration evening and weekend hours, needs of special populations, and geographic areas to be covered.
6. Documentation must demonstrate that at least 2 team members (one of whom must be licensed/credentialed) are providing IFI services in the support of each consumer served by the team in each month of service. One of these team members must be appropriately licensed/credentialed to provide the professional counseling and treatment modalities/interventions needed by the consumer and must provide these modalities/interventions as clinically appropriate according to the needs of the consumer.
7. It is critical that IFI team members are fully engaged participants in the supports of the served individuals. To that end, no more than 50% of staff can be "contracted"/1099 team members. Team members must work for only one IFI organization at a time and cannot be providing this service when they are a member of another team because they cannot be available as directed by families need or for consumer crises while providing on-call services for another program.
8. When a team is newly starting, there may be a period when the team does not have a "critical mass" of individuals to serve. During this time, a short-term waiver may be granted to the agency's team by the DBHDD Regional Coordinator/s for the counties served. The waiver request may address the part-time nature of a team leader and the paraprofessionals serving less than consumer-load capacity. For example, a team may only start by serving 4-6 families (versus full capacity 12-16 families) and therefore could request to have the team leader serve ½ time and a single paraprofessional. A waiver of this nature will not be granted for any time greater than 6 months. The waiver request to a Regional Coordinator must include:
 - (a) the agency's plan for building consumer capacity (not to exceed 6 months)
 - (b) the agency's corresponding plan for building staff capacity which shall be directly correlated to the item above

The Regional Coordinator has the authority to approve these short-term waivers and must copy APS Healthcare on its approval and/or denial of these waiver requests. No extension on these waivers will be granted.

9. It is understood that there may be periodic turn-over in the Team Leader position; however, the service fails to meet model-integrity in the absence of a licensed/credentialed professional to provide supervision, therapy, oversight of Individualized Recovery/Resiliency Plans, and team coordination. Understanding this scenario, an IFI team who loses a Team Leader must provide the critical functions articulated via one of the following means:
 - Documentation that there is a temporary contract for Team Leader who meets the Team Leader qualifications; or
 - Documentation that there is another fully licensed/credentialed professional who meets the Team Leader qualifications and is currently on the team providing the Team Leader functions temporarily (this would reduce the team staff to either 2 or 3 members based on the numbers of families served by the team); or
 - Documentation that there is another fully licensed/credentialed professional who meets the Team Leader qualifications and is currently employed by the agency providing the Team Leader functions temporarily (this professional would devote a minimum of 15-20 hours/week

- to supervision, therapy, oversight of Individualized Recovery/Resiliency Plans, and team coordination); or
- Documentation that there is an associate-licensed professional who could work full-time dedicated to therapy, oversight of Individualized Recovery/Resiliency Plans, and team coordination with a fully licensed/credentialed professional supporting the team for 5 hours/week for clinical supervision.

For this to be allowed, the agency must be able to provide documentation that recruitment is underway. Aggressive recruitment shall be evidenced by documentation in administrative files of position advertising. In the event that a position cannot be filled within 60 days OR in the event that there is no ability to provide the coverage articulated in this item (B.8.), there shall be notification to the State DBHDD Office and the Regional Coordinator of the intent to cease billing for the IFI service.

10. IFI providers may not share contracted team members with other IFI agencies. Staff may not work part-time for one agency and part-time with another agency due to the need for staff availability in accord with the specific needs, requirements, and requests of the families served. Team members must be dedicated to each specific team to ensure intensity, consistency, and continuity for the consumers served.

C. Clinical Operations:

1. In-home services include consultation with the individual, parents, or other caregivers regarding medications, behavior management skills, and dealing with the responses of the individual, other caregivers and family members, and coordinating with other child-serving treatment providers.
2. Individuals receiving this service must have a qualifying and verified diagnosis present in the medical record prior to the initiation of services. The verified diagnosis must be given by persons identified in O.C.G.A Practice Acts as qualified to provide a diagnosis. These practitioners include a licensed psychologist, a physician or a PA or APRN (NP and CNS-PMH) working in conjunction with a physician with an approved job description or protocol.
3. The Individualized Resiliency Plan must be individualized, strengths-based, and not developed from a template used for other consumers and their families. Team services are individually designed for each family, in full partnership with the family, to minimize intrusion and maximize independence.
4. Intensive Family Intervention must be provided through a team approach (as evidenced in documentation) and flexible services designed to address concrete therapeutic and environmental issues in order to stabilize a situation quickly. Services are family-driven, child focused, and focus on developing resiliency in the child. They are active and rehabilitative, and delivered primarily in the home or other locations in the community. Services are initiated when there is a reasonable likelihood that such services will lead to specific, observable improvements in the individual's functioning (with the family's needs for intensity and time of day as a driver for service delivery).
5. Service delivery must be preceded by a thorough assessment of the child and the family in order to develop an appropriate and effective treatment plan. This assessment must be clearly documented in the clinical record.
6. IFI services provided to children and youth must be coordinated with the family and significant others and with other systems of care such as the school system, the juvenile justice system, and children's protective services when appropriate to treatment and educational needs.
7. IFI providers must have the ability to deliver services in various environments, such as homes (birth, kin, adoptive, and foster), schools, homeless shelters, or street locations. The provider

should keep in mind that youth/families may prefer to meet staff at a community location other than their homes or other conspicuous locations (e.g. parents' place of employment or school), especially if staff drive a vehicle that is clearly marked as a state or agency vehicle, or if staff must identify themselves and their purpose to gain access to the individual in a way that may potentially embarrass the individual or breach the individual's privacy/confidentiality. Staff should be sensitive to and respectful of youth's privacy/confidentiality rights and preferences in this regard to the greatest extent possible (e.g. if staff must meet with a youth during their school time, mutually agree upon a meeting time during the day that is the least conspicuous from the youth's point of view).

8. The organization must have policies that govern the provision of services in natural settings and can document that it respects the youth's and/or family's right to privacy and confidentiality when services are provided in these settings
9. When a projected discharge date for the service has been set, the youth may begin to receive more intensified Community Support services two weeks prior to IFI discharge for continuity of care purposes only.
10. When there is a crisis situation identified or there is potential risk of youth harm to self or others, there must be documentation that a licensed/credentialed practitioner is involved in that crisis resolution.
11. The IFI organization will be expected to develop and demonstrate comprehensive crisis protocols and policies, and must adhere to all safety planning criteria as specified below. Safety planning with the family must be evident at the beginning of treatment, and must include evidence that safety needs are assessed for all youth and families. The family shall be a full participant in the safety planning, and all crisis stabilization steps will be clearly identified. All parties involved, including community partners, will need to know the plan and who is responsible for supporting its implementation. When aggression is an issue within the family, a written safety plan must be developed and signed by the parents/caregivers, staff, youth, and other agency staff involved in the plan. Safety plans should also include natural supports and should not rely exclusively on professional resources. This plan must be given to the family, other agency staff, the youth, and a copy kept in the consumer's record.
12. Service delivery should be organized in a way such that there is a high frequency of services delivered at the onset of support and treatment and a tapering off as the youth moves toward discharge. As it applies to the specific youth, this shall be documented in the record.

D. Service Accessibility

1. Services must be available 24 hours a day, 7 days a week, through on-call arrangements with practitioners skilled in crisis intervention. A team response is preferable when a family requires face-to-face crisis intervention.
2. Due to the intensity of the service, providers must offer a minimum of 3 contacts per week with the youth/family except during periods where service intensity is being tapered toward the goal of transition to another service or discharge.
3. Intensive Family Intervention may **not** be provided in an Institution for Mental Diseases (IMD, e.g. state or private psychiatric hospital, psychiatric residential treatment facility or Crisis Stabilization Unit with greater than 16 beds), jail, youth development center (YDC) or prison system.
4. This service may not be provided and billed for youth who are involuntarily detained in Regional Youth Detention Centers (RYDCs) awaiting criminal proceedings, penal dispositions, or other involuntary detainment proceedings. Any exception to this requires supporting documentation from the DJJ partners. The provider holds the risk for assuring the youth's eligibility

5. Services provided for over 6 hours on any given day must be supported with rigorous reasons in the documentation. Anything over 6 hours would need to relate to a crisis situation and the support administrative documentation should spell out the reasons for extended hours and be signed by the Team Leader.

E. Additional Medical Requirements

Currently, there are no additional Medicaid requirements to be added to the requirements above when billing Medicaid for this service.

F. Reporting & Billing Requirements

All applicable Medicaid, MICP, ERO, and other DBHDD reporting requirements must be followed.

G. Documentation Requirements

1. If admission criteria #2 is utilized to establish admission, notation of other services provision intensity/failure should be documented in the record (even if it is self-reported by the youth/family).
2. As the team, youth, and family work toward discharge, documentation must indicate planning with the youth/family for the supports and treatment needed post-discharge from the IFI service. Referrals to subsequent services should be a part of this documentation.
3. In addition to all the references within this service guideline, providers must also document services in accordance with the specifications for documentation requirements specified in Part II, Section IV of the Provider Manual.

Outdoor Therapeutic Program							
HIPAA Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Therapeutic Camping, Overnight		T2036					

Definition of Service: The Outdoor Therapeutic Program is a therapeutic wilderness program for troubled youth. The mission of the OTP is to operate a program that promotes growth through challenge, education, positive reinforcement and nurturing to youth and families who are deemed most in need and likely to benefit.

Referral to this program is appropriate for youth who have social, emotional, or behavioral problems in their homes, schools, and communities. Many of the youth have poor school performance, family problems, and peer relationship problems. All youth enrolled in the program are assessed by gathering information from the referral sources (sponsors) and parents or legal guardians. From the assessment process, an individualized service plan is developed with the youth, parents and referral "sponsor" to guide the youth in the program. The newly admitted youth join an existing group of peers and counselors living in a wilderness setting. Each group is an autonomous community with campers learning to accept and share responsibility for basic living requirements. Skills in teamwork, compromise and leadership emerge and develop, as campers must learn to cooperate in order for the camp community to function. The counselors provide guidance and suggestions, but the group members are responsible for planning and accomplishing the required chores and for maintaining group cohesiveness.

Target Population	Youth who are experiencing social, emotional or behavioral problems
Benefit Information	Requires a MICP New Episode Request or Update Request (to add as a single service to an existing authorization).
Utilization Criteria	N/A
Unit Value	1 day
Initial Authorization	90 days
Maximum Daily Units	1 unit
Re-Authorization	90 days
Authorization Period	90 days
UAS: Budget and Expense Categories	<u>Residential Services Provider</u> 250 – C&A Mental Health 850 – C&A Addictive Diseases
Admission Criteria	<ol style="list-style-type: none"> Youth has serious social, emotional or behavioral problems; and Youth has poor school performance, family problems, and/or peer relationship problems; and Youth has exhausted other less restrictive, community based options as demonstrated by documentation from multiple community resources Level of functioning precludes provision of services in less restrictive services Full scale IQ of 70 or higher

	6. Psychological evaluation within past 24 months
Continuing Stay Criteria	<ol style="list-style-type: none"> 1. Youth has behavior that continues to create a risk for more restrictive placement despite efforts and youth and family needs more time in the program to acquire social, functional improvements 2. Continued presence of presenting problems associated with placement. 3. Continuing stay criteria will be reviewed every 90 days. The maximum length of stay shall be 9 months. If the program is not successful within this designated amount of time, other intensive support options should be tried as alternatives.
Discharge Criteria	<ol style="list-style-type: none"> 1. No longer meets admission criteria 2. Refuses to participate in program activities 3. Alternative placement is available 4. Adequate aftercare plan have been established 5. Family/guardian requests discharge 6. Youth requires services not available through this program
Service Exclusions	Community Inpatient Services, IFI
Clinical Exclusions	<ol style="list-style-type: none"> 1. Presence of any behaviors that require a more intensive level of service due to dangerousness to self or others 2. Refuses to participate in program activities.

Additional Service Criteria:

A. Required Components

1. The Outdoor Therapeutic Camps are state-operated and administered by the DBHDD.
2. The newly admitted youth join an existing group of peers and counselors living in a wilderness setting. Each group is an autonomous community with campers learning to accept and share responsibility for basic living requirements.
3. Each camp has the capacity for 40-44 youth, ranging in age from age 12-17.
4. Staff arranges home visits/passes, when appropriate, each month to visit with their families or agency sponsors.
5. Youth typically stay in the program between 3 and 9 months, with an average length of stay of 6 months.
6. Linkages with other child-serving agencies and community supports should be clearly described within the comprehensive program descriptions.
7. There is a fully accredited school program at each camp, which is regularly monitored by the Department of Education. School attendance is required for each group and each camper is expected to demonstrate effort toward improving school behavior and school skills. Instruction is based on the Georgia Performance Standards and the assessed academic level of each camper. Teachers are certified in Special Education and one core subject area.
8. The program is accredited as an Outdoor Wilderness Program through the Council on Accreditation.
9. There will be offered 20 hours per week for school/vocational assignments.
10. There will be daily goal setting and group meetings.
11. There will be 3 meals, 1 snack, and recreation time each day.

B. Staffing Requirements

1. Two camp counselors are with each group of ten to eleven campers around the clock to monitor and supervise youth, as well as to provide training and support whenever needed.
2. Outdoor Therapeutic Camps each have four groups of ten to eleven campers. The staff to youth ratio for each group must be no less than 2:11.
3. A Camp Director who has a minimum of a bachelor's degree and experience supervising groups must supervise services.
4. The program will have one registered nurse on staff at each site that provides nursing assessment, and medication monitoring of administration under physician's orders.
5. All direct care staff must have an understanding of and ability to assess symptoms, medication issues, and behaviors in order to identify situations that require additional interventions.
6. The camp must have an educational supervisor and teachers to meet the educational needs of the campers.
7. The camp must have staff called "Family Workers" who coordinate services and help develop individualized service plans and communicate with the families, referring agencies/sponsors and provide parent/family training and education.
8. The program will refer youth who have behavioral health needs to core providers or private providers of behavioral health services and the legal guardian will have the choice of which behavioral health provider is selected. Camp staff will assist in making arrangements for youth who have identified behavioral health needs to have appointments/sessions with the outside behavioral health provider.
9. Services must have staff who has proficiency in working with the target population, with families as partners, and with local systems of care between child-serving agencies and providers of other service. They must have training and demonstrate proficiency in cultural competence as related to youth and families who are culturally different from them.
10. Staff must be trained in evidenced based practices specific to wilderness adventure-based interventions with youth/families who are experiencing social, emotional or behavioral problems.

C. Clinical Operations

1. Skills in teamwork, compromise and leadership emerge and develop, as campers must learn to cooperate in order for the camp community to function. The counselors provide guidance and suggestions, but the group members are responsible for planning and accomplishing the required chores and for maintaining group cohesiveness.
2. The most effective counseling is provided in sessions called "groups" that are called by individual campers or counselors at any time a camper's behavior or attitude is having a negative impact on the group and its goals. Campers also call "groups" to express and share feelings with other campers and to resolve conflicts.
3. Campers participate in outdoor, experiential adventure-based activities such as hiking, canoeing, caving and ropes course skills building on site and off-site as planned and scheduled by program staff.
4. When appropriate and applicable, families participate in monthly parent and family training and educational groups at camp and have opportunities to learn new parenting skills while their child is at camp.
5. Services must operate in accordance with all identified safety and health standards.
6. Services must be evidence-based, strength-based, family-driven and youth-guided and system of care oriented.
7. Discharge planning is conducted monthly and is addressed through daily monitoring of the youth's progress towards established goals in the service plan.

D. Service Access

1. Referrals are made directly to the Outdoor Therapeutic Program. The service team reviews and screens each referral to determine that the youth is appropriate and can benefit from the service. The service team also ensures that other less restrictive resources and services have been exhausted in the community. Referrals come directly from the DJJ for youth who are committed to DJJ, the Division of Family & Children Services (DFCS) for youth who are in DFCS custody and from DBHDD for youth who are in parental custody and are deemed likely to benefit from the service and other resources have been exhausted.
2. Services are available 24/7, which include monthly home visits. Youth have home visits/passes, when appropriate and applicable for family reunification goals and to practice new skills in their homes and communities.

E. Billing/Reporting Requirements

1. Youth enrolled in this service are reported through MICP enrollment and reporting mechanisms.
2. On the MICP, the required diagnostic field can be populated with 799.99 if there is no available diagnosis to report.
3. On the MICP, the required CAFAS field can be populated with 0 if there is no available CAFAS score to report.

F. Documentation Requirements

1. Documentation must reflect the activities that the youth and families participate in by date, time, and duration. Weekly documentation must indicate counselor's notes on each individual goals and objectives. Weekly group notes must be individualized and placed in each youth's medical record. Weekly documentation must reflect progress towards the resolution of presenting problems, and progress towards being fully re-integrated into school and community activities.
2. Quarterly documentation must address discharge planning progress and coordination with other agencies and the family towards this end.
3. Family Workers must coordinate with the outside behavioral health providers, such as core providers or private providers for clinical service goals and objectives that may be applicable for youth enrolled in the wilderness program. Agencies with legal custody or family members with legal custody are given choices about which provider of behavioral health services are available to serve the needs of the youth.

G. Documentation Requirements

Providers must document services in accordance with the specifications for documentation requirements specified in Part II, Section V of the Provider Manual.

Structured Activity Supports							
HIPAA Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Structured Activity Supports		SAS01					\$2.11

Definition of Service: Structured Activity Support Services provide children and adolescents who are core customers with homework assistance, leisure, and recreational activities. Services can be provided for up to two hours a day and are offered only in conjunction with treatment services, i.e. individual counseling, group training or counseling, and/or family training/counseling. For example, consumers receive one hour of group therapy and remain at the facility to participate in Structured Activity Supports or consumers arrive at the facility, participate in a recreational activity, receive assistance with homework, and then participate in a group therapy session. Services are to be utilized as an adjunct to clinical services, providing support to youth who have significant behavioral health problems and who need structured activities in addition to treatment services. Services are primarily group-based and are intended to provide consumers with opportunities for positive socialization experiences and skill building. Services will provide the child or adolescent with experiences and supports that will enable them to develop skills to become fully integrated into their communities and to develop positive and emotionally satisfying peer relationships. Services are planned in partnership with the youth and family and are designed to assist consumers in progressing toward treatment goals identified in the IRP.

Recreational and leisure activities may include group sports, games or hobbies and are designed to promote pro-social behaviors, competence and confidence in working and playing with others, and a positive attitude toward physical activities as an important component of a healthy and satisfying life. Play activities are also important to the development of positive relationships with adults. Diversionary activities that do not encourage interaction with consumers and staff, such as watching entertainment videos or movies, are not allowed. Homework assistance may be provided for consumers to improve or maintain academic achievement and to ensure that consumers complete school assignments. The service assists consumers according to level of need in an atmosphere of support. Homework assistance activities provide academic enrichment and skill building. It is designed to help children perform well in school, increase their experiences of success in academics, and internalize learning and academic goal attainment as positive experiences and is not simply monitoring youths while they complete their homework.

Youth typically attend Structured Activity Supports from three to five days a week. This service may be billed only when offered in conjunction (on the same day) with individual counseling, group training, group counseling, family training, and/or family counseling. It is primarily facility-based, although activities may involve excursions into the community for recreation.

Target Population	C&A with SED C&A with AD Issues C&A with Co-occurring SED/AD
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Benefit Information	Available to Core Customers enrolled in MRO or Fee-For-Services Core Services and in need of Ongoing Services and requires a MICP.
Utilization Criteria	<u>Available to those with CAFAS scores:</u> 100-130: High Intensity Community-Based Services *May be used for consumers transitioning to the community from structured residential settings even when the CAFAS score is below 60.
Ordering Practitioner	Physician, Psychologist, Physician's Assistant, Advanced Practice Registered Nurse (Clinical Nurse Specialist or Nurse Practitioner), LPC, LMFT, LCSW
Unit Value	15 minutes
Initial Authorization	1248 units
Re-Authorization	1248 units
Maximum Daily Units	8 units
Authorization Period	180 days
UAS: Budget and Expense Categories	<u>Core Services Provider</u> 270 – C&A Mental Health 870 – C&A Addictive Diseases
Admission Criteria	1. Individual must meet target population criteria as indicated above; and 2. Individual needs assistance with developing, maintaining, or enhancing social supports or other community coping skills; and 3. Individual needs assistance with daily living skills including homework assistance and social activity supervision
Continuing Stay Criteria	1. Individual continues to meet admission criteria; and 2. Individual demonstrates documented progress or maintenance of community skills relative to goals identified in the Individualized Resiliency Plan.
Discharge Criteria	1. An adequate continuing care plan has been established; and one or more of the following: 2. Goals of Individualized Resiliency Plan have been substantially met; or 3. Individual/family requests discharge or 4. Transfer to another service is warranted by change in the individual's condition.
Service/Clinical Exclusions	PRTF Individuals served through CMOs or other insurance plans

Additional Service Criteria:

A. Required Components

1. Because this service must be offered in conjunction with individual counseling, family training/counseling, or group training/counseling, it may only be provided by providers offering the whole range of core services as defined in a DBHDD "Core Services" Provider Agreement/Contract.
2. This service is facility-based, although excursions into the community are allowed.
3. Structured Activity Supports are provided in small groups up to 1:5 staff to child ratio according to the specific educational and behavioral support needs of the child or adolescent.
4. Collaboration occurs with parents and/or school personnel regarding homework assignments and recreational and leisure activity needs.

5. Structured Activity Supports staff providing homework assistance must be familiar with best and promising practices in homework assistance and out-of-school learning programs and these practices, i.e. positive support and reinforcement, creating an organized homework environment, and communicating with teachers and parents must be evident. (Information about effective homework assistance is available on the Internet.)
6. Structured Activity Supports uses a wide range of materials that are appropriate for youth and will provide further enhancement in the development of recreation, leisure, and homework skills.
7. Direct supervision of computer use and/or blocking software must be ensured by program staff in order to protect youth from inappropriate material on the Internet.

B. Staffing Requirements

1. Program planning and supervision must be provided by a staff member with a master's degree in behavioral sciences. This supervisor must be on-site and available to the program during the hours it is in operation. The supervisor must accompany the group during off-site activities.
2. Because this service may be provided for extended periods of time, adequate supervision must be present at all times. A staff to consumer ratio of at least 1 staff member for 5 children must be maintained.
3. Direct services may be provided by paraprofessionals with experience serving children and adolescents in behavioral health settings.

C. Clinical Operations

1. Individualized services must be provided to the consumer and must be related to goals identified on the IRP.
2. This service is provided on the same day that the consumer is scheduled for individual therapy, group training or counseling and/or family training/counseling. For example, the child has group therapy and after that service participates in Structured Activity Supports with other consumers. Under no circumstance may a child receive this service as a stand alone, but instead must be provided Structured Activity Supports in conjunction with having participated in a clinical service on the same day.
3. Structured Activity Support Services must be coordinated with the parent/caregiver, the school system, and other child-serving agencies when appropriate and indicated regarding the consumer's homework and recreational/leisure needs.

D. Service Access

1. Structured Activity Services must be available at least 2 days per week and up to 6 days a week according to the needs of consumers and the capacity of the Provider agency.
2. Structured Activity Services is primarily facility-based but may involve excursions into the community.
3. This service may not be used to supplant or duplicate other support/supervision/activity services that are funded through other sources. For example, a residential program where structured group activities are program expectations may not supplant residential programming with this service.

E. Additional Medicaid Requirements

This is not a Medicaid reimbursable service.

F. Reporting & Billing Requirements

All applicable MICP and other required DBHDD reporting must be followed.

G. Documentation Requirements

1. As with all interventions, this intervention must be documented on the IRP and must be tied to a treatment goal. There must be a weekly summary note indicating progress towards IRP goals. In addition, a daily attendance log that captures the amount of time each consumer spent in the program and supports billing must be maintained. Any unusual or significant events must be documented and communicated to the program supervisor on the day of the occurrence. A current schedule of activities must be posted. All collateral contacts should be documented in the consumer's medical record.
2. Providers must document services in accordance with the specifications for documentation requirements specified in Part II, Section V of the Provider Manual.

Structured Residential Supports							
HIPAA Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Structured Residential	Child Program	H0043	HA				As negotiated

Definition of Service: Structured Residential Supports (formerly Rehabilitation Supports for Individuals in Residential Alternatives, Levels 1 & 2) are comprehensive rehabilitative services to aid youth in developing daily living skills, interpersonal skills, and behavior management skills; and to enable youth to learn about and manage symptoms; and aggressively improve functioning/behavior due to SED, substance abuse, and/or co-occurring disorders. This service provides support and assistance to the youth and caregivers to identify, monitor, and manage symptoms; enhance participation in group living and community activities; and, develop positive personal and interpersonal skills and behaviors to meet the youth's developmental needs as impacted by his/her behavioral health issues.

Services are delivered to youth according to their specific needs. Individual and group activities and programming must consist of services to develop skills in functional areas that interfere with the ability to live in the community, participate in educational activities; develop or maintain social relationships; or participate in social, interpersonal, recreational or community activities.

Rehabilitative services must be provided in a licensed residential setting (see A.2.) with no more than 16 individuals and must include supportive counseling, psychotherapy and adjunctive therapy supervision, and recreational, problem solving, and interpersonal skills development. All facilities providing residential rehabilitative supports must be staffed 24 hours a day, 7 days a week.

Target Population	Children & Adolescents with Serious Emotional Disturbance, Children & Adolescents with Substance Abuse Issues, Children & Adolescents with Co-Occurring Substance Abuse and Mental Illness Children & Adolescents with Co-Occurring Mental Illnesses and MR/DD. Children & Adolescents with Co-Occurring Substance Related Disorders and MR/DD.
Benefit Information	Available to Core Customers in need of Ongoing Services and requires a MICP New Episode Request or Update Request (to add as a single service to an existing authorization).
Utilization Criteria	<u>Available to those with CAFAS scores:</u> 140-180: Medically Monitored Community Residential 190-240: Medically Managed Community Residential 190-240: Medically Managed Inpatient Residential or clinical justification is explained in the justification text on the MICP for lower CAFAS scores
Ordering Practitioner	Physician, Psychologist, Physician's Assistant, Advanced Practice Registered Nurse (Clinical Nurse Specialist or Nurse Practitioner), LPC, LMFT, LCSW
Unit Value	1 day
Initial Authorization	180 days

Re-Authorization	180 days
Maximum Daily Units	1 unit
Authorization Period	180 days
UAS: Budget and Expense Categories	<u>Residential Services Provider</u> 244 – C&A Mental Health 844 – C&A Addictive Diseases
Admission Criteria	<ol style="list-style-type: none"> 1. Youth must have symptoms of a SED or a substance related disorder; and one or more of the following: 2. Youth's symptoms/behaviors indicate a need for continuous monitoring and supervision by 24-hour staff to ensure safety; or 3. Youth/family has insufficient or severely limited skills to maintain an adequate level of functioning, specifically identified deficits in daily living and social skills and/or community/family integration; or 4. Youth has adaptive behaviors that significantly strain the family's or current caretaker's ability to adequately respond to the youth's needs; or 5. Youth has a history of unstable housing due to a behavioral health issue or a history of unstable housing which exacerbates a behavioral health condition.
Continuing Stay Criteria	Youth continues to meet Admissions Criteria.
Discharge Criteria	<ol style="list-style-type: none"> 1. Youth/family requests discharge; or 2. Youth has acquired rehabilitative skills to independently manage his/her own housing; or 3. Transfer to another service is warranted by change in youth's condition
Service Exclusions	Cannot be billed on the same day as Crisis Stabilization Unit.
Clinical Exclusions	<ol style="list-style-type: none"> 1. Severity of identified youth issues precludes provision of services in this service 2. Youth with the following conditions are excluded from admission unless there is clearly documented evidence of psychiatric condition overlaying the primary diagnosis: mental retardation, autism, organic mental disorder, or traumatic brain injury. 3. Youth is actively using unauthorized drugs or alcohol (which should not indicate a need for discharge, but for a review of need for more intensive services). 4. Youth can effectively and safely be supported with a lower intensity service.

Additional Service Criteria:

A. Required Components:

1. The organization must have an executive director or program director charged with the responsibility for day-to-day management of the organization.
2. If applicable, the organization must be licensed by the Georgia Department of Human Services/CCI or the Department of Community Health/HRF to provide residential services to youth with SED and/or substance abuse diagnosis. If the agency does not have a license/letter from either the DHS/CCI or DCH/HRF related to operations, there must be enough administrative documentation to support the non-applicability of a license.

3. The residential program must provide a structured and supported living environment 24 hours a day, 7 days a week.
4. Structured Residential Supports must provide at least 5 hours per week of structured programming and/or services.

B. Staffing Requirements:

1. Any Level 5 and higher practitioner may provide all Residential Rehabilitation Services.
2. If applicable, facilities must comply with any staffing requirements set forth for mental health and substance abuse facilities by the Office of Regulatory Services (see A.2).
3. An independently licensed practitioner or CACII/MAC/CADC must provide clinical supervision for all Residential Support Services. This person is available for emergencies 24 hours/7 days a week.
4. The organization that provides direct residential services must have written policies and procedures for selecting and hiring residential and clinical staff in accordance with their applicable license/accreditation/certification.
5. The organization must have a mechanism for ongoing monitoring of staff licensure, certification, or registration such as an annual confirmation process concurrent with a performance evaluation that includes repeats of screening checks outlined above.

C. Clinical Operations

1. The organization must have a written description of the Structured Residential Support services it offers that includes, at a minimum, the purpose of the service; the intended population to be served; treatment modalities provided by the service; level of supervision and oversight provided; and typical treatment objectives and expected outcomes.
2. Individuals receiving this service must have a qualifying diagnosis present in the medical record prior to the initiation of services. The diagnosis must be given by persons identified in O.C.G.A Practice Acts as qualified to provide a diagnosis. These practitioners include a licensed psychologist, a physician or a PA or APRN (NP and CNS-PMH) working in conjunction with a physician with an approved job description or protocol.
3. Structured Residential Supports assist youth in developing daily living skills that enable them to manage the symptoms and behaviors linked to their psychiatric or addictive disorder. Services must be delivered to individuals according to their specific needs. Individual and group activities and programming consists of services geared toward developing skills in functional areas that interfere with the youth's ability to participate in the community, retain school tenure, develop or maintain social relationships, or age-appropriately participate in social, interpersonal, or community activities.
4. Structured Residential Supports must include symptom management or supportive counseling; behavioral management; medication education, training and support; support, supervision, and problem solving skill development; development of community living skills that serve to promote age-appropriate utilization of community-based services; and/or social or recreational skill training to improve communication skills, manage symptoms, and facilitate age-appropriate interpersonal behavior.

D. Service Access

E. Additional Medicaid Requirements

This is not a Medicaid-billable service.

F. Reporting & Billing Requirements

All applicable MICP and other DBHDD reporting requirements must be adhered to.

G. Documentation Requirements

1. Providers must document services in accordance with the specifications for documentation requirements specified in Part II, Section V of the Provider Manual.
2. The organization must develop and maintain sufficient written documentation to support the Structured Residential Support Services for which billing is made. This documentation, at a minimum, must confirm that the individual for whom billing is requested was a resident of the residential service on the date of service. The youth's record must also include each week's programming/service schedule in order to document the provision of the required amount of service.
3. Weekly progress notes must be entered in the youth's record to enable the monitoring of the youth's progress toward meeting treatment and rehabilitation goals and to reflect the Individualized Resiliency Plan implementation. Each note must be signed and dated and must include the professional designation of the individual making the entry.
4. Documentation must be legible and concise and include the printed name and the signature of the treating practitioner. The name, title, and credentials of the individual providing the service must reflect the staffing requirements established for the Rehabilitation Service being delivered.

H. Facilities Management (applicable to traditional residential settings such as group homes, treatment facilities, etc)

1. Structured Residential Supports may only be provided in facilities that have no more than 16 beds.
2. Each residential facility must be arranged and maintained to provide adequate measures for the health, safety, access and well being of the residents.
3. Each residential facility must comply with all relevant fire safety codes.
4. All areas of the residential facility must appear clean, safe, appropriately equipped, and furnished for the services delivered.
5. The organization must comply with the Americans with Disabilities Act.
6. The organization must maintain a written evacuation plan to be used in the case of fire or other disaster. An appropriate written certificate of compliance must be obtained indicating that all applicable fire and safety code requirements have been satisfied. Periodic fire drills must be conducted.
7. Evacuation routes must be clearly marked by exit signs.
8. The program must be responsible for providing physical facilities that are structurally sound and that meet all applicable federal, state, and local regulations for adequacy of construction, safety, sanitation, and health.

Substance Abuse Intensive Outpatient Package (C&A): (SA Adolescent Day Treatment)

HIPAA Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
See Item E.1. Below							

Definition of Service: A time limited multi-faceted approach treatment service for adolescents who require structure and support to promote resiliency and achieve and sustain recovery from substance related disorders. These specialized services are available after school and/or weekends and include:

1. Behavioral Health Assessment
2. Nursing Assessment
3. Psychiatric Treatment
4. Diagnostic Assessment
5. Community Support
6. Individual Counseling
7. Group Counseling (including psycho-educational groups focusing, relapse prevention and recovery)
8. Family Counseling/Psycho-Educational Groups for Family Members
9. Structured Activity Supports

These services are to be available at least 5 days per week to allow youth's access to support and treatment within his/her community, school, and family. These services are to be age appropriate and providers are to use best/evidenced based practices for service delivery to adolescent consumers. Intense coordination with schools and other child serving agencies is mandatory. This service promotes resiliency and recovery from substance abuse disorders incorporating the basic tenets of clinical practice. These services should follow Adolescent ASAM Level Guidelines. These guidelines are as follows: II.1 (at least 6 hours of structured programming per week); II.2 (at least 9 hours per week); II.3 (at least 12 hours per week); II.4 (at least 15 hours per week); and II.5 (at least 20 hours of structured activity per week). The maximum number of units that can be billed differs depending on the individual service. Please refer to the table below or in the Mental Health and Addictive Disease Orientation to Authorization Packages Section of this manual.

A consumer may have variable length of stay. The level of care should be determined as a result of consumers' multiple assessments. It is recommended that individuals attend at a frequency appropriate to their level of need. Ongoing clinical assessment should be conducted to determine step down in level of care.

Target Population	Adolescents with substance abuse related disorders, including those with co-occurring mental illness and secondary development disability
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Benefit Information	available to all ongoing core customers, requires a MICP New Episode or Ongoing Authorization
Utilization Criteria	<u>Available to those with CAFAS Scores</u> 100-130: High Intensity Community Based Services 140-180: Medically Monitored Community Residential (transition) 190-240: Medically Managed Community Residential (transition) 190-240: Medically Managed Inpatient Residential (transition)
Ordering Practitioner	Physician, Physician's Assistant, Advanced Practice Registered Nurse (Clinical Nurse Specialist or Nurse Practitioner)
Unit Value	See Authorization/Group Package Detail
Initial Authorization	See Authorization/Group Package Detail
Re-Authorization	See Authorization/Group Package Detail
Maximum Daily Units	See Authorization/Group Package Detail
Authorization Period	180 Days
UAS: Budget and Expense Categories	See Authorization/Group Package Detail
Admission Criteria	<ol style="list-style-type: none"> 1. A DSM IV diagnosis of Substance Abuse or Dependence or substance-related disorder with a co-occurring DSM IV-TR diagnosis of mental illness and 2. Consumer meets the age criteria for adolescent treatment; and 3. Youth's biomedical conditions are stable or are being concurrently addressed (if applicable) and one or more of the following: <ol style="list-style-type: none"> a. Youth is currently unable to maintain behavioral stability for more than a 72 hour period, as evidenced by distractibility, negative emotions, or generalized anxiety or b. Youth has a diagnosed emotional/behavioral disorder that requires monitoring and/or management due to a history indicating a high potential for distracting the individual from recovery/treatment, or c. There is a likelihood of drinking or drug use without close monitoring and structured support d. The substance use is incapacitating, destabilizing or causing the individual anguish or distress and the individual demonstrates a pattern of alcohol and/or drug use that has resulted in a significant impairment of interpersonal, occupational and/or educational <p>See also Adolescent ASAM Level II continued service criteria</p>
Continuing Stay Criteria	<ol style="list-style-type: none"> 1. Youth continues to meet admission criteria 1, 2, and/or 3 or 2. Youth is responding to treatment as evidenced by progress towards goals, but has not yet met the full expectation of the objectives or 3. Youth begins to recognize and understand his/her responsibility for addressing his/her illness, but still requires services and strategies to sustain personal responsibility and progress in treatment or 4. Youth recognizes and understands relapse triggers, but has not developed sufficient coping skills to interrupt or postpone gratification or to change related inadequate impulse control behaviors or

	<p>5. Youth's substance seeking behaviors, while diminishing, have not been reduced sufficiently to support function outside of a structure treatment environment</p>
Discharge Criteria	<p>An adequate continuing care or discharge plan is established and linkages are in place; and one or more of the following:</p> <ol style="list-style-type: none"> 1. Goals of the treatment plan have been substantially met; or 2. Youth's problems have diminished in such a way that they can be managed through less intensive services; or 3. Youth recognizes the severity of his/her drug/alcohol usage and is beginning to apply the skills necessary to maintain recovery by accessing appropriate community supports 4. Clinical staff determines that youth no longer needs ASAM Level II and is now eligible for aftercare and/or transitional services <p>Transfer to a higher level of service is warranted by change in the</p> <ol style="list-style-type: none"> 1. Youth's condition or nonparticipation; or 2. The youth refuses to submit to random drug screens; or 3. Youth's exhibits symptoms of acute intoxication and/or withdrawal or 4. The youth requires services not available at this level or 5. Youth has consistently failed to achieve essential treatment objectives despite revisions to the treatment plan and advice concerning the consequences of continues alcohol/drug use to such an extent that no further process is likely to occur <p>See also Adolescent ASAM Level II discharge criteria</p>
Service Exclusions	<ol style="list-style-type: none"> 1. Substance Abuse C&A Intensive Outpatient Package cannot be offered at the same time as C&A Mental Health IOP Package. Documentation must indicate efforts to minimize duplication of services and effectively transition the individual to the appropriate services. This combination of services is subject to review by the External Review Organization.
Clinical Exclusions	<ol style="list-style-type: none"> 1. Youth manifests overt physiological withdrawal symptoms 2. Youth with any of the following unless there is clearly documented evidence of an acute psychiatric/addiction episode overlaying primary diagnosis <ol style="list-style-type: none"> a. Autism b. Developmental Disabilities c. Organic mental disorder d. Traumatic Brain Injury

A. Required Components

1. This service must be licensed by DCH/HFR under the Rules and Regulations for Drug Abuse Treatment Programs, 290-4-2.
2. The program provides structured treatment or therapeutic services, utilizing activity schedules as part of its operational method, i.e., plans or schedules of days or times of day for certain activities. The program should also utilize group and/or individual counseling and/or therapy.

3. Best/evidence based practice must be utilized. Some examples are motivational interviewing, behavioral family therapy, functional family therapy, brief strategic family therapy, cognitive behavioral therapy, seven challenges, teen MATRIX and ACRA.
4. The program utilizes methods, materials, settings, and outside resources appropriate to the developmental and cognitive levels, capabilities, age, and gender of participants.
5. The program utilizes methods, materials, approaches, activities, settings, and outside resources appropriate for and targeted to individuals with co-occurring disorders of mental illness and substance abuse and targeted to individuals with co-occurring and substance abuse when such individuals are referred to the program.
6. The program conducts random drug screening and uses the results of these tests for marking consumers' progress toward goals and for service planning.
7. The program is provided over a period of several weeks or months and often follows detoxification or residential services and should be evident in individual youth records.
8. Intense coordination with schools and other child serving agencies is mandatory.
9. This service must operate at an established site approved to bill Medicaid for services. However, limited individual or group activities may take place off-site in natural community settings as is appropriate to each individual's treatment plan.
 - a. Narcotics Anonymous (NA) and/or Alcoholics Anonymous (AA) meetings offsite may be considered part of these limited individual or group activities for billing purposes only when time limited and only when the purpose of the activity is introduction of the participating individual to available NA and/or AA services, groups or sponsors. NA and AA meetings occurring during the SA C&A Intensive Outpatient Package may not be counted toward the billable hours for any individual outpatient services, nor may billing related to these meetings be counted beyond the basic introduction of an individual to the NA/AA experience.
10. This service may operate in the same building as other services; however, there must be a distinct separation between services in staffing, program description, and physical space during the hours the SA Intensive Outpatient Services is in
11. Adequate space, equipment, furnishings, supplies, and other resources must be provided in order to effectively provide services and so that the program environment is clean and in good repair. Space, equipment, furnishings, supplies, transportation, and other resources for participating individuals' use within the Substance Abuse C&A Intensive Outpatient package must not be substantially different from that provided for other uses for similar numbers of individuals.

B. Staffing Requirements

1. The program must be under the clinical supervision of a **Level 4 or above** who is onsite a minimum of 50% of the hours the service is in operation.
2. Services must be provided by staff who are at least:
 - a. An LAPC, LMSW, CACII, CADC, CCADC, and Addiction Counselor Trainee with supervision
 - b. Paraprofessionals, RADTs under the supervision of a Level 4 or above
3. It is necessary for all staff who treat "co-occurring capable" services to have basic knowledge in the Georgia DBHDD Suggested Best Practices catering co-occurring consumers
4. Programs must have documentation that there is one Level 4 staff (excluding Addiction Counselor Trainee) that is "co-occurring capable." This person's knowledge must go beyond basic understanding and must demonstrate actual staff capabilities in using that knowledge for individuals with co-occurring disorders. Personnel documentation should demonstrate that this staff

person has received a minimum of 4 hours of training in co-occurring treatment within the past 2 years.

5. There must be at least a Level 4 on-site at all times the service is in operation, regardless of the number of individuals participating.
6. The maximum face-to-face ratio cannot be more than 10 youths to 1 direct program staff based on average daily attendance of individuals in the program.
7. A physician and/or a Registered Nurse or a Licensed Practical Nurse with appropriate supervision must be available to the program either by a physician and/or nurse employed by the agency, through a contract with a licensed practitioner, or by written referral or affiliation agreement with another agency or agencies that offer such services.
 - a. The physician is responsible for addiction and psychiatric consultation, assessment, and care (including but not limited to ordering medications and/or laboratory testing) as needed.
 - b. The nurse is responsible for nursing assessments, health screening, medication administration, health education, and other nursing duties as needed.
8. Staff identified in B.2.a. may be shared with other programs as long as they are available as required for supervision and clinical operations and as long as their time is appropriately allocated to staffing ratios for each program.

C. Clinical Operations

1. It is expected that the transition planning for less intensive service will begin at the onset of these services. Documentation must demonstrate this planning.
2. Consumers receiving the Substance Abuse C&A Intensive Outpatient Package must have a qualifying diagnosis present in the medical record prior to the initiation of services. The diagnosis must be given by persons identified in O.C.G.A Practice Acts as qualified to provide a diagnosis.
3. Services are to be age appropriate with each youth and address the needs of C&A which will include an educational component, relapse prevention/refusal skills, healthy coping mechanisms and sober social activities.
4. Each consumer must be provided assistance in the development and acquisition of needed skills and resources necessary to achieve sobriety and/or reduction in abuse and maintenance of recovery.
5. Substance Abuse C&A Intensive Outpatient Package must offer a range of skill-building and recovery activities within the program.

The functions/activities of the Substance Abuse C&A Intensive Outpatient Package include but are not limited to:

- a. **Group Outpatient Services:**
 - i. Age appropriate psycho-educational activities focusing on the disease of addiction, prevention, and recovery
 - ii. Therapeutic group treatment and counseling
 - iii. Linkage to natural supports and self-help opportunities
- b. **Individual Outpatient Services**
 - i. Individual counseling
 - ii. Individualized treatment, service, and recovery planning
- c. **Family Outpatient Services**
 - i. Family education and engagement focusing on adolescent developmental issues and impact of addiction on the family

- ii. Interpersonal skills building including family communication and developing relationships with healthy individuals
 - d. **Community Support**
 - e. Educational/Vocational readiness and support
 - i. Services/resources coordination unless provided through another service provider
 - ii. Community living skills
 - iii. Linkage to health care
 - f. **Structured Activity Supports**
 - i. Leisure and social skill-building activities without the use of substances
 - g. **Behavioral Health Assessment & Service Plan Development and Diagnostic Assessment**
 - i. Assessment and reassessment
 - h. **Pharmacy/Labs (Core providers may report costs via "Pharmacy/Lab")**
 - i. Drug screening/toxicology examinations
- 6. In addition to the above required activities within the program, the following must be offered as needed either within the program or through referral to/or affiliation with another agency or practitioner, and may be billed in addition to the billing for Substance Abuse C&A Intensive Outpatient Package:
 - i. Community Support –for housing, legal and other issues
 - j. Individual counseling in exceptional circumstances for traumatic stress and other mental illnesses for which special skills or licenses are required
 - k. Physician assessment and care
 - l. Psychological testing
 - m. Health screening (Nursing Assessment & Care)
- 7. The program must have a Substance Abuse C&A Intensive Outpatient Services Organizational Plan addressing the following:
 - n. The philosophical model of the program and the expected outcomes for program participants (i.e., harm reduction, abstinence, beginning of or maintaining individually defined recovery, employment readiness, relapse prevention, stabilization and treatment of those with co-occurring disorders).
 - o. The schedule of activities and hours of operations.
 - p. Staffing patterns for the program.
 - q. How assessments will be conducted.
 - r. How staff will be trained in the administration of addiction services and technologies.
 - s. How staff will be trained in the recognition and treatment of substance abuse and treatment in an adolescent population
 - t. How services for individuals with co-occurring disorders will be flexible and will include services and activities addressing both mental health and substance abuse issues of varying intensities and dosages based on the symptoms, presenting problems, functioning, and capabilities of such individuals.
 - u. How individuals with co-occurring disorders who cannot be served in the regular program activities will be provided and/or referred for time-limited special integrated services that are co-occurring enhanced as described in the Georgia Suggested Best Practices
 - v. How services will be coordinated with the substance abuse array of services including assuring or arranging for appropriate referrals and transitions.
 - w. How the requirements in these service guidelines will be met.

D. Service Access

1. This package is to be available at least 5 days per week to allow youth's access to support and treatment within his/her community, school, and family.
2. These services should follow Adolescent ASAM Level Guidelines II.1 (at least 6 hours of structured programming per week) and II.5 (at least 20 hours of structured activity per week).

E. Additional Medicaid Requirements

The Substance Abuse C&A Intensive Outpatient Package allows providers to select all services that will be offered in a substance abuse outpatient setting. Billable services and daily limits within SA C&A Intensive Outpatient are as follows:

Service	Maximum Authorization Units	Maximum Daily Units
Behavioral Health Assessment & Service Plan Development	32	24
Diagnostic Assessment	4	2
Psychiatric Treatment	12	1
Nursing Assessment & Care	48	16
Community Support	600	96
Individual Outpatient Services	36	1
Group Outpatient Services	1170	20
Family Outpatient Services	100	8
Structured Activity Support	320	8

F. Billing/Reporting Requirements

1. The maximum number of units that can be billed differs depending on the individual service.
2. All applicable Medicaid, MICP, ERO, and other DBHDD reporting requirements must be met.

G. Documentation Requirements

1. Provider must document services in accordance with the specifications for documentation requirements specified in Part II, Section V of the Provider Manual.
2. Every admission and assessment must be documented.
3. Progress notes must include written daily documentation of important occurrences; level of functioning; acquisition of skills necessary for recovery; progress on goals identified in the IRP including acknowledgement of addiction, progress toward recovery and use/abuse reduction and/or abstinence; use of drug screening results by staff; and evaluation of service effectiveness.
4. Daily attendance of each youth participating in the program must be documented showing the number of units in attendance for billing purposes.
5. Documentation of a structured activity support is also required (see specific guideline for detail).

GEORGIA DBHDD – BEST PRACTICE SUGGESTIONS

PRINCIPLES AND STAFF CAPABILITIES FOR SERVICES WITH CO-OCCURRING DISORDERS – April 17, 2002

Principles

1. Services for persons with co-occurring disorders should be integrated, rather than sequential. That is, they should be structured to deal with both disorders at once rather than requiring one disorder or one set of symptoms to be dealt with before services for the other can begin.
2. Psychosocial Rehabilitation (PSR) programs and Substance Abuse (SA) Day Services programs will be initially encouraged and eventually required to work toward becoming “co-occurring capable,” that is, able to deal flexibly with the issues of persons with co-occurring disorders.
3. “Co-occurring enhanced” services are time limited and go beyond co-occurring capable services and programs. They are characterized by the following:
 - Additional or special assessments requiring additional training or competencies, perhaps utilizing additional or specialized assessment tools;
 - Special training, experience, licensure, certification, or other qualifications of staff beyond basic recognition and general capabilities of addressing the needs of persons with co-occurring disorders within a larger program (see recommended staff capabilities below);
 - Availability of addictionologist and/or MAC, CACII, or CADC consultation;
 - Availability of psychiatric consultation and/or medication management;
 - Availability of crisis services if needed, either directly or through an interagency agreement with a mobile crisis service;
 - Additional staff to client ratio beyond the minimum requirements for a limited period of time, in order to deal effectively with individuals needing more intense or more frequent services than those offered in a co-occurring capable day services program; and
 - Additional programming intensity or specialized approaches or activities requiring significant adjustments to the usual day services activities to assure adequate dosing, frequency, and integration of services for individuals with co-occurring disorders.
4. Programs that provide PSR or SA Day Services will be required to either provide or arrange for co-occurring enhanced integrated services for adults with co-occurring disorders until those individuals can move back into regular co-occurring capable day services. Adults with co-occurring disorders should not be expected to simply adapt to usual or routine PSR or SA Day Services activities.
5. Co-occurring enhanced day services may be provided within a larger SA Day Services or PSR program, may be a separate day services program within a larger agency, or may be a stand-alone service provider.
6. An adult with serious and persistent mental illness and a co-occurring substance abuse disorder should be served in a co-occurring capable or co-occurring enhanced PSR program. Adults with substance abuse or dependence who also have a co-occurring mental health needs that do not rise to the level of serious and persistent mental illness should be served in a co-occurring capable or co-occurring enhanced SA Day Services.
7. An adult with serious and persistent mental illness whose symptoms are stable enough so that Intensive Day Treatment is not indicated; whose cognitive functioning is high enough to participate in and benefit from a co-occurring capable SA Day Services program without distraction; whose coping skills and abilities are sufficiently intact to allow attention to his/her substance abuse; and who can

understand the emotional concerns related to the negative consequences and effects of addiction should be allowed to choose service in a SA Day Services program. An adult with serious and persistent mental illness may not be refused service in an SA Day Services program simply because he/she is seriously and persistently mentally ill. Likewise, a seriously and persistently mentally ill adult may not be refused service in a PSR program simply because he/she is abusing or dependent on alcohol or other drugs.

8. Adults with serious and persistent mental illness whose symptoms, cognition, functioning, or coping skills are sufficiently impaired to prevent participation or benefit from a co-occurring capable day services program but who meet the admission criteria for either PSR or SA Day Services, must be served by a co-occurring enhanced PSR or SA Day Services program.
9. The service guidelines for PSR Services and for SA Day Services will include the same requirements about cross training and capabilities of staff to recognize and treat adults with co-occurring disorders.
10. DMHM RSA will work to ensure that there is no financial disincentive to serving individuals with co-occurring disorders in any particular day services program.
12. Basic knowledge necessary for all staff serving persons with mental illness or substance abuse in "co-occurring capable" day services must include the content areas below. For programs that are "co-occurring enhanced," this knowledge must go beyond basic understanding and must demonstrate actual staff competencies in using that knowledge to serve adults with co-occurring disorders.
13. PSR and SA Day Services Program Managers and staff are encouraged to become familiar with ASAM Patient Placement Criteria – 2R and current evidence-based practices literature about serving adults with co-occurring disorders.

GEORGIA DBHDD – BEST PRACTICES SUGGESTIONS

Staff Knowledge and Capabilities
About
Serving Persons with Co-Occurring Disorders

Necessary Capabilities For Substance Abuse Staff	Necessary Capabilities For Mental Health Staff
<ul style="list-style-type: none"> • knowledge of mental illness diagnoses, symptoms, and cognitive impairments where applicable; • medications used to treat various types of mental illness and their effects, including undesired medication side effects and the effects of discontinuing these medications; • assessment of mental illness; • likely coping strategies of individuals with mental illness, including use and abuse of substances, • concept of role of family members and psychoeducational approaches for working collaboratively with them; • motivational counseling for clients who are not ready to take full responsibility for self-management and recovery from substance abuse; • behavioral counseling for those who are actively working on recovery; • denial about mental illness or its symptoms, while respecting and encouraging individual choice and responsibility; • individual strategies for preventing symptom exacerbation; and • difference between recovery and engagement concepts in mental health and in substance abuse. 	<ul style="list-style-type: none"> • knowledge of substances of abuse and how they affect mental illnesses; • symptoms of withdrawal from various types of substances of abuse; • complications of interactions between psychotropic medications and substances of abuse, especially in detoxification and withdrawal processes; • assessment of substance abuse; • special considerations in assessing substance abuse in adults who have symptoms associated with a mental illness or who are taking or are candidates for taking prescribed medications for a diagnosed mental illness; • motivational counseling to use with clients who appear to be unmotivated for substance abuse treatment; • behavioral substance abuse counseling for those who are motivated to work toward abstinence; • denial and its role in addiction; • methods for overcoming denial while respecting and encouraging individual choice and responsibility; • relapse prevention strategies for persons with addictions; and • difference between recovery and engagement concepts in substance abuse and in mental health.

Mental Health and Addictive Disease Services

Adults' CORE Benefit Package

Behavioral Health Assessment

HIPAA Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Mental Health Assessment by a non-Physician	Practitioner Level 2, In-Clinic	H0031	U2	U6			\$38.97
	Practitioner Level 3, In-Clinic	H0031	U3	U6			\$30.01
	Practitioner Level 4, In-Clinic	H0031	U4	U6			\$20.30
	Practitioner Level 5, In-Clinic	H0031	U5	U6			\$15.13
	Practitioner Level 2, Out-of-Clinic	H0031	U2	U7			\$46.76
	Practitioner Level 3, Out-of-Clinic	H0031	U3	U7			\$36.68
	Practitioner Level 4, Out-of-Clinic	H0031	U4	U7			\$24.36
	Practitioner Level 5, Out-of-Clinic	H0031	U5	U7			\$18.15

Definition of Service: The Behavioral Health Assessment process consists of a face-to-face comprehensive clinical assessment with the individual, which must include the individual's perspective, and may also include consumer-identified family and/or significant others as well as interviews with collateral agencies/treatment providers (including Certified Peer Specialists who have been working with consumers on goal discovery) and other relevant individuals.

The purpose of the assessment process is to determine the individual's problems, strengths, needs, abilities and preferences, to develop a social (extent of natural supports and community integration) and medical history, to determine functional level and degree of ability versus disability, and to engage with collateral contacts for other assessment information. A suicide risk assessment shall also be completed. The information gathered should support the determination of a differential diagnosis and assist in screening for/ruling-out potential co-occurring disorders.

As indicated, information from medical, nursing, peer, vocational, nutritional, etc. staff should serve as the basis for the comprehensive assessment and the resulting IRP.

The entire process should involve the individual as a full partner and should include strengths and resources as identified by the individual.

Target Population	An adult with a known or suspected mental health diagnosis and/or substance-related disorder.
Benefit Information	Available to all known or suspected Core Customers. Requires a MICP Registration or a MICP New Episode.
Utilization Criteria	<u>Available to those with LOCUS scores:</u> 1: Recovery Maintenance and Health Management 2: Low Intensity Community-Based Services 3: High Intensity Community-Based Services 4: Medically Monitored Non-Residential

	5: Medically Monitored Community Residential 6: Medically Managed Residential
Ordering Practitioner	Physician, Psychologist, Physician's Assistant, Advanced Practice Registered Nurse (Clinical Nurse Specialist or Nurse Practitioner), LPC, LMFT, LCSW
Unit Value	15 minutes
Initial Authorization*	32 units (Combined with H0032 – Service Plan Development)
Re-Authorization*	32 units (Combined with H0032 – Service Plan Development)
Maximum Daily Units*	24 units (Combined with H0032 – Service Plan Development)
Authorization Period*	180 days
UAS: Budget and Expense Categories	Adult Core Services Provider 131 – Adult Mental Health 731 – Adult Addictive Diseases
Admission Criteria	1. Individual has a known or suspected mental illness or substance-related disorder; and 2. Initial screening/intake information indicates a need for further assessment; and 3. It is expected that individual meets Core Customer eligibility.
Continuing Stay Criteria	Individual's situation/functioning has changed in such a way that previous assessments are outdated.
Discharge Criteria	1. An adequate continuing care plan has been established; and one or more of the following: 2. Individual has withdrawn or been discharged from service; or 3. Individual no longer demonstrates need for continued behavioral health assessment.
Service Exclusions	Assertive Community Treatment
Clinical Exclusions	None

**(unless authorized as a part of a specific "package" which changes the authorization parameters)*

Additional Service Criteria:

A. Required Components

1. Any diagnosis given to an individual must come from persons identified in O.C.G.A Practice Acts as qualified to provide a diagnosis. These practitioners include a licensed psychologist, a physician or a PA or APRN (NP and CNS-PMH) working in conjunction with a physician with an approved job description or protocol.
2. As indicated and with consumer permission, medical, nursing, peer, nutritional, etc. staff can provide information from records, and various multi-disciplinary resources to complete the comprehensive nature of the assessment and time spent gathering this information may be billed as long as the detailed documentation justifies the time and need for capturing said information
3. An initial Behavioral Health Assessment is required within the first 30 days of service, with ongoing assessments completed as demanded by changes with an individual.
4. "Out-of-Clinic" may only be billed when:
 - Travel by the practitioner is to a non-contiguous location; and/or
 - Travel by the practitioner is to a facility not owned, leased, controlled or named as a service site by the agency who is billing the service(excepting visits to Shelter Plus sites); and/or

- Travel is to a facility owned, leased or controlled by the agency billing the service, but no more than 6 individuals are being served in the course of that day by a single practitioner in non-group services; and/or
- Travel is to a facility owned, leased, controlled or named as a service site by the agency, but no more than 24 individuals are being served in groups at that site in the course of a day. If the service does not qualify to be billed as "out of clinic," then the "in-clinic" rate may still be billed.

B. Staffing Requirements

1. The following practitioners may provide Behavioral Health Assessment services:

- Practitioner Level 2: Psychologist, APRN, PA
- Practitioner Level 3: LCSW, LPC, LMFT, RN
- Practitioner Level 4: LMSW; LAPC; LAMFT; Psychologist/LCSW/LPC/LMFT's supervisee/trainee with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology, functioning within the scope of the practice acts of the state; MAC, CAC-II, CADC, CCADC, GCADC (II, III); CAC-I or Addiction Counselor Trainees with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology (addictions counselors may only perform these functions related to treatment of addictive diseases).
- Practitioner Level 5: Certified Addiction Counselor-I, Registered Alcohol and Drug Technician (I, II, or III), Addiction Counselor Trainee with high school diploma/equivalent (practitioners at this level may only perform these functions related to treatment of addictive diseases).

C. Clinical Operations

The individual consumer (and caregiver/responsible family members etc as appropriate) should actively participate in the assessment processes.

D. Service Access

1. Individuals access this service when it has been determined through an initial screening that the person has suspected mental health or addictive disease needs.
2. Behavioral Health Assessment may **not** be provided in an Institution for Mental Diseases (IMD, e.g. state or private psychiatric hospital or Crisis Stabilization Unit with greater than 16 beds), jail, or prison system.
3. This service may not be provided and billed for individuals who are involuntarily detained awaiting criminal proceedings, penal dispositions, or other involuntary detainment proceedings.

E. Additional Medicaid Requirements

The daily maximum within a CSU for combined Behavioral Health Assessment and Service Plan Development is 24 units/day.

F. Reporting & Billing Requirements

All other applicable Medicaid, MICP, ERO, and other DBHDD reporting requirements must be met.

G. Documentation Requirements

1. Providers must document services in accordance with the specifications for documentation requirements specified in Part II, Section V of the Provider Manual.
2. In addition to the authorization, documentation of clinical assessment findings from this service should also be completed and placed in the individual's chart as a Comprehensive Assessment.

Community Support

HIPAA Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Community Support Services	Practitioner Level 4, In-Clinic	H2015	U4	U6			\$20.30
	Practitioner Level 5, In-Clinic	H2015	U5	U6			\$15.13
	Practitioner Level 4, Out-of-Clinic	H2015	U4	U7			\$24.36
	Practitioner Level 5, Out-of-Clinic	H2015	U5	U7			\$18.15
	Practitioner Level 4, In-Clinic, Collateral Contact	H2015	UK	U4	U6		\$20.30
	Practitioner Level 5, In-Clinic, Collateral Contact	H2015	UK	U5	U6		\$15.13
	Practitioner Level 4, Out-of-Clinic, Collateral Contact	H2015	UK	U4	U7		\$24.36
	Practitioner Level 5, Out-of-Clinic, Collateral Contact	H2015	UK	U5	U7		\$18.15

Definition of Service: Community Support services consist of rehabilitative skills building, the development of environmental supports and resources coordination considered essential to assist a person in improving functioning, gaining access to necessary services and in creating environments that promote recovery and support the emotional and functional improvement of the individual. The service activities of Community Support include:

- Assistance to the person and other identified recovery partners in the facilitation and coordination of the Individual Recovery Plan (IRP) including providing skills support in the person's self-articulation of personal goals and objectives;
- Planning in a proactive manner to assist the person in managing or preventing crisis situations;
- Individualized interventions, which shall have as objectives:
 - 1) Identification, with the person, of strengths which may aid him/her in achieving recovery, as well as barriers that impede the development of skills necessary for functioning in work, with peers, and with family/friends;
 - 2) Support to facilitate enhanced natural supports (including support/assistance with defining what wellness means to the person in order to assist them with recovery-based goal setting and attainment);
 - 3) Assistance in the development of interpersonal, community coping and functional skills (which may include adaptation to home, adaptation to work, adaptation to healthy social environments, learning/practicing skills such as personal financial management, medication self-monitoring, symptom self-monitoring, etc);
 - 4) Encouraging the development and eventual succession of natural supports in living, learning, working, other social environments;
 - 5) Assistance in the acquisition of skills for the person to self-recognize emotional triggers and to

- self-manage behaviors related to the behavioral health issue;
- 6) Assistance with personal development, work performance, and functioning in social and family environments through teaching skills/strategies to ameliorate the effect of behavioral health symptoms;
 - 7) Assistance in enhancing social and coping skills that ameliorate life stresses resulting from the person's mental illness/addiction;
 - 8) Service and resource coordination to assist the person in gaining access to necessary rehabilitative, medical, social and other services and supports;
 - 9) Assistance to the person and other supporting natural resources with illness understanding and self-management (including medication self-monitoring);
 - 10) Any necessary monitoring and follow-up to determine if the services accessed have adequately met the person's needs;
 - 11) Identification, with the individual and named natural supporters, of risk indicators related to substance related disorder relapse, and strategies to prevent relapse.

This service is provided in order to promote stability and build towards functioning in their daily environment. Stability is measured by a decreased number of hospitalizations, by decreased frequency and duration of crisis episodes and by increased and/or stable participation in community/work activities. Supports based on the person's needs are used to promote recovery while understanding the effects of the mental illness and/or substance use/abuse and to promote functioning. The Community Support staff will serve as the primary coordinator of behavioral health services and will provide linkage to community; general entitlements; and psychiatric, substance use/abuse, medical services, crisis prevention and intervention services.

Target Population	Individuals with one of the following: Mental Health Diagnosis Substance-Related Disorder Co-Occurring Substance-Related Disorder and Mental Health Diagnosis, Co-Occurring Mental Health Diagnosis and Mental Retardation/Developmental Disabilities Co-Occurring Substance-Related Disorder and Mental Retardation/Developmental Disabilities
Benefit Information	Available to Core Customers. Requires a MICP Registration or a MICP New Episode.
Utilization Criteria	<u>Available to those with LOCUS scores:</u> 1: Recovery Maintenance and Health Management 2: Low Intensity Community-Based Services 3: High Intensity Community-Based Services 4: Medically Monitored Non-Residential 5: Medically Monitored Community Residential 6: Medically Managed Residential
Ordering Practitioner	Physician, Psychologist, Physician's Assistant, Advanced Practice Registered Nurse (Clinical Nurse Specialist or Nurse Practitioner), LPC, LMFT, LCSW
Unit Value	15 minutes
Initial Authorization*	600 units

Re-Authorization*	600 units
Maximum Daily Units*	48 units
Authorization Period*	180 days
UAS: Budget and Expense Categories	<u>Core Services Provider</u> 126 – Mental Health 726 – Addictive Diseases
Admission Criteria	<ol style="list-style-type: none"> 1. Individual must meet target population criteria as indicated above; and one or more of the following: 2. Individual may need assistance with developing, maintaining, or enhancing social supports or other community coping skills; or 3. Individual may need assistance with daily living skills including coordination to gain access to necessary rehabilitative and medical services
Continuing Stay Criteria	<ol style="list-style-type: none"> 1. Individual continues to meet admission criteria; and 2. Individual demonstrates documented progress or maintenance of community skills relative to goals identified in the Individualized Resiliency Plan.
Discharge Criteria	<ol style="list-style-type: none"> 1. An adequate continuing care plan has been established; and one or more of the following: 2. Goals of the Individualized Recovery Plan have been substantially met; or 3. Individual requests discharge and the individual is not in imminent danger of harm to self or others; or 4. Transfer to another service/level of care is warranted by change in individual's condition; or 5. Individual requires more intensive services.
Service Exclusions	
Clinical Exclusions	<ol style="list-style-type: none"> 1. There is a significant lack of community coping skills such that a more intensive service is needed. 2. Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of a psychiatric condition overlaying the primary diagnosis: <ul style="list-style-type: none"> • mental retardation • autism • organic mental disorder, or • traumatic brain injury

**(unless authorized as a part of a specific “package” which changes the authorization parameters)*

Additional Service Criteria:

A. Required Components

1. Community Support services must include a variety of interventions in order to assist the consumer in developing:
 - Symptom self-monitoring and self-management of symptoms
 - Strategies and supportive interventions for avoiding out-of-community treatment for adults and building stronger knowledge of the adult's strengths and limitations

- Relapse prevention strategies and plans
2. Community Support services focus on building and maintaining a therapeutic relationship with the individual and facilitating treatment and recovery goals.
 3. The organization must have policies and procedures for protecting the safety of staff that engage in these community-based service delivery activities.
 4. Contact must be made with the individual receiving Community Support services a minimum of twice each month. At least one of these contacts must be face-to-face and the second may be either face-to-face or telephone contact (denoted by the UK modifier) depending on the individual's support needs and documented preferences.
 5. At least 50% of CSI service units must be delivered face-to-face with the identified individual receiving the service and at least 80% of all face-to-face service units must be delivered in non-clinic settings over the authorization period (these units are specific to single individual consumer records and are not aggregate across an agency/program or multiple payors).
 6. In the absence of the required monthly face-to-face contact **and** if at least two unsuccessful attempts to make face-to-face contact have been tried and documented, the provider may bill for a maximum of two telephone contacts in that specified month (denoted by the UK modifier).
 7. Unsuccessful attempts to make contact with the consumer are not billable.
 8. Any diagnosis given to a youth must come from persons identified in O.C.G.A Practice Acts as qualified to provide a diagnosis. These practitioners include a licensed psychologist, a physician or a PA or APRN (NP and CNS-PMH) working in conjunction with a physician with an approved job description or protocol.
 9. When the primary focus of Community Support services for is medication maintenance, the following allowances apply:
 - a. These consumers are not counted in the offsite service requirement or the consumer-to-staff ratio; and
 - b. These consumers are not counted in the monthly face-to-face contact requirement; however, face-to-face contact is required every 3 months and monthly calls are an allowed billable service.
 10. CSI is an individual intervention and may **not** be provided or billed for more than one consumer during the same time period.
 11. "Out-of-Clinic" may only be billed when:
 - Travel by the practitioner is to a non-contiguous location; and/or
 - Travel by the practitioner is to a facility not owned, leased, controlled or named as a service site by the agency who is billing the service(excepting visits to Shelter Plus sites); and/or
 - Travel is to a facility owned, leased or controlled by the agency billing the service, but no more than 6 individuals are being served in the course of that day by a single practitioner in non-group services; and/or
 - Travel is to a facility owned, leased, controlled or named as a service site by the agency, but no more than 24 individuals are being served in groups at that site in the course of a day.
 If the service does not qualify to be billed as "out of clinic," then the "in-clinic" rate may still be billed.

B. Staffing Requirements

1. The following practitioners may provide Community Support services:
 - Practitioner Level 1: Physician/Psychiatrist (reimbursed at Level 4 rate)
 - Practitioner Level 2: Psychologist, APRN, PA (reimbursed at Level 4 rate)

- Practitioner Level 3: LCSW, LPC, LMFT, RN (reimbursed at Level 4 rate)
 - Practitioner Level 4: LMSW; LAPC; LAMFT; Psychologist/LCSW/LPC/LMFT's supervisee/trainee with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology, functioning within the scope of the practice acts of the state; MAC, CAC-II, CADC, CCADC, GCADC (II, III); CPS, PP, CPRP, CAC-I or Addiction Counselor Trainees with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology
2. When provided by one of the practitioners cited below, must be under the documented supervision (organizational charts, supervisory notation, etc.) of one of the licensed/credentialed professionals above:
 - Certified Peer Specialists
 - Paraprofessional staff
 - Certified Psychiatric Rehabilitation Professional
 - Certified Addiction Counselor-I
 - Registered Alcohol and Drug Technician (I,II, or III)
 - Addiction Counselor Trainee
 3. Community Support practitioners may have the recommended consumer-to-staff ratio of 30 consumers per staff member and must maintain a maximum ratio of 50 consumers per staff member. Youth who receive only medication maintenance are not counted in the staff ratio calculation.

C. Clinical Operations

1. Community Support may include (with the permission of the Adult consumer) coordination with family and significant others and with other systems/supports (e.g., work, religious entities, corrections, aging agencies, etc) when appropriate for treatment and recovery needs. Coordination is an essential component of Community Support and can be billed for up to 70 percent of the contacts when directly related to the support and enhancement of the person's recovery.
2. Community Support providers must have the ability to deliver services in various environments, such as homes, homeless shelters, or street locations. The provider should keep in mind that individuals may prefer to meet staff at a community location other than their homes or other conspicuous locations (e.g. their place of employment), especially if staff drive a vehicle that is clearly marked as a state or agency vehicle, or if staff must identify themselves and their purpose to gain access to the individual in a way that may potentially embarrass the individual or breach the individual's privacy/confidentiality. Staff should be sensitive to and respectful of individuals' privacy/confidentiality rights and preferences in this regard to the greatest extent possible (e.g. if staff must meet with an individual during their work time, if the consumer wishes, mutually agree upon a meeting place nearby that is the least conspicuous from the individual's point of view).
3. The organization must have policies that govern the provision of services in natural settings and can document that it respects individuals' rights to privacy and confidentiality when services are provided in these settings.
4. The organization must have established procedures/protocols for handling emergency and crisis situations that describe methods for supporting individuals as they transition to and from psychiatric hospitalization/crisis stabilization.

5. Each provider must have policies and procedures for the provision of individual-specific outreach services, including means by which these services and individuals are targeted for such efforts.
6. The organization must have a Community Support Organizational Plan that addresses the following:
 - description of the particular rehabilitation, recovery and natural support development models utilized, types of intervention practiced, and typical daily schedule for staff
 - description of the staffing pattern and how staff are deployed to assure that the required staff-to-consumer ratios are maintained, including how unplanned staff absences, illnesses, or emergencies are accommodated, case mix, access, etc.
 - description of the hours of operations as related to access and availability to the individuals served and
 - description of how the plan for services is modified or adjusted to meet the needs specified in every Individualized Recovery Plan
7. Utilization (frequency and intensity) of CSI should be directly related to the LOCUS and to the other functional elements in the person's assessment. In addition, when clinical/functional needs are great, there should be complementary therapeutic services by licensed/credential professionals paired with the provision of CSI (individual, group, family, etc.).

D. Service Accessibility

1. Specific to the "Medication Maintenance Track," consumers who require more than 4 contacts per quarter for two consecutive quarters (as based upon clinical need) are expected to be re-evaluated with the LOCUS for enhanced access to CSI and/or other services. The designation of the CSI "medication maintenance track" should be lifted and exceptions stated above in A.10 are no longer applied.
2. Community Support may **not** be provided in an Institution for Mental Diseases (IMD, e.g. state or private psychiatric hospital or Crisis Stabilization Unit with greater than 16 beds), jail, or prison system.
3. This service may not be provided and billed for individuals who are involuntarily detained awaiting criminal proceedings, penal dispositions, or other involuntary detention proceedings.

E. Additional Medicaid Requirements

Currently, there are no additional Medicaid requirements to be added to the requirements above when billing Medicaid for this service.

F. Reporting & Billing Requirements

1. When a billable collateral contact is provided, the UK reporting modifier shall be utilized. A collateral contact is classified as any contact that is not face-to-face with the individual.
2. All other applicable Medicaid, MICP, ERO, and other DBHDD reporting requirements must be followed.

G. Documentation Requirements

Providers must document services in accordance with the specifications for documentation requirements specified in Part II, Section V of the Provider Manual.

Community Transition Planning							
Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Community Transition Planning	Community Transition Planning (State Hospital)	T2038	ZH				\$20.92
	Community Transition Planning (Crisis Stabilization Unit)	T2038	ZC				\$20.92
	Community Transition Planning (Jail /Prison)	T2038	ZJ				\$20.92
	Community Transition Planning(Other)	T2038	ZO				\$20.92

Definition of Service: Community Transition Planning is a service for contracted Core and ACT providers to address the care, service, and support needs of adults with mental illness and/or addictive diseases to ensure a coordinated plan of transition from a qualifying facility to the community. Each episode of Community Transition Planning must include contact with the consumer and their identified family with a minimum of one (1) face-to-face contact with the consumer prior to release from the state hospital/facility. Additional Transition Planning activities include: educating the consumer and their identified family on service options offered by the chosen primary service agency; participating in state hospital or facility treatment team meetings to develop a transition plan, and making collateral contacts with other agencies and community resources when indicated.

In partnership between other community service providers and the hospital/facility staff, the community service agency maintains responsibility for carrying out transitional activities either by the consumer's chosen primary service coordinator or by the service coordinator's designated Community Transition Liaison. Community Transition Planning may also be used for Community Support staff, ACT team members and Certified Peer Specialists who work with the consumer in the community or will work with the consumer in the future to maintain or establish contact.

Community Transition Planning consists of the following interventions to ensure the person transitions successfully from the facility to their local community:

- Establishing a connection or reconnection with the person through supportive contacts while in the qualifying facility. By engaging with the person, this helps to develop and strengthen a foundation for the therapeutic relationship.
- Educate the person and his/her identified supports about local community resources and service options available to meet their needs upon transition into the community. This allows the person to make self-directed, educated choices on those service options that they feel will best meet their needs and increases the likelihood of post-facility engagement.
- Participating in qualifying facility team meetings especially in person centered planning for those in a treatment facility for longer than 60 days, to share hospital and community information related to estimated length of stay, present problems related to admission, discharge/release criteria, progress toward treatment goals, personal strengths, available supports and assets, medical condition, medication issues, and community treatment needs.

- Linking the adult with community services including visits between the person and the Community Support staff, ACT team members and/or Certified Peer Support Specialists who will be working with the consumer in the community (including visits and telephone contacts between the consumer and the community-based providers).

Target Population	Adults with one of the following: Mental Health Diagnosis Substance Related Disorder Co-Occurring Substance-Related Disorder and Mental Health Diagnosis
Benefit Information	Available to Core Customers in need of Brief Stabilization or Ongoing Services. Requires a MICP Registration or MICP New Episode.
Utilization Criteria	Available to those currently in state hospitals and other qualifying facilities who meet Core Customer Eligibility Definition
Unit Value	15 minutes
Reimbursement Rate	\$20.92 /unit
Initial Authorization	10 units
Re-Authorization	10 units
Authorization Period	90 days (Registration) 180 days (New Episode)
UAS: Budget and Expense Categories	Core Service Providers 162 – Adult Mental Health 762 – Adult Addictive Diseases ACT Providers 152 – Adult Mental Health (include with MIER for ACT)
Admission Criteria	Individual who meet Core Customer Eligibility while in one of the following qualifying facilities: 1. State Operated Hospital 2. Crisis Stabilization Unit (CSU) 3. Jail/Prison 4. Other (ex: Community Psychiatric Hospital) Note: Modifier on Procedure Code indicates setting in which the consumer is transitioning from.
Continuing Stay Criteria	Same as above.
Discharge Criteria	1. Individual/family requests discharge; or 2. Individual no longer meets Core Customer Eligibility; or 3. Individual is discharged from a state hospital or qualifying facility.
Service Exclusions	None

Clinical Exclusions	<p>Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of a co-occurring Behavioral Health condition:</p> <ol style="list-style-type: none"> a. Developmental Disability without a co-occurring mental illness or addictive disease diagnosis b. Autism c. Organic Mental Disorder d. Traumatic Brain Injury
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Additional Service Criteria:

A. Required Components

Prior to Release from a State Hospital or Qualifying Facility:

When the person has had (a) a length of stay of 60 days or longer in a facility or (b) youth is readmitted to a facility within 30 days of discharge, a community transition plan in partnership with the facility is required. Evidence of planning shall be recorded and a copy of the Plan shall be included in both the adult's hospital and community records.

B. Staffing Requirements

1. A Master's/Bachelor's degree in behavioral or social science that is primarily psychological in nature under the supervision of a licensed practitioner; **or**
2. A Georgia Certified Peer Specialist or trained Paraprofessional under the supervision of a licensed practitioner; **or**
3. An LPN practicing under supervision in accordance with the Georgia Practice Acts.

C. Clinical Operations

Community Transition Planning activities shall include:

1. Telephone and Face-to-face contacts with consumer and their identified family;
2. Participating in consumer's clinical staffing(s) prior to their discharge from the facility;
3. Applications for consumer resources and services prior to discharge from the facility including:
 - a. Healthcare
 - b. Entitlements (i.e., SSI, SSDI) for which they are eligible
 - c. Self-Help Groups and Peer Supports
 - d. Housing
 - e. Employment, Education, Training
 - f. Consumer Support Services

D. Service Access

1. This service must be available 7 days a week (if the state hospital/qualifying facility discharges or releases 7 days a week).
2. This service may be delivered via telemedicine technology or via telephone conferencing.

E. Reporting & Billing Requirements

1. There must be a minimum of one face-to-face with the youth prior to release from hospital or qualifying facility in order to bill for any telephone contacts.

2. Complete the Multipurpose Information Consumer Profile (MICP) information
3. Providers must document services in accordance with the specifications for documentation requirements specified in PART II, Section V of the Provider Manual.

F. Documentation Requirements

1. A documented Community Transition Plan for:
 - a. Individuals with a length of stay greater than 60 days; or
 - b. Individuals readmitted within 30 days of discharge.
2. Documentation of all face-to-face and telephone contacts and a description of progress with Community Transition Plan implementation and outcomes.

Crisis Intervention

HIPAA Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Crisis Intervention	Practitioner Level 1, In-Clinic	H2011	U1	U6			\$58.21
	Practitioner Level 2, In-Clinic	H2011	U2	U6			\$38.97
	Practitioner Level 3, In-Clinic	H2011	U3	U6			\$30.01
	Practitioner Level 4, In-Clinic	H2011	U4	U6			\$20.30
	Practitioner Level 1, Out-of-Clinic	H2011	U1	U7			\$74.09
	Practitioner Level 2, Out-of-Clinic	H2011	U2	U7			\$46.76
	Practitioner Level 3, Out-of-Clinic	H2011	U3	U7			\$36.68
	Practitioner Level 4, Out-of-Clinic	H2011	U4	U7			\$24.36

Definition of Service: Services directed toward the support of an individual who is experiencing an abrupt and substantial change in behavior which is usually associated with a precipitating situation and which is in the direction of severe impairment of functioning or a marked increase in personal distress. Crisis Intervention is designed to prevent out of community placement or hospitalization. Often, a crisis exists at such time as an individual consumer and his or her identified natural resources decide to seek help and/or the individual, identified natural resources, or practitioner identifies the situation as a crisis. Crisis services are time-limited and present-focused in order to address the immediate crisis and develop appropriate links to alternate services. Services may involve the individual consumer and the individual's family and/or significant other, as well as other service providers.

The individual's current behavioral health care advanced directive, if existing, should be utilized to help manage the crisis. Interventions provided should honor and respect the individual's wishes/choices by following the plan/advanced directive as closely as possible in line with appropriate clinical judgment. Plans/advanced directives developed during the Behavioral Health Assessment/IRP process should be reviewed and updated (or developed if the individual is a new consumer) as part of those services to help prevent or manage future crisis situations.

Some examples of interventions that may be used to de-escalate a crisis situation could include: a situational assessment; active listening and empathic responses to help relieve emotional distress; effective verbal and behavioral responses to warning signs of crisis related behavior; assistance to, and involvement/participation of the individual (to the extent he or she is capable) in active problem solving planning and interventions; facilitation of access to a myriad of crisis stabilization and other services deemed necessary to effectively manage the crisis; mobilization of natural support systems; and other crisis interventions as appropriate to the individual and issues to be addressed.

Target Population	Adults with Mental Health issues and/or Substance Related Disorders Adults experiencing a severe situational crisis
Benefit Information	Available to all Core Customers. Requires a MICP Registration or a MICP

	New Episode.
Utilization Criteria	Available to those with LOCUS scores: 1: Recovery Maintenance and Health Management 2: Low Intensity Community-Based Services 3: High Intensity Community-Based Services 4: Medically Monitored Non-Residential 5: Medically Monitored Community Residential 6: Medically Monitored Inpatient Residential
Ordering Practitioner	Physician, Psychologist, Physician's Assistant, Advanced Practice Registered Nurse (Clinical Nurse Specialist or Nurse Practitioner), LPC, LMFT, LCSW
Unit Value	15 minutes
Initial Authorization*	16 units
Re-Authorization*	16 units <i>Any use beyond 16 units will not be denied but will trigger an immediate retrospective review.</i>
Maximum Daily Units*	16 units
Authorization Period	180 days
UAS: Budget and Expense Categories	Adult Core Services Provider 121– Adult Mental Health 721 – Adult Addictive Diseases
Admission Criteria	1. Treatment at a lower intensity has been attempted or given serious consideration; and #2 and/or #3 are met: 2. Individual has a known or suspected mental health diagnosis or Substance Related Disorder; or 3. Individual is at risk of harm to self, others and/or property. Risk may range from mild to imminent; and one or both of the following: 4. Individual has insufficient or severely limited resources or skills necessary to cope with the immediate crisis; or 5. Individual demonstrates lack of judgment and/or impulse control and/or cognitive/perceptual abilities.
Continuing Stay Criteria	This service may be utilized at various points in the individual's course of treatment and recovery, however, each intervention is intended to be a discrete time-limited service that stabilizes the individual and moves him/her to the appropriate level of care.
Discharge Criteria	1. Individual no longer meets continued stay guidelines; and 2. Crisis situation is resolved and an adequate continuing care plan has been established.
Service Exclusions	
Clinical Exclusions	Severity of clinical issues precludes provision of services at this level of care.

**(unless authorized as a part of a specific “package” which changes the authorization parameters)*

Additional Service Criteria:

A. Required Components

1. Any diagnosis given to an individual must come from persons identified in O.C.G.A Practice Acts as qualified to provide a diagnosis. These practitioners include a licensed psychologist, a physician or a PA or APRN (NP and CNS-PMH) working in conjunction with a physician with an approved job description or protocol.
2. "Out-of-Clinic" may only be billed when:
 - Travel by the practitioner is to a non-contiguous location; and/or
 - Travel by the practitioner is to a facility not owned, leased, controlled or named as a service site by the agency who is billing the service(excepting visits to Shelter Plus sites); and/or
 - Travel is to a facility owned, leased or controlled by the agency billing the service, but no more than 6 individuals are being served in the course of that day by a single practitioner in non-group services; and/or
 - Travel is to a facility owned, leased, controlled or named as a service site by the agency, but no more than 24 individuals are being served in groups at that site in the course of a day.If the service does not qualify to be billed as "out of clinic," then the "in-clinic" rate may still be billed.

B. Staffing Requirements

1. The following practitioners may provide Crisis Intervention services:
 - Practitioner Level 1: Physician/Psychiatrist
 - Practitioner Level 2: Psychologist, APRN, PA
 - Practitioner Level 3: LCSW, LPC, LMFT, RN
 - Practitioner Level 4: LMSW; LAPC; LAMFT; Psychologist/LCSW/LPC/LMFT's supervisee/trainee with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology, functioning within the scope of the practice acts of the state.

C. Clinical Operations

In any review of clinical appropriateness of this service, the mix of services offered to the individual is important. The use of crisis units will be looked at by the External Review Organization in combination with other supporting services. For example, if an individual presents in crisis and the crisis is alleviated within an hour but ongoing support continues, it is expected that 4 units of crisis will be billed and then some supporting service such as individual counseling will be utilized to support the individual during that interval of service

D. Service Access

1. All crisis service response times for this service must be within 2 hours of the consumer or other constituent contact to the provider agency.
2. Services are available 24-hours per day, 7 days per week, and may be offered by telephone and/or face-to-face in any setting (e.g. home, jail, hospital, clinic etc).
3. Crisis Intervention may **not** be provided in an Institution for Mental Diseases (IMD, e.g. state or private psychiatric hospital or Crisis Stabilization Unit with greater than 16 beds), jail, or prison system.

4. This service may not be provided and billed for individuals who are involuntarily detained awaiting criminal proceedings, penal dispositions, or other involuntary detainment proceedings.

E. Additional Medicaid Requirements

The daily maximum within a CSU for Crisis Intervention is 8 units/day.

F. Billing/Reporting Requirements

1. This service must be billed as either In-Clinic or Out-of-Clinic Crisis Management/ Intervention for Medicaid recipients in accordance with A. above.
2. Any use of a telephonic intervention must be coded/reported with a U6 modifier as the person providing the telephonic intervention is not expending the additional agency resources in order to be in the community where the person served is at during the time of crisis.
3. All other applicable Medicaid, MICP, ERO, and other DBHDD reporting requirements must be met.

G. Documentation Requirements

Providers must document services in accordance with the specifications for documentation requirements specified in Part II, Section V of the Provider Manual.

Diagnostic Assessment

HIPAA Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Psychiatric Diagnostic Examination	Practitioner Level 1, In-Clinic	90801	U1	U6			\$174.63
	Practitioner Level 1, Out-of-Clinic	90801	U1	U7			\$222.26
	Practitioner Level 1, Via interactive audio and video telecommunication systems	90801	GT	U1			\$174.63
	Practitioner Level 2, In-Clinic	90801	U2	U6			\$116.90
	Practitioner Level 2, Out-of-Clinic	90801	U2	U7			\$140.28
	Practitioner Level 2, Via interactive audio and video telecommunication systems	90801	GT	U2			\$116.90
Psychiatric Diagnostic Examination, Interactive	Practitioner Level 1, In-Clinic	90802	U1	U6			\$174.63
	Practitioner Level 1, Out-of-Clinic	90802	U1	U7			\$222.26
	Practitioner Level 1, Via interactive audio and video telecommunication systems	90802	GT	U1			\$174.63
	Practitioner Level 2, In-Clinic	90802	U2	U6			\$116.90
	Practitioner Level 2, Out-of-Clinic	90802	U2	U7			\$140.28
	Practitioner Level 2, Via interactive audio and video telecommunication systems	90802	GT	U2			\$116.90

Definition of Service: Psychiatric diagnostic interview examination includes a history; mental status exam; evaluation and assessment of physiological phenomena (including co-morbidity between behavioral and physical health care issues); psychiatric diagnostic evaluation (including assessing for co-occurring disorders and the development of a differential diagnosis); screening and/or assessment of

any withdrawal symptoms for individuals with substance related diagnoses; assessment of the appropriateness of initiating or continuing services; and a disposition. These are completed by face-to-face evaluation of the individual (which may include the use of telemedicine) and may include communication with family and other sources, as well as the ordering and medical interpretation of laboratory or other medical diagnostic studies.

Interactive diagnostic interview examinations are typically furnished to children (but may be justified for use with adults) and involve the use of physical aids and non-verbal communication to overcome barriers to therapeutic interaction between the clinician and a patient as a result of expressive or receptive language deficits. Interactive diagnostic interview examinations are also used when a sign language interpreter or other language interpreter is utilized order to facilitate communication between the clinician and an individual with a hearing impairment or with limited English proficiency.

Target Population	Adults with known or suspected Mental Illness or Substance Related Disorders
Benefit Information	Available to all known or suspected Core Customers. Requires a MICP Registration or a MICP New Episode.
Utilization Criteria	<u>Available to those with LOCUS scores:</u> 1: Recovery Maintenance and Health Management 2: Low Intensity Community-Based Services 3: High Intensity Community-Based Services 4: Medically Monitored Non-Residential 5: Medically Monitored Community Residential 6: Medically Monitored Inpatient Residential
Ordering Practitioner	Physician, Physician's Assistant, Advanced Practice Registered Nurse (Clinical Nurse Specialist or Nurse Practitioner)
Unit Value	1 encounter
Initial Authorization*	2 units
Re-Authorization*	2 units
Maximum Daily Units*	1 unit per procedure code
Authorization Period*	180 days
UAS: Budget and Expense Categories	<u>Core Services Provider</u> 120 – Mental Health 720 – Addictive Diseases
Admission Criteria	1. Individual has a known or suspected mental illness or a substance-related disorder and has recently entered the service system; or 2. Individual is in need of annual assessment and re-authorization of service array; or 3. Individual has need of an assessment due to a change in clinical/functional status.
Continuing Stay Criteria	Individual's situation/functioning has changed in such a way that previous assessments are outdated.

Discharge Criteria	1. An adequate continuing care plan has been established; and one or more of the following: a. Individual has withdrawn or been discharged from service; or a. Individual no longer demonstrates need for additional assessment.
Service Exclusions	Not offered in conjunction with Intensive Day Treatment or ACT
Clinical Exclusions	Services defined as a part of ACT and Intensive Day Treatment.

**(unless authorized as a part of a specific "package" which changes the authorization parameters)*

Additional Service Criteria:

A. Required Components

1. Telemedicine may be utilized for an initial Psychiatric Diagnostic Examination as well as for ongoing Psychiatric Diagnostic Examination via the use of appropriate procedure codes with the GT modifier.
2. Any diagnosis given to an individual must come from persons identified in O.C.G.A Practice Acts as qualified to provide a diagnosis. These practitioners include a licensed psychologist, a physician or a PA or APRN (NP and CNS-PMH) working in conjunction with a physician with an approved job description or protocol. **Note:** Diagnostic evaluations conducted by psychologists are covered under Behavioral Health Assessment service.
3. "Out-of-Clinic" may only be billed when:
 - Travel by the practitioner is to a non-contiguous location; and/or
 - Travel by the practitioner is to a facility not owned, leased, controlled or named as a service site by the agency who is billing the service(excepting visits to Shelter Plus sites); and/or
 - Travel is to a facility owned, leased or controlled by the agency billing the service, but no more than 6 individuals are being served in the course of that day by a single practitioner in non-group services; and/or
 - Travel is to a facility owned, leased, controlled or named as a service site by the agency, but no more than 24 individuals are being served in groups at that site in the course of a day.

If the service does not qualify to be billed as "out of clinic," then the "in-clinic" rate may still be billed.

B. Staffing Requirements

The following practitioners can provide a Psychiatric Diagnostic Examination:

- Practitioner Level 1: Physician/Psychiatrist
- Practitioner Level 2: Psychologist, APRN, PA

C. Clinical Operations

It is expected that the individual will be treated as a full partner in the treatment regimen/services planned and received. As such, it is expected that practitioners will fully discuss treatment options and allow for individual choice when possible. Discussion of treatment options should include a full disclosure of the pros and cons of each option (e.g. full disclosure of medication/treatment regimen potential side effects, potential adverse reactions--including potential adverse reaction from not taking medication as prescribed, and expected benefits).

D. Service Access

1. Diagnostic Assessment may **not** be provided in an Institution for Mental Diseases (IMD, e.g. state or private psychiatric hospital or Crisis Stabilization Unit with greater than 16 beds), jail, or prison system.
2. This service may not be provided and billed for individuals who are involuntarily detained awaiting criminal proceedings, penal dispositions, or other involuntary detainment proceedings.

E. Additional Medicaid Requirements

1. The daily maximum within a CSU for Diagnostic Assessment (Psychiatric Diagnostic Interview) for adults is 2 units. Two units should be utilized only if it is necessary in a complex diagnostic case for the physician extender (PA or APRN) to call in the physician for an assessment of the individual to corroborate or verify the correct diagnosis.
2. Nutritional Assessments which were billed to the Diagnostic Assessment service definition prior to July 1, 2006 are no longer be encompassed under this code. Please see the Nursing Assessment and Care definition.

F. Reporting & Billing Requirements

All applicable Medicaid, MICP, ERO, and other DBHDD reporting requirements must be adhered to.

G. Documentation Requirements

Providers must document services in accordance with the specifications for documentation requirements specified in Part II, Section V of the Provider Manual.

Family Outpatient Services: Family Counseling

HIPAA Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Family – Behavioral health counseling and therapy (without client present)	Practitioner Level 2, In-Clinic	H0004	HS	U2	U6		\$38.97
	Practitioner Level 3, In-Clinic	H0004	HS	U3	U6		\$30.01
	Practitioner Level 4, In-Clinic	H0004	HS	U4	U6		\$20.30
	Practitioner Level 5, In-Clinic	H0004	HS	U5	U6		\$15.13
	Practitioner Level 2, Out-of-Clinic	H0004	HS	U2	U7		\$46.76
	Practitioner Level 3, Out-of-Clinic	H0004	HS	U3	U7		\$36.68
	Practitioner Level 4, Out-of-Clinic	H0004	HS	U4	U7		\$24.36
	Practitioner Level 5, Out-of-Clinic	H0004	HS	U5	U7		\$18.15
Family -- Behavioral health counseling and therapy (with client present)	Practitioner Level 2, In-Clinic	H0004	HR	U2	U6		\$38.97
	Practitioner Level 3, In-Clinic	H0004	HR	U3	U6		\$30.01
	Practitioner Level 4, In-Clinic	H0004	HR	U4	U6		\$20.30
	Practitioner Level 5, In-Clinic	H0004	HR	U5	U6		\$15.13
	Practitioner Level 2, Out-of-Clinic	H0004	HR	U2	U7		\$46.76
	Practitioner Level 3, Out-of-Clinic	H0004	HR	U3	U7		\$36.68
	Practitioner Level 4, Out-of-Clinic	H0004	HR	U4	U7		\$24.36
	Practitioner Level 5, Out-of-Clinic	H0004	HR	U5	U7		\$18.15
Family Psycho-therapy without the patient present (appropriate license required)	Practitioner Level 2, In-Clinic	90846	U2	U6			\$38.97
	Practitioner Level 3, In-Clinic	90846	U3	U6			\$30.01
	Practitioner Level 4, In-Clinic	90846	U4	U6			\$20.30
	Practitioner Level 5, In-Clinic	90846	U5	U6			\$15.13
	Practitioner Level 2, Out-of-Clinic	90846	U2	U7			\$46.76
	Practitioner Level 3, Out-of-Clinic	90846	U3	U7			\$36.68
	Practitioner Level 4, Out-of-Clinic	90846	U4	U7			\$24.36
	Practitioner Level 5, Out-of-Clinic	90846	U5	U7			\$18.15

Conjoint Family Psychotherapy with the patient present (appropriate license required)	Practitioner Level 2, In-Clinic	90847	U2	U6	\$38.97
	Practitioner Level 3, In-Clinic	90847	U3	U6	\$30.01
	Practitioner Level 4, In-Clinic	90847	U4	U6	\$20.30
	Practitioner Level 5, In-Clinic	90847	U5	U6	\$15.13
	Practitioner Level 2, Out-of-Clinic	90847	U2	U7	\$46.76
	Practitioner Level 3, Out-of-Clinic	90847	U3	U7	\$36.68
	Practitioner Level 4, Out-of-Clinic	90847	U4	U7	\$24.36
	Practitioner Level 5, Out-of-Clinic	90847	U5	U7	\$18.15

Definition of Service: A therapeutic intervention or counseling service shown to be successful with identified family populations, diagnoses and service needs, provided by a qualified clinician or practitioner. Services are directed toward achievement of specific goals defined with/by the individual consumer and targeted to the consumer-identified family and specified in the Individualized Recovery Plan (note: although interventions may involve the family, the focus or primary beneficiary of intervention must always be the individual consumer). Family counseling provides systematic interactions between the identified individual consumer, staff and the individual's identified family members directed toward the restoration, development, enhancement or maintenance of functioning of the identified consumer/family unit. This includes support of the family and specific therapeutic interventions/activities to enhance family roles, relationships, communication and functioning that promote the recovery of the individual. Specific goals/issues to be addressed though these services may include the restoration, development, enhancement or maintenance of:

1. processing skills;
2. healthy coping mechanisms;
3. adaptive behaviors and skills;
4. interpersonal skills;
5. family roles and relationships;
6. the family's understanding of mental illness and substance related disorders, the steps necessary to facilitate recovery, and methods of intervention, interaction and mutual support the family can use to assist their family member.

Best practices such as Multi-systemic Family Therapy, Multidimensional Family Therapy, Behavioral Family Therapy, Functional Family Therapy or others appropriate for the family and issues to be addressed should be utilized in the provision of this service.

Target Population	Individuals with Mental Illness and/or Substance-Related Disorders
Benefit Information	Available to all Core Customers. Requires a MICP Registration or a MICP New Episode.
Utilization Criteria	<u>Available to those with LOCUS scores:</u> 1: Recovery Maintenance and Health Management 2: Low Intensity Community-Based Services 3: High Intensity Community-Based Services 4: Medically Monitored Non-Residential 5: Medically Monitored Community Residential 6: Medically Monitored Inpatient Residential

Ordering Practitioner	Physician, Psychologist, Physician's Assistant, Advanced Practice Registered Nurse (Clinical Nurse Specialist or Nurse Practitioner), LPC, LMFT, LCSW
Unit Value	15 minutes
Initial Authorization*	If a MICP Registration is submitted -32 units (combined with Family Training) If a MICP New Episode is submitted - 60 units (combined with Family Training)
Reauthorization*	60 units (Family Training and Family Counseling combined)
Maximum Daily Units*	8 units (Family Training and Family Counseling combined)
Authorization Period*	180 days
UAS: Budget and Expense Categories	Adult Core Services Provider 130 – Adult Mental Health 730 – Adult Addictive Diseases
Admission Criteria	<ol style="list-style-type: none"> 1. Individual must have a mental illness and/or substance-related disorder diagnosis that is at least destabilizing (markedly interferes with the ability to carry out activities of daily living or places others in danger) or distressing (causes mental anguish or suffering); and 2. Individual's level of functioning does not preclude the provision of services in an outpatient milieu; and 3. Individual's assessment indicates needs that may be supported by a therapeutic intervention shown to be successful with identified family populations and individual's diagnoses.
Continuing Stay Criteria	<ol style="list-style-type: none"> 1. Individual continues to meet Admission Criteria as articulated above; and 2. Progress notes document progress relative to goals identified in the Individualized Recovery Plan, but all treatment/support goals have not yet been achieved.
Discharge Criteria	<ol style="list-style-type: none"> 1. An adequate continuing care plan has been established; and one or more of the following: 2. Goals of the Individualized Recovery Plan have been substantially met; or 3. Individual requests discharge and individual is not in imminent danger of harm to self or others; or 4. Transfer to another service is warranted by change in individual's condition; or 5. Individual requires more intensive services.
Service Exclusions	ACT
Clinical Exclusions	<ol style="list-style-type: none"> 1. Severity of behavioral health impairment precludes provision of services. 2. Severity of cognitive impairment precludes provision of services in this level of care. 3. There is a lack of social support systems such that a more intensive level of service is needed. 4. This service is not intended to supplant other services such as MR/DD Personal and Family Support or any day services where the individual may more appropriately receive these services with staff in various

	<p>community settings.</p> <p>5. Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of a psychiatric condition overlaying the primary diagnosis: mental retardation, autism, organic mental disorder and traumatic brain injury.</p>
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**(unless authorized as a part of a specific "package" which changes the authorization parameters)*

Additional Service Criteria:

A. Required Components

1. The treatment orientation, modality and goals must be specified and agreed upon by the individual.
2. Couples counseling is included under this service code as long as the counseling is directed toward the identified consumer and his/her goal attainment as identified in the Individualized Recovery Plan.
3. The Individualized Recovery Plan for the individual includes goals and objectives specific to the consumer-identified family for whom the service is being provided.
4. Any diagnosis given to an individual must come from persons identified in O.C.G.A Practice Acts as qualified to provide a diagnosis. These practitioners include a licensed psychologist, a physician or a PA or APRN (NP and CNS-PMH) working in conjunction with a physician with an approved job description or protocol.
5. "Out-of-Clinic" may only be billed when:
 - Travel by the practitioner is to a non-contiguous location; and/or
 - Travel by the practitioner is to a facility not owned, leased, controlled or named as a service site by the agency who is billing the service(excepting visits to Shelter Plus sites); and/or
 - Travel is to a facility owned, leased or controlled by the agency billing the service, but no more than 6 individuals are being served in the course of that day by a single practitioner in non-group services; and/or
 - Travel is to a facility owned, leased, controlled or named as a service site by the agency, but no more than 24 individuals are being served in groups at that site in the course of a day.

If the service does not qualify to be billed as "out of clinic," then the "in-clinic" rate may still be billed.

B. Staffing Requirements

The following individuals can provide behavioral health counseling and psychotherapy to families:

- Practitioner Level 1: Physician/Psychiatrist (reimbursed at Level 2 rate)
- Practitioner Level 2: Psychologist, CNS-PMH
- Practitioner Level 3: LCSW, LPC, LMFT, RN
- Practitioner Level 4: LMSW; LAPC; LAMFT; Psychologist/LCSW/LPC/LMFT's supervisee/trainee with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology, functioning within the scope of the practice acts of the state; MAC, CAC-II, CADC, CCADC, GCADC (II, III); CAC-I or Addiction Counselor Trainees with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling,

psychology, or criminology (addiction counselors may only perform these functions related to treatment of addictive diseases).

- Practitioner Level 5: CAC-I, RADT (I, II, or III), Addiction Counselor Trainees with high school diploma/equivalent (practitioners at this level may only perform these functions related to treatment of addictive diseases).

C. Clinical Operations

Models of best practice delivery may include (as clinically appropriate) Multidimensional Family Therapy, Behavioral Family Therapy, Functional Family Therapy, and others as appropriate the family and issues to be addressed.

D. Service Access

1. Services may not exceed 8 Billable units (combined Family Counseling and Family Therapy) in a single day. If clinical need indicates this level of intensity, other services may need to be considered for authorization.
2. Family Counseling may **not** be provided in an Institution for Mental Diseases (IMD, e.g. state or private psychiatric hospital or Crisis Stabilization Unit with greater than 16 beds), jail, or prison system.
3. This service may not be provided and billed for individuals who are involuntarily detained awaiting criminal proceedings, penal dispositions, or other involuntary detainment proceedings.

E. Additional Medicaid Requirements

Currently, there are no additional Medicaid requirements to be added to the requirements above when billing Medicaid for this service.

F. Reporting & Billing Requirements

All applicable Medicaid, MICP, ERO, and other DBHDD reporting requirements must be met.

H. Documentation Requirements

1. Providers must document services in accordance with the specifications for documentation requirements specified in Part II, Section V of the Provider Manual.
2. If there are multiple family members in the Family Counseling session who are enrolled consumers for whom the focus of treatment is related to goals on their treatment plans, we recommend the following:
 - a. Document the family session in the charts of each individual consumer for whom the treatment is related to a specific goal on the individual's IRP
 - b. Charge the Family Counseling session units to **one** of the consumers.
 - c. Indicate "NC" (No Charge) on the documentation for the other consumer(s) in the family session and have the note reflect that the charges for the session are assigned to another family member in the session.

Family Outpatient Services: Family Training

HIPAA Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Family Skills Training and Development	Practitioner Level 4, In-Clinic, without client present	H2014	HS	U4	U6		\$20.30
	Practitioner Level 5, In-Clinic, without client present	H2014	HS	U5	U6		\$15.13
	Practitioner Level 4, Out-of-Clinic, without client present	H2014	HS	U4	U7		\$24.36
	Practitioner Level 5, Out-of-Clinic, without client present	H2014	HS	U5	U7		\$18.15
	Practitioner Level 4, In-Clinic, with client present	H2014	HR	U4	U6		\$20.30
	Practitioner Level 5, In-Clinic, with client present	H2014	HR	U5	U6		\$15.13
	Practitioner Level 4, Out-of-Clinic, with client present	H2014	HR	U4	U7		\$24.36
	Practitioner Level 5, Out-of-Clinic, with client present	H2014	HR	U5	U7		\$18.15

Definition of Service: A therapeutic interaction shown to be successful with identified family populations, diagnoses and service needs. Services are directed toward achievement of specific goals defined by the individual consumer and targeted to the consumer-identified family and specified in the Individualized Recovery Plan (note: although interventions may involve the family, the focus or primary beneficiary of intervention must always be the individual consumer). Family training provides systematic interactions between the identified individual consumer, staff and the individual's identified family members directed toward the enhancement or maintenance of functioning of the identified consumer/family unit. This may include support of the family, as well as training and specific activities to enhance functioning that promote the recovery of the individual. Specific goals/issues to be addressed though these services may include the restoration, development, enhancement or maintenance of:

1. illness and medication self-management knowledge and skills (e.g. symptom management, behavioral management, relapse prevention skills, knowledge of medications and side effects, and motivational/skill development in taking medication as prescribed);
2. problem solving and practicing functional skills;
3. healthy coping mechanisms;
4. adaptive behaviors and skills;
5. interpersonal skills;
6. daily living skills;
7. resource access and management skills; and
8. the family's understanding of mental illness and substance related disorders, the steps necessary to facilitate recovery, and methods of intervention, interaction and mutual support the family can use to assist their family member.

Target Population	Individuals with Mental Illness and/or Substance-Related Disorders
Benefit Information	Available to all Core Customers. Requires a MICP Registration or a MICP New Episode.
Utilization Criteria	<u>Available to those with LOCUS scores:</u> 1: Recovery Maintenance and Health Management 2: Low Intensity Community-Based Services 3: High Intensity Community-Based Services 4: Medically Monitored Non-Residential 5: Medically Monitored Community Residential 6: Medically Monitored Inpatient Residential
Ordering Practitioner	Physician, Psychologist, Physician's Assistant, Advanced Practice Registered Nurse (Clinical Nurse Specialist or Nurse Practitioner), LPC, LMFT, LCSW
Unit Value	15 minutes
Initial Authorization*	If a MICP Registration is submitted -32 units (combined with Family Counseling) If a MICP New Episode is submitted - 60 units (combined with Family Counseling)
Reauthorization*	60 units (Family Training and Family Counseling combined)
Maximum Daily Units*	8 units (Family Training and Family Counseling combined)
Authorization Period*	180 days
UAS: Budget and Expense Categories	Adult Core Services Provider 130 – Adult Mental Health 730 – Adult Addictive Diseases
Admission Criteria	1. Individual must have a mental illness and/or substance-related disorder diagnosis that is at least destabilizing (markedly interferes with the ability to carry out activities of daily living or places others in danger) or distressing (causes mental anguish or suffering); and 2. Individual's level of functioning does not preclude the provision of services in an outpatient milieu; and 3. Individual's assessment indicates needs that may be supported by a therapeutic intervention shown to be successful with identified family populations and individual's diagnoses.
Continuing Stay Criteria	1. Individual continues to meet Admission Criteria as articulated above; and 2. Progress notes document progress relative to goals identified in the Individualized Recovery Plan, but all treatment/support goals have not yet been achieved.

Discharge Criteria	<ol style="list-style-type: none"> 1. An adequate continuing care plan has been established; and one or more of the following: 2. Goals of the Individualized Recovery Plan have been substantially met; or 3. Individual requests discharge and individual is not in imminent danger of harm to self or others; or 3. Transfer to another service is warranted by change in individual's condition; or 4. Individual requires more intensive services.
Service Exclusions	ACT
Clinical Exclusions	<ol style="list-style-type: none"> 1. Severity of behavioral health impairment precludes provision of services. 2. Severity of cognitive impairment precludes provision of services in this level of care. 3. There is a lack of social support systems such that a more intensive level of service is needed. 4. There is no outlook for improvement with this particular service. 5. This service is not intended to supplant other services such as Personal and Family Support or any day services where the individual may more appropriately receive these services with staff in various community settings. 6. Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of a psychiatric condition overlaying the primary diagnosis: mental retardation, autism, organic mental disorder and traumatic brain injury.

**(unless authorized as a part of a specific "package" which changes the authorization parameters)*

Additional Service Criteria:

A. Required Components

1. The treatment orientation, modality and goals must be specified and agreed upon by the individual.
2. The Individualized Recovery Plan for the individual includes goals and objectives specific to the consumer-identified family for whom the service is being provided.
3. Any diagnosis given to an individual must come from persons identified in O.C.G.A Practice Acts as qualified to provide a diagnosis. These practitioners include a licensed psychologist, a physician or a PA or APRN (NP and CNS-PMH) working in conjunction with a physician with an approved job description or protocol.
4. "Out-of-Clinic" may only be billed when:
 - Travel by the practitioner is to a non-contiguous location; and/or
 - Travel by the practitioner is to a facility not owned, leased, controlled or named as a service site by the agency who is billing the service(excepting visits to Shelter Plus sites); and/or
 - Travel is to a facility owned, leased or controlled by the agency billing the service, but no more than 6 individuals are being served in the course of that day by a single practitioner in non-group services; and/or
 - Travel is to a facility owned, leased, controlled or named as a service site by the agency, but no more than 24 individuals are being served in groups at that site in the course of a day.

If the service does not qualify to be billed as "out of clinic," then the "in-clinic" rate may still be billed.

B. Staffing Requirements

The following individuals can provide skills training and development to families:

- Practitioner Level 1: Physician/Psychiatrist (reimbursed at Level 4 rate)
- Practitioner Level 2: Psychologist, APRN, PA (reimbursed at Level 4 rate)
- Practitioner Level 3: LCSW, LPC, LMFT, RN (reimbursed at Level 4 rate)
- Practitioner Level 4: LMSW; LAPC; LAMFT; Psychologist's supervisee/trainee with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology functioning within the scope of the practice acts of the state; MAC, CAC-II, CADC, CCADC, GCADC (II, III); PP, CPRP, CAC-I or Addiction Counselor Trainees with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology
- Practitioner Level 5: CPS, PP, CPRP, CAC-I, RADT (I, II, or III), Addiction Counselor Trainees with high school diploma/equivalent under supervision of one of the licensed/credentialed professionals above

C. Clinical Operation

D. Service Access

1. Services may not exceed 8 Billable units (combined Family Counseling and Family Therapy) in a single day. If clinical need indicates this level of intensity, other services may need to be considered for authorization.
2. Family Training may **not** be provided in an Institution for Mental Diseases (IMD, e.g. state or private psychiatric hospital or Crisis Stabilization Unit with greater than 16 beds), jail, or prison system.
3. This service may not be provided and billed for individuals who are involuntarily detained awaiting criminal proceedings, penal dispositions, or other involuntary detainment proceedings.

E. Additional Medicaid Requirements

Currently, there are no additional Medicaid requirements to be added to the requirements above when billing Medicaid for this service.

F. Reporting & Billing Requirements

All applicable Medicaid, MICP, ERO, and other DBHDD reporting requirements must be met.

G. Documentation Requirements

1. Providers must document services in accordance with the specifications for documentation requirements specified in Part II, Section V of the Provider Manual.

2. If there are multiple family members in the Family Training session who are enrolled consumers for whom the focus of treatment in the group is related to goals on their treatment plans, we recommend the following:
 - a. Document the family session in the charts of each individual consumer for whom the treatment is related to a specific goal on the individual's IRP
 - b. Charge the Family Training session units to **one** of the consumers.
 - c. Indicate "NC" (No Charge) on the documentation for the other consumer(s) in the family session and have the note reflect that the charges for the session are assigned to another family member in the session.

Group Outpatient Services: Group Counseling

HIPAA Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Group – Behavioral health counseling and therapy	Practitioner Level 2, In-Clinic	H0004	HQ	U2	U6		\$8.50
	Practitioner Level 3, In-Clinic	H0004	HQ	U3	U6		\$6.60
	Practitioner Level 4, In-Clinic	H0004	HQ	U4	U6		\$4.43
	Practitioner Level 5, In-Clinic	H0004	HQ	U5	U6		\$3.30
	Practitioner Level 2, Out-of-Clinic	H0004	HQ	U2	U7		\$10.39
	Practitioner Level 3, Out-of-Clinic	H0004	HQ	U3	U7		\$8.25
	Practitioner Level 4, Out-of-Clinic	H0004	HQ	U4	U7		\$5.41
	Practitioner Level 5, Out-of-Clinic	H0004	HQ	U5	U7		\$4.03
	Practitioner Level 2, In-Clinic, Multi-family group, with client present	H0004	HQ	HR	U2	U6	\$8.50
	Practitioner Level 3, In-Clinic, Multi-family group, with client present	H0004	HQ	HR	U3	U6	\$6.60
	Practitioner Level 4, In-Clinic, Multi-family group, with client present	H0004	HQ	HR	U4	U6	\$4.43
	Practitioner Level 5, In-Clinic, Multi-family group, with client present	H0004	HQ	HR	U5	U6	\$3.30
	Practitioner Level 2, Out-of-Clinic, Multi-family group, with client present	H0004	HQ	HR	U2	U7	\$10.39
	Practitioner Level 3, Out-of-Clinic, Multi-family group, with client present	H0004	HQ	HR	U3	U7	\$8.25
	Practitioner Level 4, Out-of-Clinic, Multi-family group, with client present	H0004	HQ	HR	U4	U7	\$5.41
	Practitioner Level 5, Out-of-Clinic, Multi-family group, with client present	H0004	HQ	HR	U5	U7	\$4.03
	Practitioner Level 2, In-Clinic, Multi-family group, without client present	H0004	HQ	HS	U2	U6	\$8.50

	Practitioner Level 3, In-Clinic, Multi-family group, without client present	H0004	HQ	HS	U3	U6	\$6.60
	Practitioner Level 4, In-Clinic, Multi-family group, without client present	H0004	HQ	HS	U4	U6	\$4.43
	Practitioner Level 5, In-Clinic, Multi-family group, without client present	H0004	HQ	HS	U5	U6	\$3.30
	Practitioner Level 2, Out-of-Clinic, Multi-family group, without client present	H0004	HQ	HS	U2	U7	\$10.39
	Practitioner Level 3, Out-of-Clinic, Multi-family group, without client present	H0004	HQ	HS	U3	U7	\$8.25
	Practitioner Level 4, Out-of-Clinic, Multi-family group, without client present	H0004	HQ	HS	U4	U7	\$5.41
	Practitioner Level 5, Out-of-Clinic, Multi-family group, without client present	H0004	HQ	HS	U5	U7	\$4.03
Group Psychotherapy other than of a multiple family group (appropriate license required)	Practitioner Level 2, In-Clinic	90853	U2	U6			\$8.50
	Practitioner Level 3, In-Clinic	90853	U3	U6			\$6.60
	Practitioner Level 4, In-Clinic	90853	U4	U6			\$4.43
	Practitioner Level 5, In-Clinic	90853	U5	U6			\$3.30
	Practitioner Level 2, Out-of-Clinic	90853	U2	U7			\$10.39
	Practitioner Level 3, Out-of-Clinic	90853	U3	U7			\$8.25
	Practitioner Level 4, Out-of-Clinic	90853	U4	U7			\$5.41
	Practitioner Level 5, Out-of-Clinic	90853	U5	U7			\$4.03

Definition of Service: A therapeutic intervention or counseling service shown to be successful with identified populations, diagnoses and service needs, provided in a group format by a qualified clinician or practitioner. Services are directed toward achievement of specific goals defined by the individual consumer and specified in the Individualized Recovery Plan. Services may address goals/issues such as promoting recovery, and the restoration, development, enhancement or maintenance of:

- 1) cognitive processing skills;
- 2) healthy coping mechanisms;
- 3) adaptive behaviors and skills;
- 4) interpersonal skills;
- 5) identifying and resolving personal, social, intrapersonal and interpersonal concerns

Target Population	Individuals with Mental Illness and/or Substance-Related Disorders
Benefit Information	Available to all Core Customers. Requires a MICP Registration or a MICP New Episode.

Utilization Criteria	<u>Available to those with LOCUS scores:</u> 1: Recovery Maintenance and Health Management 2: Low Intensity Community-Based Services 3: High Intensity Community-Based Services 4: Medically Monitored Non-Residential 5: Medically Monitored Community Residential 6: Medically Monitored Inpatient Residential
Ordering Practitioner	Physician, Psychologist, Physician's Assistant, Advanced Practice Registered Nurse (Clinical Nurse Specialist or Nurse Practitioner), LPC, LMFT, LCSW
Unit Value	15 minutes
Initial Authorization*	If a MICP Registration is submitted - 32 units If a MICP New Episode is submitted - 200 units <i>(unless authorized as a part of a specific "package" which changes the authorization parameters)</i>
Re-Authorization*	200 units
Maximum Daily Units*	20 units
Authorization Period*	180 days
UAS: Budget and Expense Categories	<u>Core Services Provider</u> 129 – Adult Mental Health 729 – Adult Addictive Diseases
Admission Criteria	1. Individual must have a primary mental illness/substance-related disorder diagnosis that is at least destabilizing (markedly interferes with the ability to carry out activities of daily living or places others in danger) or distressing (causes mental anguish or suffering); and 2. The individual's level of functioning does not preclude the provision of services in an outpatient milieu; and 3. The individual's recovery goal/s which are to be addressed by this service must be conducive to response by a group milieu.
Continuing Stay Criteria	1. Individual continues to meet admission criteria; and 2. Individual demonstrates documented progress relative to goals identified in the Individualized Recovery Plan, but treatment goals have not yet been achieved.
Discharge Criteria	1. An adequate continuing care plan has been established; and one or more of the following: 2. Goals of the Individualized Recovery Plan have been substantially met; or 3. Individual requests discharge and individual is not in imminent danger of harm to self or others; or 4. Transfer to another service/level of care is warranted by change in individual's condition; or 5. Individual requires more intensive services.
Service Exclusions	See also below, Item A.2. and A.3.

Clinical Exclusions	<ol style="list-style-type: none"> 1. Severity of behavioral health impairment precludes provision of services. 2. Severity of cognitive impairment precludes provision of services in this level of care. 3. There is a lack of social support systems such that a more intensive level of service is needed. 4. This service is not intended to supplant other services such as MR Personal and Family Support or any day services where the individual may more appropriately receive these services with staff in various community settings. 5. Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of a psychiatric condition overlaying the primary diagnosis: mental retardation, autism, organic mental disorder and traumatic brain injury.
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**(unless authorized as a part of a specific "package" which changes the authorization parameters)*

Additional Service Criteria:

A. Required Components

1. The treatment orientation, modality and goals must be specified and agreed upon by the individual.
2. Group outpatient services should very rarely be offered in addition to day services such as Psychosocial Rehabilitation. Any exceptions must be clinically justified in the record and may be subject to scrutiny by the external review organization. Exceptions in offering group outpatient services external to day services include such sensitive and targeted clinical issue groups as incest survivor groups, perpetrator groups, and sexual abuse survivors groups. When an exception is clinically justified, services must not duplicate day services activities.
3. When billed concurrently with ACT services, group counseling must be curriculum-based.
4. Any diagnosis given to an individual must come from persons identified in O.C.G.A Practice Acts as qualified to provide a diagnosis. These practitioners include a licensed psychologist, a physician or a PA or APRN (NP and CNS-PMH) working in conjunction with a physician with an approved job description or protocol.
 - D> "Out-of-Clinic" may only be billed when:
 - Travel by the practitioner is to a non-contiguous location; and/or
 - Travel by the practitioner is to a facility not owned, leased, controlled or named as a service site by the agency who is billing the service(excepting visits to Shelter Plus sites); and/or
 - Travel is to a facility owned, leased or controlled by the agency billing the service, but no more than 6 individuals are being served in the course of that day by a single practitioner in non-group services; and/or
 - Travel is to a facility owned, leased, controlled or named as a service site by the agency, but no more than 24 individuals are being served in groups at that site in the course of a day.

If the service does not qualify to be billed as "out of clinic," then the "in-clinic" rate may still be billed.

B. Staffing Requirements

1. The following individuals can provide group counseling:
 - Practitioner Level 1: Physician/Psychiatrist (reimbursed at Level 2 rate)

- Practitioner Level 2: Psychologist, CNS-PMH
 - Practitioner Level 3: LCSW, LPC, LMFT, RN
 - Practitioner Level 4: LMSW; LAPC; LAMFT; Psychologist/LCSW/LPC/LMFT's supervisee/trainee with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology, functioning within the scope of the practice acts of the state; MAC, CAC-II, CADC, CCADC, GCADC (II, III); CAC-I or Addiction Counselor Trainees with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology (may only perform these functions related to treatment of addictive diseases).
 - Practitioner Level 5: CAC-I, RADT (I, II, or III), Addiction Counselor Trainees with high school diploma/equivalent (practitioners at this level may only perform these functions related to treatment of addictive diseases).
2. Students and individuals working toward licensure as a professional counselor, social worker, or marriage and family therapist must work under direction and documented clinical supervision of a licensed professional in accordance with the rules of the Georgia Composite Board of Professional Counselors, Social Workers and Marriage and Family Therapists. Agencies should refer to O.C.G.A. 43-10A-3 for the definitions of "direction" and "supervision" and the Documentation Guidelines included in this Provider Manual.
 3. The three specialties governed by the board referenced in B.2. above have different supervision requirements for individuals working toward licensure and it is the responsibility of the agency to ensure that the supervision requirements specified by the Board for the specialty (professional counseling, social work or marriage and family therapy) for which the individual is working toward licensure are met (also reference Documentation Guidelines included in this manual).
 4. Addiction counselor trainees may perform counseling as a trainee for a period of up to 3 years if they meet the requirements in O.C.G.A. 43-10A. This is limited to the provision of chemical dependency treatment under direction and supervision of a clinical supervisor approved by the certification body under which the trainee is seeking certification. Agencies should refer to O.C.G.A. 43-10A-3 for the definitions of "direction" and "supervision" and to the Documentation Guidelines set forth in this Provider Manual.
 5. The status of students, trainees, and individuals working toward licensure must be disclosed to the individuals receiving services from trainees and interns and signatures/titles of these practitioners must also include "S/T."
 6. Maximum face-to-face ratio cannot be more than 10 consumers to 1 direct service staff based on average group attendance

C. Clinical Operations

1. The membership of a multiple family group (H0004 HQ) consists of multiple family units such as a group of two or more parent(s) from different families either with (HR) or without (HS) participation of their child/children.
2. Practitioners and supervisors of those providing this service are expected to maintain knowledge and skills regarding group practice such as selecting appropriate participants for a particular group, working with the group to establish necessary group norms and goals, and understanding and managing group dynamics and processes.

D. Service Access

1. Group Counseling may **not** be provided in an Institution for Mental Diseases (IMD, e.g. state or private psychiatric hospital or Crisis Stabilization Unit with greater than 16 beds), jail, or prison system.
2. This service may not be provided and billed for individuals who are involuntarily detained awaiting criminal proceedings, penal dispositions, or other involuntary detainment proceedings.

E. Additional Medicaid Requirements

The daily maximum within a CSU for combined Group Training/Counseling is 4 units/day.

F. Reporting & Billing Requirements

All applicable Medicaid, MICP, ERO, and other DBHDD reporting requirements must be met.

G. Documentation Requirements

Providers must document services in accordance with the specifications for documentation requirements specified in Part II, Section V of the Provider Manual.

Group Outpatient Services: Group Training

HIPAA Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Group Skills Training & Development	Practitioner Level 4, In-Clinic	H2014	HQ	U4	U6		\$4.43
	Practitioner Level 5, In-Clinic	H2014	HQ	U5	U6		\$3.30
	Practitioner Level 4, Out-of-Clinic	H2014	HQ	U4	U7		\$5.41
	Practitioner Level 5, Out-of-Clinic	H2014	HQ	U5	U7		\$4.03
	Practitioner Level 4, In-Clinic, with client present	H2014	HQ	HR	U4	U6	\$4.43
	Practitioner Level 5, In-Clinic, with client present	H2014	HQ	HR	U5	U6	\$3.30
	Practitioner Level 4, Out-of-Clinic, with client present	H2014	HQ	HR	U4	U7	\$5.41
	Practitioner Level 5, Out-of-Clinic, with client present	H2014	HQ	HR	U5	U7	\$4.03
	Practitioner Level 4, In-Clinic, without client present	H2014	HQ	HS	U4	U6	\$4.43
	Practitioner Level 5, In-Clinic, without client present	H2014	HQ	HS	U5	U6	\$3.30
	Practitioner Level 4, Out-of-Clinic, without client present	H2014	HQ	HS	U4	U7	\$5.41
	Practitioner Level 5, Out-of-Clinic, without client present	H2014	HQ	HS	U5	U7	\$4.03

Definition of Service: A therapeutic interaction shown to be successful with identified populations, diagnoses and service needs. Services are directed toward achievement of specific goals defined by the individual and specified in the Individualized Resiliency Plan. Services may address goals/issues such as promoting recovery, and the restoration, development, enhancement or maintenance of:

- 1) illness and medication self-management knowledge and skills (e.g. symptom management, behavioral management, relapse prevention skills, knowledge of medications and side effects, and motivational/skill development in taking medication as prescribed);
- 2) problem solving skills;
- 3) healthy coping mechanisms;
- 4) adaptive skills;
- 5) interpersonal skills;
- 6) daily living skills;
- 7) resource management skills;
- 8) knowledge regarding mental illness, substance related disorders and other relevant topics that

	assist in meeting the youth's and family's needs; and 9) skills necessary to access and build community resources and natural support systems.
Target Population	Individuals with Mental Illness and/or Substance-Related Disorders
Benefit Information	Available to all Core Customers. Requires a MICP Registration or a MICP New Episode.
Utilization Criteria	<u>Available to those with LOCUS scores:</u> 1: Recovery Maintenance and Health Management 2: Low Intensity Community-Based Services 3: High Intensity Community-Based Services 4: Medically Monitored Non-Residential 5: Medically Monitored Community Residential 6: Medically Monitored Inpatient Residential
Ordering Practitioner	Physician, Psychologist, Physician's Assistant, Advanced Practice Registered Nurse (Clinical Nurse Specialist or Nurse Practitioner), LPC, LMFT, LCSW
Unit Value	15 minutes
Initial Authorization*	If a MICP Registration is submitted - 32 units (combined with Group Counseling) If a MICP New Episode is submitted - 200 units (combined with Group Counseling)
Re-Authorization*	200 units
Maximum Daily Units*	16 units
Authorization Period*	180 days
UAS: Budget and Expense Categories	<u>Core Services Provider</u> 129 – Adult Mental Health 729 – Adult Addictive Diseases
Admission Criteria	1. Individuals must have a primary mental illness/substance-related disorder diagnosis that is at least destabilizing (markedly interferes with the ability to carry out activities of daily living or places others in danger) or distressing (causes mental anguish or suffering); and 2. The individual's level of functioning does not preclude the provision of services in an outpatient milieu; and 3. The individual's resiliency goal/s that are to be addressed by this service must be conducive to response by a group milieu.
Continuing Stay Criteria	1. Individual continues to meet admission criteria; and 2. Individual demonstrates documented progress relative to goals identified in the Individualized Recovery Plan, but treatment goals have not yet been achieved.
Discharge Criteria	1. An adequate continuing care plan has been established; and one or more of the following: 2. Goals of the Individualized Recovery Plan have been substantially met; or 3. Individual requests discharge and the individual is not in imminent danger of harm to self or others; or 4. Transfer to another service/level of care is warranted by change in individual's condition; or 5. Individual requires more intensive services.

Service Exclusions	See also below, Item A.2.
Clinical Exclusions	<ol style="list-style-type: none"> 1. Severity of behavioral health issue precludes provision of services. 2. Severity of cognitive impairment precludes provision of services in this level of care. 3. There is a lack of social support systems such that a more intensive level of service is needed. 4. This service is not intended to supplant other services such as MR/DD Personal and Family Support or any day services where the individual may more appropriately receive these services with staff in various community settings. 5. Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of a psychiatric condition overlaying the primary diagnosis: mental retardation, autism, organic mental disorder, traumatic brain injury.

**(unless authorized as a part of a specific “package” which changes the authorization parameters)*

Additional Service Criteria:

A. Required Components

1. The functional goals addressed through this service must be specified and agreed upon by the individual.
2. Group outpatient services should very rarely be offered in addition to day services such as Psychosocial Rehabilitation. Any exceptions must be clinically justified in the record and may be subject to scrutiny by the external review organization. Exceptions in offering group outpatient services external to day services include such sensitive and targeted clinical issue groups as incest survivor groups, perpetrator groups, and sexual abuse survivors groups. When an exception is clinically justified, services must not duplicate day services activities.
3. Any diagnosis given to an individual must come from persons identified in O.C.G.A Practice Acts as qualified to provide a diagnosis. These practitioners include a licensed psychologist, a physician or a PA or APRN (NP and CNS-PMH) working in conjunction with a physician with an approved job description or protocol.
4. “Out-of-Clinic” may only be billed when:
 - Travel by the practitioner is to a non-contiguous location; and/or
 - Travel by the practitioner is to a facility not owned, leased, controlled or named as a service site by the agency who is billing the service(excepting visits to Shelter Plus sites); and/or
 - Travel is to a facility owned, leased or controlled by the agency billing the service, but no more than 6 individuals are being served in the course of that day by a single practitioner in non-group services; and/or
 - Travel is to a facility owned, leased, controlled or named as a service site by the agency, but no more than 24 individuals are being served in groups at that site in the course of a day.
 If the service does not qualify to be billed as "out of clinic," then the "in-clinic" rate may still be billed.

B. Staffing Requirements

1. The following individuals can provide group training:
 - Practitioner Level 1: Physician/Psychiatrist (reimbursed at Level 4 rate)

- Practitioner Level 2: Psychologist, APRN, PA (reimbursed at Level 4 rate)
 - Practitioner Level 3: LCSW, LPC, LMFT, RN (reimbursed at Level 4 rate)
 - Practitioner Level 4: LMSW; LAPC; LAMFT; Psychologist/LCSW/LPC/LMFT's supervisee/trainee with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology, functioning within the scope of the practice acts of the state; MAC, CAC-II, CADC, CCADC, GCADC (II, III); PP, CPRP, CAC-I or Addiction Counselor Trainees with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology
 - Practitioner Level 5: CPS, PP, CPRP, CAC-I, RADT (I, II, or III), Addiction Counselor Trainees with high school diploma/equivalent under supervision of one of the licensed/credentialed professionals above
2. Maximum face-to-face ratio cannot be more than 10 consumers to 1 direct service staff based on average group attendance

C. Clinical Operations

1. Practitioners providing this service are expected to maintain knowledge and skills regarding group practice such as selecting appropriate participants for a particular group, working with the group to establish necessary group norms and goals, and understanding and managing group dynamics and processes.
2. Out-of-clinic group skills training is allowable and clinically valuable for some consumers; therefore, this option should be explored to the benefit of the consumer. In this event, staff must be able to assess and address the individual needs and progress of each consumer consistently throughout the intervention/activity (e.g. in an example of teaching 2-3 consumers to access public transportation in the community, group training may be given to help each consumer individually to understand the bus schedule in a way that makes sense to them, to address questions/concerns each may have about how to use the bus, perhaps to spend time riding the bus with the consumers and assisting each to understand and become comfortable with riding the bus in accordance with *individual* goals, etc).

D. Service Access

1. Group Training may **not** be provided in an Institution for Mental Diseases (IMD, e.g. state or private psychiatric hospital or Crisis Stabilization Unit with greater than 16 beds), jail, or prison system.
2. This service may not be provided and billed for individuals who are involuntarily detained awaiting criminal proceedings, penal dispositions, or other involuntary detainment proceedings.

E. Additional Medicaid Requirements

The daily maximum within a CSU for combined Group Training/Counseling is 4 units/day.

F. Reporting & Billing Requirements

1. All applicable Medicaid, MICP, ERO, and other DBHDD reporting requirements must be followed.
2. If this service is provided out-of-clinic, a U7 modifier is utilized on the claim/encounter submission.

G. Documentation Requirements

Providers must document services in accordance with the specifications for documentation requirements specified in Part II, Section V of the Provider Manual.

Individual Counseling

HIPAA Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Individual Psychotherapy, insight oriented, behavior-modifying and/or supportive in an office or outpatient facility, <u>approx-irately 20-30 minutes</u> face-to-face with patient	Practitioner Level 2, In-Clinic	90804	U2	U6			64.95
	Practitioner Level 3, In-Clinic	90804	U3	U6			50.02
	Practitioner Level 4, In-Clinic	90804	U4	U6			33.83
	Practitioner Level 5, In-Clinic	90804	U5	U6			25.21.
	Practitioner Level 2, Out-of-Clinic	90804	U2	U7			77.93
	Practitioner Level 3, Out-of-Clinic	90804	U3	U7			61.13
	Practitioner Level 4, Out-of-Clinic	90804	U4	U7			40.59
	Practitioner Level 5, Out-of-Clinic	90804	U5	U7			30.25
Individual Psychotherapy, insight oriented, behavior-modifying and/or supportive in an office or outpatient facility, <u>approx-imately 45-50 minutes</u> face-to-face with patient	Practitioner Level 2, In-Clinic	90806	U2	U6			116.90
	Practitioner Level 3, In-Clinic	90806	U3	U6			90.03
	Practitioner Level 4, In-Clinic	90806	U4	U6			60.89
	Practitioner Level 5, In-Clinic	90806	U5	U6			45.38
	Practitioner Level 2, Out-of-Clinic	90806	U2	U7			140.28
	Practitioner Level 3, Out-of-Clinic	90806	U3	U7			110.04
	Practitioner Level 4, Out-of-Clinic	90806	U4	U7			73.07
	Practitioner Level 5, Out-of-Clinic	90806	U5	U7			54.46
Individual Psychotherapy, insight oriented, behavior-	Practitioner Level 2, In-Clinic	90808	U2	U6			194.84
	Practitioner Level 3, In-Clinic	90808	U3	U6			150.05
	Practitioner Level 4, In-Clinic	90808	U4	U6			101.48

modifying and/or supportive in an office or outpatient facility, approximately <u>75-80 minutes</u> face-to-face with patient	Practitioner Level 5, In-Clinic	90808	U5	U6	75.64
	Practitioner Level 2, Out-of-Clinic	90808	U2	U7	233.80
	Practitioner Level 3, Out-of-Clinic	90808	U3	U7	183.39
	Practitioner Level 4, Out-of-Clinic	90808	U4	U7	121.78
	Practitioner Level 5, Out-of-Clinic	90808	U5	U7	90.76
Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately <u>20-30 minutes</u> face-to-face with patient	Practitioner Level 2, In-Clinic	90810	U2	U6	64.95
	Practitioner Level 3, In-Clinic	90810	U3	U6	50.02
	Practitioner Level 4, In-Clinic	90810	U4	U6	33.83
	Practitioner Level 5, In-Clinic	90810	U5	U6	25.21
	Practitioner Level 2, Out-of-Clinic	90810	U2	U7	77.93
	Practitioner Level 3, Out-of-Clinic	90810	U3	U7	61.13
	Practitioner Level 4, Out-of-Clinic	90810	U4	U7	40.59
	Practitioner Level 5, Out-of-Clinic	90810	U5	U7	30.25
Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other	Practitioner Level 2, In-Clinic	90812	U2	U6	116.90
	Practitioner Level 3, In-Clinic	90812	U3	U6	90.03
	Practitioner Level 4, In-Clinic	90812	U4	U6	60.89
	Practitioner Level 5, In-Clinic	90812	U5	U6	45.38

mechanisms of non-verbal communication, in an office or outpatient facility, approximately <u>45-50 minutes</u> face-to-face with patient	Practitioner Level 2, Out-of-Clinic	90812	U2	U7	140.28
	Practitioner Level 3, Out-of-Clinic	90812	U3	U7	110.04
	Practitioner Level 4, Out-of-Clinic	90812	U4	U7	73.07
	Practitioner Level 5, Out-of-Clinic	90812	U5	U7	54.46
Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately <u>75-80 minutes</u> face-to-face with patient	Practitioner Level 2, In-Clinic	90814	U2	U6	194.84
	Practitioner Level 3, In-Clinic	90814	U3	U6	150.05
	Practitioner Level 4, In-Clinic	90814	U4	U6	101.48
	Practitioner Level 5, In-Clinic	90814	U5	U6	75.64
	Practitioner Level 2, Out-of-Clinic	90814	U2	U7	233.80
	Practitioner Level 3, Out-of-Clinic	90814	U3	U7	183.39
	Practitioner Level 4, Out-of-Clinic	90814	U4	U7	121.78
	Practitioner Level 5, Out-of-Clinic	90814	U5	U7	90.76

Definition of Service: A therapeutic intervention or counseling service shown to be successful with identified populations, diagnoses and service needs, provided by a qualified clinician. Techniques employed involve the principles, methods and procedures of counseling that assist the person in identifying and resolving personal, social, vocational, intrapersonal and interpersonal concerns. Services are directed toward achievement of specific goals defined by the individual consumer and specified in the Individualized Recovery Plan. These services address goals/issues such as promoting recovery, and the restoration, development, enhancement or maintenance of:

- 1) illness and medication self-management knowledge and skills (e.g. symptom management, behavioral management, relapse prevention skills, knowledge of medications and side effects, and motivational/skill development in taking medication as prescribed);
- 2) problem solving and cognitive skills;
- 3) healthy coping mechanisms;

- 4) adaptive behaviors and skills;
- 5) interpersonal skills; and
- 6) knowledge regarding mental illness, substance related disorders and other relevant topics that assist in meeting the individual's or the support system's needs.

Best/evidence based practice modalities may include (as clinically appropriate): Motivational Interviewing/Enhancement, Cognitive Behavioral Therapy, Behavioral Modification, Behavioral Management, Rational Behavioral Therapy, Dialectical Behavioral Therapy, and others as appropriate to the individual and clinical issues to be addressed.

Target Population	Individuals with Mental Illness and/or Substance-Related Disorders
Benefit Information	Available to all Core Customers. Requires a MICP Registration or a MICP New Episode.
Utilization Criteria	<u>Available to those with LOCUS scores:</u> 1: Recovery Maintenance and Health Management 2: Low Intensity Community-Based Services 3: High Intensity Community-Based Services 4: Medically Monitored Non-Residential 5: Medically Monitored Community Residential 6: Medically Monitored Inpatient Residential
Ordering Practitioner	Physician, Psychologist, Physician's Assistant, Advanced Practice Registered Nurse (Clinical Nurse Specialist or Nurse Practitioner), LPC, LMFT, LCSW
Unit Value	1 encounter
Initial Authorization*	24 units
Re-Authorization*	24 units
Maximum Daily Units*	1 unit
Authorization Period*	180 days
UAS: Budget and Expense Categories	<u>Core Services Provider</u> 128 – Adult Mental Health 728 – Adult Addictive Diseases
Admission Criteria	1. Individual must have a primary mental illness/substance-related disorder diagnosis that is at least destabilizing (markedly interferes with the ability to carry out activities of daily living or places others in danger) or distressing (causes mental anguish or suffering); and 2. The individual's level of functioning does not preclude the provision of services in an outpatient milieu
Continuing Stay Criteria	1. Individual continues to meet admission criteria; and . 2. Individual demonstrates documented progress relative to goals identified in the Individualized Recovery Plan, but treatment goals have not yet been achieved.

Discharge Criteria	<ol style="list-style-type: none"> 1. Adequate continuing care plan has been established; and one or more of the following: 2. Goals of the Individualized Recovery Plan have been substantially met; or 3. Individual requests discharge and individual is not in imminent danger of harm to self or others; or 4. Transfer to another service is warranted by change in individual's condition; or 5. Individual requires a service approach that supports less or more intensive need.
Service Exclusions	ACT and Crisis Stabilization Unit services
Clinical Exclusions	<ol style="list-style-type: none"> 1. Severity of behavioral health impairment precludes provision of services. 2. Severity of cognitive impairment precludes provision of services in this level of care. 3. There is a lack of social support systems such that a more intensive level of service is needed. 4. Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of a psychiatric condition overlaying the primary diagnosis: mental retardation, autism, organic mental disorder and traumatic brain injury.

**(unless authorized as a part of a specific "package" which changes the authorization parameters)*

Additional Service Criteria:

A. Required Components

1. The treatment orientation, modality and goals must be specified and agreed upon by the individual.
2. Any diagnosis given to an individual must come from persons identified in O.C.G.A Practice Acts as qualified to provide a diagnosis. These practitioners include a licensed psychologist, a physician or a PA or APRN (NP and CNS-PMH) working in conjunction with a physician with an approved job description or protocol.
3. "Out-of-Clinic" may only be billed when:
 - Travel by the practitioner is to a non-contiguous location; and/or
 - Travel by the practitioner is to a facility not owned, leased, controlled or named as a service site by the agency who is billing the service(excepting visits to Shelter Plus sites); and/or
 - Travel is to a facility owned, leased or controlled by the agency billing the service, but no more than 6 individuals are being served in the course of that day by a single practitioner in non-group services; and/or
 - Travel is to a facility owned, leased, controlled or named as a service site by the agency, but no more than 24 individuals are being served in groups at that site in the course of a day.

If the service does not qualify to be billed as "out of clinic," then the "in-clinic" rate may still be billed.

B. Staffing Requirements

1. The following individuals can provide group training:
 - Practitioner Level 1: Physician/Psychiatrist (reimbursed at Level 2 rate)

- Practitioner Level 2: Psychologist, CNS-PMH
 - Practitioner Level 3: LCSW, LPC, LMFT, RN
 - Practitioner Level 4: LMSW; LAPC; LAMFT; Psychologist/LCSW/LPC/LMFT's supervisee/trainee with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology, functioning within the scope of the practice acts of the state; MAC, CAC-II, CADC, CCADC, GCADC (II, III); CAC-I or Addiction Counselor Trainee with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology (addiction counselors may only perform these functions related to treatment of addictive diseases).
 - Practitioner Level 5: CAC-I, RADT (I, II, or III), Addiction Counselor Trainees with high school diploma/equivalent (practitioners at this level may only perform these functions related to treatment of addictive diseases).
2. Students and individuals working toward licensure as a professional counselor, social worker, or marriage and family therapist must work under direction and documented clinical supervision of a licensed professional in accordance with the rules of the Georgia Composite Board of Professional Counselors, Social Workers and Marriage and Family Therapists. Agencies should refer to O.C.G.A. 43-10A-3 for the definitions of "direction" and "supervision" and the Documentation Guidelines included in this Provider Manual.
 3. The three specialties governed by the board referenced in B.2. above have different supervision requirements for individuals working toward licensure and it is the responsibility of the agency to ensure that the supervision requirements specified by the Board for the specialty (professional counseling, social work or marriage and family therapy) for which the individual is working toward licensure are met.
 4. Addiction counselor trainees may perform counseling as a trainee for a period of up to 3 years if they meet the requirements in O.C.G.A. 43-10A. This is limited to the provision of chemical dependency treatment under direction and supervision of a clinical supervisor approved by the certification body under which the trainee is seeking certification. Agencies should refer to O.C.G.A. 43-10A-3 and to the Documentation Guidelines included in this Provider Manual for the definitions of "direction" and "supervision".
 5. The status of students, trainees, and individuals working toward licensure must be disclosed to the individuals receiving services from trainees and interns and signatures/titles of these practitioners must also include "S/T."

C. Clinical Operations

Practitioners and supervisors of those providing this service are expected to maintain knowledge and skills regarding current research trends in best/evidence based counseling practices.

D. Service Access

1. Individual Counseling may **not** be provided in an Institution for Mental Diseases (IMD, e.g. state or private psychiatric hospital or Crisis Stabilization Unit with greater than 16 beds), jail, or prison system.
2. This service may not be provided and billed for individuals who are involuntarily detained awaiting criminal proceedings, penal dispositions, or other involuntary detainment proceedings.

E. Additional Medicaid Requirements

Currently, there are no additional Medicaid requirements to be added to the requirements above when billing Medicaid for this service.

F. Reporting & Billing Requirements

All applicable Medicaid, MICP, ERO, and other DBHDD reporting requirements must be met.

G. Documentation Requirements

Providers must document services in accordance with the specifications for documentation requirements specified in Part II, Section V of the Provider Manual.

Legal Skills / Competency Training						
HIPAA Transaction Code	Code	Mod1	Mod2	Mod3	Mod4	Rate
Patient Education, Not otherwise Classified, Non-Physician Provider, Individual per Session	S9445	H9				
Patient Education, Not otherwise Classified, Non-Physician Provider, Group per Session	S9446	H9				

Definition of Service: A therapeutic interaction shown to be successful with mentally ill or developmentally disabled individuals involved with the criminal justice system. Services are directed toward achievement of specific goals defined in a Court Order and/or pretrial forensic report. Services will address goals/issues related to development or restoration of skills related to competency to stand trial. This would include some or all of the following:

- 1) Communication skills that enable the individual to effectively convey information to another
- 2) Listening skills that allow the individual to summarize information heard, maintain attention, and identify false statements
- 3) Decision making skills to aid in responding to well-explained alternatives
- 4) Knowledge of the role of courtroom participants and procedures
- 5) Understanding of the adversarial nature of legal proceedings and one's role as a defendant

Target Population	Individuals with Mental Illness and/or Developmental Disabilities and/or Substance-Related Disorders who have been found Incompetent to Stand Trial.
Benefit Information	Available to anyone with a court order for competency restoration. Does not currently require a MICP.
Utilization Criteria	Available to anyone with a court order for competency restoration.
Ordering Practitioner	Physician, Psychologist, Physician's Assistant, Advanced Practice Registered Nurse (Clinical Nurse Specialist or Nurse Practitioner), LPC, LMFT, LCSW
Unit Value	15 minutes (1 Session = 1 Unit = 15 minutes)
Reimbursement Rate	\$16.69
Initial Authorization	N/A
Re-Authorization	N/A
Authorization Period	N/A
UAS: Budget and Expense Categories	<u>Core Services Provider</u> 161 – Adult Mental Health 761 – Adult Addictive Diseases
Admission Criteria	1. Individuals must have a court order authorizing community restoration for competency and 2. The individual's level of functioning does not preclude the provision of services in an outpatient milieu.

Continuing Stay Criteria	<ol style="list-style-type: none"> 1. Individual continues to be incompetent to stand trial or individual is presently competent, but needs additional intervention or refresher sessions to maintain competency until trial; and 2. Individual remains under a court order that authorizes competency restoration.
Discharge Criteria	<ol style="list-style-type: none"> 1. Individual is presently competent to stand trial as determined by a DHR Forensic Evaluator or judge and not in need of ongoing training to maintain competency for trial. 2. Individual continues to be incompetent to stand trial and it has been determined by a DHR Forensic Evaluator or judge that the individual is not restorable or 3. Individual has participated in this service for 12 consecutive months; or 4. Transfer to another service/level of care is warranted by change in individual's condition; or 5. Individual requires more intensive services.
Service Exclusions	See Below
Clinical Exclusions	<ol style="list-style-type: none"> 1. Individual presents significant and imminent risk to self or other such that a more intensive level of service is needed.

Additional Service Criteria:

A. Required Components

1. The functional goals addressed through this service must be specified.
2. Any services in excess of 3 hours in a given day (combination of individual legal/competency skills training, group legal/competency skills training) may be subject to scrutiny by the external review organization.
3. Provider shall notify DHR Evaluator Contact of decompensation in consumer mental status or need for more intensive services.
4. Provider shall notify DHR Evaluator Contact in a timely manner of either of the following situations:
 - a. the individual appears to have attained competency
 - b. it is determined that the individual has achieved maximum benefits
5. Practitioners are to utilize accepted or established competency training materials consistent with best practices. (Practitioners may request sample materials from DBHDD's Office of Forensic Services and may submit proposed materials for review.)

B. Staffing Requirements

1. Training is provided by staff with a minimum education of bachelor's degree.
2. Individual: Maximum consumer to staff ratio cannot be more than one consumer to one direct service staff.
Group: Maximum consumer to staff ratio cannot be more than 10 consumers to one direct service staff.
3. Practitioners providing this service are expected to maintain knowledge and skills regarding group training and competency restoration.

C. Clinical Operations

D. Service Access

1. Consumers will be referred by the Director of Forensic Services or designee at the state hospital in the catchment area of the provider.
2. The provider shall notify the referring state hospital if the consumer appears to be competent, is not likely to ever become competent, or appears to be in need of more intensive mental health services.

E. Additional Medicaid Requirements

This is not a Medicaid reimbursable service.

F. Reporting & Billing Requirements

1. All applicable DBHDD reporting requirements must be met.
2. Provider shall report to DBHDD's Office of Forensic Services quarterly (March 31, June 30, September 30, and December 31) the names of consumers served and for each consumer, the date and type of service (individual or group) and the number of 15-minute units delivered (e.g. 60 minute group = 4 units of S9446 H9)

G. Documentation Requirements

Providers must document services in accordance with the specifications for documentation requirements specified in Part II, Section V of this Provider Manual

Medication Administration							
HIPAA Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Comprehensive Medication Services	Practitioner Level 2, In-Clinic	H2010	U2	U6			\$33.40
	Practitioner Level 3, In-Clinic	H2010	U3	U6			\$25.39
	Practitioner Level 4, In-Clinic	H2010	U4	U6			\$17.40
	Practitioner Level 5, In-Clinic	H2010	U5	U6			\$12.97
	Practitioner Level 2, Out-of-Clinic	H2010	U2	U7			\$42.51
	Practitioner Level 3, Out-of-Clinic	H2010	U3	U7			\$33.01
	Practitioner Level 4, Out-of-Clinic	H2010	U4	U7			\$22.14
Therapeutic, prophylactic or diagnostic injection	Practitioner Level 2, In-Clinic	96372	U2	U6			\$33.40
	Practitioner Level 3, In-Clinic	96372	U3	U6			\$25.39
	Practitioner Level 4, In-Clinic	96372	U4	U6			\$17.40
	Practitioner Level 2, Out-of-Clinic	96372	U2	U7			\$42.51
	Practitioner Level 3, Out-of-Clinic	96372	U3	U7			\$33.01
	Practitioner Level 4, Out-of-Clinic	96372	U4	U7			\$22.14
Alcohol, and/or drug services, methadone administration and/or service (provision of the drug by a licensed program)	Practitioner Level 2, In-Clinic	H0020	U2	U6			\$33.40
	Practitioner Level 3, In-Clinic	H0020	U3	U6			\$25.39
	Practitioner Level 4, In-Clinic	H0020	U4	U6			\$17.40
<p>Definition of Service: As reimbursed through this service, medication administration includes the act of introducing a drug (any chemical substance that, when absorbed into the body of a living organism, alters normal bodily function) into the body of another person by any number of routes including, but not limited to the following: oral, nasal, inhalant, intramuscular injection, intravenous, topical, suppository or intraocular. Medication administration requires a physician's order and must be administered by licensed or credentialed* medical personnel under the supervision of a physician or registered nurse in accordance with O.C.G.A.</p>							

This service does **not** cover the supervision of self-administration of medications (See Clinical Exclusions below).

The service must include:

1. An assessment, by the licensed or credentialed medical personnel administering the medication, of the individual's physical, psychological and behavioral status in order to make a recommendation regarding whether to continue the medication and/or its means of administration, and whether to refer the individual to the physician for a medication review.
2. Education to the individual and/or family/responsible caregiver(s), by appropriate licensed medical personnel, on the proper administration and monitoring of prescribed medication in accordance with the youth's resiliency plan.

For individuals who need opioid maintenance, the Opioid Maintenance service should be requested

Target Population	Individuals with Mental Illness Individuals with Substance Related Disorders Individuals with Co-occurring Mental Illness and Substance Related Disorders Individuals with Co-occurring Mental Illness and MR/DD Individuals with Co-occurring Substance Related Disorders and MR/DD
Benefit Information	Available to all Core Customers. Requires a MICP Registration or a MICP New Episode.
Utilization Criteria	<u>Available to those with LOCUS scores:</u> 1: Recovery Maintenance and Health Management 2: Low Intensity Community-Based Services 3: High Intensity Community-Based Services 4: Medically Monitored Non-Residential 5: Medically Monitored Community Residential 6: Medically Monitored Inpatient Residential
Ordering Practitioner	Physician, Physician's Assistant, Advanced Practice Registered Nurse (Clinical Nurse Specialist or Nurse Practitioner)
Unit Value	1 encounter
Initial Authorization*	With the submission of MICP Registration - 6 units shared With the submission of MICP New Episode: H2010 & 96372= 60 units shared
Re-Authorization*	H2010 & 96372= 60 units shared
Authorization Period*	180 days
UAS: Budget and Expense Categories	<u>Core Services Provider</u> 124 – Adult Mental Health 724 – Adult Addictive Diseases

<p>Admission Criteria</p>	<ol style="list-style-type: none"> 1. Individual presents symptoms that are likely to respond to pharmacological interventions; and 2. Individual has been prescribed medications as a part of the treatment array; and 3. Individual /family/responsible caregiver is unable to self-administer/administer prescribed medication because: <ol style="list-style-type: none"> a. Although the individual is willing to take the prescribed medication, it is in an injectable form and must be administered by licensed medical personnel; or b. Although individual is willing to take the prescribed medication, it is a Class A controlled substance which must be stored and dispensed by medical personnel in accordance with state law; or c. Administration by licensed/credentialed medical personnel is necessary because an assessment of the individual's physical, psychological and behavioral status is required in order to make a determination regarding whether to continue the medication and/or its means of administration and/or whether to refer the individual to the physician for a medication review. d. Due to the family/caregiver's lack of capacity there is no responsible party to manage/supervise self-administration of medication (refer individual /family for CSI and/or Family or Group Training in order to teach these skills)
<p>Continuing Stay Criteria</p>	<p>Individual continues to meet admission criteria.</p>
<p>Discharge Criteria</p>	<ol style="list-style-type: none"> 1. Individual no longer needs medication; or 2. Individual is able to self-administer medication; and 3. Adequate continuing care plan has been established
<p>Service Exclusions</p>	<ol style="list-style-type: none"> 1. Does not include medication given as a part of Ambulatory Detoxification. Medication administered as part of Ambulatory Detoxification is billed as "Ambulatory Detoxification." 2. Must not be billed in the same day as Nursing Assessment. 3. Must not be billed while enrolled in ACT except if this Medication Administration service is utilized only for the administration of methadone (for Medicaid recipients). 4. May not be billed in conjunction with Intensive Day Treatment (Partial Hospitalization).
<p>Clinical Exclusions</p>	<p>This service does not cover the supervision of self-administration of medications. Self-administration of medications can be done by anyone physically and mentally capable of taking or administering medications to himself/herself. Youth and adults with mental health issues, or developmental disabilities are very often capable of self-administration of medications even if supervision by others is needed in order to adequately or safely manage self-administration of medication and other activities of daily living.</p>

**(unless authorized as a part of a specific "package" which changes the authorization parameters)*

Additional Service Criteria:

A. Required Components

1. There must be a physician's order for the medication and for the administration of the medication. The order must be in the individual's chart. Telephone/verbal orders are acceptable provided they are signed by the physician in accordance with DBHDD standards.
2. Documentation must support that the individual is being trained in the risks and benefits of the medications being administered and that symptoms are being monitored by the staff member administering the medication.
3. Documentation must support the medical necessity of administration by licensed/credentialed medical personnel rather than by the individual, family or caregiver.
4. Documentation must support that the individual is being trained in the principle of self-administration of medication or that the individual is physically or mentally unable to self-administer. This documentation will be subject to scrutiny by the External Review Organization in reauthorizing services in this category.
5. This service does **not** include the supervision of self-administration of medication.
6. Any diagnosis given to an individual must come from persons identified in O.C.G.A Practice Acts as qualified to provide a diagnosis. These practitioners include a licensed psychologist, a physician or a PA or APRN (NP and CNS-PMH) working in conjunction with a physician with an approved job description or protocol.
7. "Out-of-Clinic" may only be billed when:
 - Travel by the practitioner is to a non-contiguous location; and/or
 - Travel by the practitioner is to a facility not owned, leased, controlled or named as a service site by the agency who is billing the service(excepting visits to Shelter Plus sites); and/or
 - Travel is to a facility owned, leased or controlled by the agency billing the service, but no more than 6 individuals are being served in the course of that day by a single practitioner in non-group services; and/or
 - Travel is to a facility owned, leased, controlled or named as a service site by the agency, but no more than 24 individuals are being served in groups at that site in the course of a day.If the service does not qualify to be billed as "out of clinic," then the "in-clinic" rate may still be billed.

B. Staffing Requirements

1. The following individuals can provide comprehensive medication services:
 - Practitioner Level 2: Advanced Practice Registered Nurse (APRN), PA, Pharmacist
 - Practitioner Level 3: Registered Nurse (RN)
 - Practitioner Level 4: Licensed Practical Nurse (LPN)
 - Practitioner Level 5: Qualified Medication Aide (QMA) who works in a CLA
2. The following individuals can provide therapeutic, prophylactic or diagnostic injections:
 - Practitioner Level 2: Advanced Practice Registered Nurse (APRN), PA, Pharmacist

- Practitioner Level 3: Registered Nurse (RN)
 - Practitioner Level 4: Licensed Practical Nurse (LPN)
3. The following individuals can provide alcohol to drug services, methadone administration and/or service provision:
 - Practitioner Level 2: Advanced Practice Registered Nurse (APRN), PA, Pharmacist
 - Practitioner Level 3: Registered Nurse (RN)
 - Practitioner Level 4: Licensed Practical Nurse (LPN)
 4. Qualified Medication Aides working in a Community Living Arrangement (CLA) may administer medication only in a CLA.

C. Clinical Operations

1. Medication administration may not be billed for the provision of single or multiple doses of medication that a consumer has the ability to self-administer, either independently or with supervision by a caregiver, either in a clinic or a community setting. In a group home/CCI setting, for example, medications may be managed by the house parents or residential care staff and kept locked up for safety reasons. Staff may hand out medication to the residents but this does not constitute administration of medication for the purposes of this definition and, like other watchful oversight and monitoring functions, are not reimbursable treatment services.
2. If consumer/family requires training in skills needed in order to learn to manage his/her own medications and their safe self-administration and/or supervision of self-administration, this skills training service can be provided via the Community Support or Family/Group Training services in accordance with the person's individualized recovery/resiliency plan.

D. Service Access

1. Medication Administration may **not** be provided in an Institution for Mental Diseases (IMD, e.g. state or private psychiatric hospital or Crisis Stabilization Unit with greater than 16 beds), jail, or prison system.
2. This service may not be provided and billed for individuals who are involuntarily detained awaiting criminal proceedings, penal dispositions, or other involuntary detention proceedings.

E. Additional Medicaid Requirements

As in all other settings, the daily maximum within a CSU for Medication Administration is 1 unit/day.

F. Reporting & Billing Requirements

All applicable Medicaid, MICP, ERO, and other DBHDD reporting requirements must be met.

G. Documentation Requirements

Providers must document services in accordance with the specifications for documentation requirements specified in Part II, Section V of the Provider Manual.

Nursing Assessment and Health Services

HIPAA Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Nursing Assessment/ Evaluation	Practitioner Level 2, In-Clinic	T1001	U2	U6			\$38.97
	Practitioner Level 3, In-Clinic	T1001	U3	U6			\$30.01
	Practitioner Level 4, In-Clinic	T1001	U4	U6			\$20.30
	Practitioner Level 2, Out-of-Clinic	T1001	U2	U7			\$46.76
	Practitioner Level 3, Out-of-Clinic	T1001	U3	U7			\$36.68
	Practitioner Level 4, Out-of-Clinic	T1001	U4	U7			\$24.36
RN Services, up to 15 minutes	Practitioner Level 2, In-Clinic	T1002	U2	U6			\$38.97
	Practitioner Level 3, In-Clinic	T1002	U3	U6			\$30.01
	Practitioner Level 2, Out-of-Clinic	T1002	U2	U7			\$46.76
	Practitioner Level 3, Out-of-Clinic	T1002	U3	U7			\$36.68
LPN/LVN Services, up to 15 minutes	Practitioner Level 4, In-Clinic	T1003	U4	U6			\$20.30
	Practitioner Level 4, Out-of-Clinic	T1003	U4	U7			\$24.36
Health and Behavior Assessment, Face-to-Face with the Patient, Initial Assessment	Practitioner Level 2, In-Clinic	96150	U2	U6			\$38.97
	Practitioner Level 3, In-Clinic	96150	U3	U6			\$30.01
	Practitioner Level 4, In-Clinic	96150	U4	U6			\$20.30
	Practitioner Level 2, Out-of-Clinic	96150	U2	U7			\$46.76
	Practitioner Level 3, Out-of-Clinic	96150	U3	U7			\$36.68
	Practitioner Level 4, Out-of-Clinic	96150	U4	U7			\$24.36
Health and Behavior Assessment, Face-to-Face with the Patient, Re- assessment	Practitioner Level 2, In-Clinic	96151	U2	U6			\$38.97
	Practitioner Level 3, In-Clinic	96151	U3	U6			\$30.01
	Practitioner Level 4, In-Clinic	96151	U4	U6			\$20.30
	Practitioner Level 2, Out-of-Clinic	96151	U2	U7			\$46.76
	Practitioner Level 3, Out-of-Clinic	96151	U3	U7			\$36.68
	Practitioner Level 4, Out-of-Clinic	96151	U4	U7			\$24.36

Definition of Service: This service requires face-to-face contact with the individual to monitor, evaluate, assess, and/or carry out a physician's orders regarding the physical and/or psychological problems of the individual. It includes:

- 1) Providing nursing assessments and interventions to observe, monitor and care for the physical,

- nutritional, behavioral health and related psychosocial issues, problems or crises manifested in the course of an individual's treatment;
- 2) Assessing and monitoring individual's response to medication(s) to determine the need to continue medication and/or to determine the need to refer the individual to a physician for a medication review;
 - 3) Assessing and monitoring an individual's medical and other health issues that are either directly related to the mental health or substance related disorder, or to the treatment of the disorder (e.g. diabetes, cardiac and/or blood pressure issues, substance withdrawal symptoms, weight gain and fluid retention, seizures, etc);
 - 4) Consulting with the individual and individual-identified family and significant other(s) about medical, nutritional and other health issues related to the individual's mental health or substance related issues;
 - 5) Educating the individual and any identified family about potential medication side effects (especially those which may adversely affect health such as weight gain or loss, blood pressure changes, cardiac abnormalities, development of diabetes or seizures, etc);
 - 6) Consulting with the individual and the individual-identified family and significant other(s) about the various aspects of informed consent (when prescribing occurs/APRN);
 - 7) Training for self-administration of medication; and
 - 8) Venipuncture required to monitor and assess mental health, substance disorders or directly related conditions, and to monitor side effects of psychotropic medications, as ordered by a Licensed Physician, Physician Assistant or Advanced Practice Nurse.
 - 9) Providing assessment, testing, and referral for infectious diseases.

Target Population	Individuals with Mental Health issues/Serious Mental Illness and/or Substance Related Disorders Individuals with Mental Health issues/Serious Mental Illness and MR/DD Individuals with Substance Related Disorders and MR/DD
Benefit Information	Available to all Core Customers. Requires a MICP Registration or a MICP New Episode.
Utilization Criteria	<u>Available to those with LOCUS scores:</u> 1: Recovery Maintenance and Health Management 2: Low Intensity Community-Based Services 3: High Intensity Community-Based Services 4: Medically Monitored Non-Residential 5: Medically Monitored Community Residential 6: Medically Managed Residential
Ordering Practitioner	Physician, Physician's Assistant, Advanced Practice Registered Nurse (Clinical Nurse Specialist or Nurse Practitioner)
Unit Value	15 minutes
Initial Authorization*	With the submission of MICP Registration -12 units With the submission of MICP New Episode- 60 units
Re-Authorization*	60 units
Maximum Daily Units*	16 units (32 for Ambulatory Detox)
Authorization Period*	180 days

UAS: Budget and Expense Categories	<u>Core Services Provider</u> 123 – Adult Mental Health 723 – Adult Addictive Diseases
Admission Criteria	1. Individual presents with symptoms that are likely to respond to medical/nursing interventions; or 2. Individual has been prescribed medications as a part of the treatment array or has a confounding medical condition.
Continuing Stay Criteria	1. Individual continues to demonstrate symptoms that are likely to respond to or are responding to medical interventions; or 2. Individual exhibits acute disabling conditions of sufficient severity to bring about a significant impairment in day-to-day functioning; or 3. Individual demonstrates progress relative to goals identified in the Individualized Recovery Plan, but treatment goals have not yet been achieved.
Discharge Criteria	1. An adequate continuing care plan has been established; and one or more of the following: 2. Individual no longer demonstrates symptoms that are likely to respond to or are responding to medical/nursing interventions; or 3. Goals of the Individualized Recovery Plan have been substantially met; or 4. Individual requests discharge and individual is not in imminent danger of harm to self or others.
Service Exclusions	ACT, Medication Administration, Opioid Maintenance.
Clinical Exclusions	Routine nursing activities that are included as a part of medication administration/methadone administration

**(unless authorized as a part of a specific “package” which changes the authorization parameters)*

Additional Service Criteria:

A. Required Components

1. Nutritional assessments indicated by an individual's confounding health issues may be billed under this code (96150, 96151). No more than 8 units specific to nutritional assessments can be billed for an individual within a year. This specific assessment must be provided by a Registered Nurse or by a Licensed Dietician.
2. This service does **not** include the supervision of self-administration of medication.
3. Each nursing contact should document the checking of vital signs (Temperature, Pulse, Blood Pressure, Respiratory Rate, and weight, if medically indicated or if related to behavioral health symptom or behavioral health medication side effect) in accordance with general psychiatric nursing practice.
4. Nursing assessments should assess health risks, health indicators, and health conditions given that behavioral health conditions, behavioral health medications, and physical health are intertwined. Personal and family history of Diabetes, Hypertension, and Cardiovascular Disease should be explored as well as tobacco use history, substance use history, blood pressure status, and Body Mass Index (BMI). Any sign of major health concerns should yield a medical referral to a primary health care physician/center.
5. Any diagnosis given to an individual must come from persons identified in O.C.G.A Practice Acts as qualified to provide a diagnosis. These practitioners include a licensed psychologist, a

physician or a PA or APRN (NP and CNS-PMH) working in conjunction with a physician with an approved job description or protocol.

E> "Out-of-Clinic" may only be billed when:

- Travel by the practitioner is to a non-contiguous location; and/or
 - Travel by the practitioner is to a facility not owned, leased, controlled or named as a service site by the agency who is billing the service(excepting visits to Shelter Plus sites); and/or
 - Travel is to a facility owned, leased or controlled by the agency billing the service, but no more than 6 individuals are being served in the course of that day by a single practitioner in non-group services; and/or
 - Travel is to a facility owned, leased, controlled or named as a service site by the agency, but no more than 24 individuals are being served in groups at that site in the course of a day.
- If the service does not qualify to be billed as "out of clinic," then the "in-clinic" rate may still be billed.

B. Staffing Requirements

1. The following individuals can provide nursing assessment and evaluation services:

- Practitioner Level 2: Advanced Practice Registered Nurse (APRN)
- Practitioner Level 3: Registered Nurse (RN),
- Practitioner Level 4: Licensed Practical Nurse (LPN), Licensed Dietician (LD)

2. The following individuals can provide RN services:

- Practitioner Level 2: Advanced Practice Registered Nurse (APRN)
- Practitioner Level 3: Registered Nurse (RN)

3. The following individuals can provide LPN/LVN services:

- Practitioner Level 4: Licensed Practical Nurse (LPN)

4. The following individuals can provide Health or Behavior Assessment (initial and reassessment) services:

- Practitioner Level 2: Advanced Practice Registered Nurse (APRN)
- Practitioner Level 3: Registered Nurse (RN), Licensed Dietician (LD)
- Practitioner Level 4: Licensed Practical Nurse (LPN)

C. Clinical Operations

1. Venipuncture billed under this service must include documentation that includes canula size utilized, insertion site, number of attempts, location, and consumer tolerance of procedure.
2. All nursing procedures must include relevant consumer centered education regarding the procedure.

D. Service Access

1. Nursing Assessment and Health Services may **not** be provided in an Institution for Mental Diseases (IMD, e.g. state or private psychiatric hospital or Crisis Stabilization Unit with greater than 16 beds), jail, or prison system.
2. This service may not be provided and billed for individuals who are involuntarily detained awaiting criminal proceedings, penal dispositions, or other involuntary detention proceedings.

E. Additional Medicaid Requirements

The daily maximum within a CSU for Nursing Assessment and Health Services is 5 units/day.

F. Reporting & Billing Requirements

All applicable Medicaid, MICP, ERO, and other DBHDD reporting requirements must be met.

G. Documentation Requirements

Providers must document services in accordance with the specifications for documentation requirements specified in Part II, Section V of the Provider Manual.

Pharmacy & Lab

Definition of Service: Pharmacy and Lab Services include operating or purchasing services to order, package, and distribute prescription medications. It includes provision of assistance to consumers to access indigent medication programs, sample medication programs and payment for necessary medications when no other funding source is available. This service provides for appropriate lab work, such as drug screens and medication levels, to be performed. This service is to ensure that necessary medication and lab services are not withheld or delayed to consumers based on inability to pay.

Target Population	Individuals with Mental Illness or Substance Related Disorders
Benefit Information	Available to all Core Customers with emphasis on priority populations.
Utilization Criteria	<u>Available to those with LOCUS scores:</u> 1: Recovery Maintenance and Health Management 2: Low Intensity Community-Based Services 3: High Intensity Community-Based Services 4: Medically Monitored Non-Residential 5: Medically Monitored Community Residential 6: Medically Managed Residential
Unit Value	
Initial Authorization	
Re-Authorization	
Authorization Period	
UAS: Budget and Expense Categories	
Admission Criteria	
Continuing Stay Criteria	Individual continues to meet the admission criteria as determined by the prescribing professional
Discharge Criteria	1. Individual no longer demonstrates symptoms that are likely to respond to or are responding to pharmacologic interventions; or 2. Individual requests discharge and individual is not imminently dangerous or under court order for this intervention.
Service Exclusions	
Clinical Exclusions	

Additional Service Requirements:

A. Required Components

1. Service must be provided by a licensed pharmacy or through contract with a licensed pharmacy.
2. Agency must participate in any pharmaceutical rebate programs or pharmacy assistance programs that promote consumer access in obtaining medication.

3. Providers shall refer all consumers who have an inability to pay for medications or services to the local county offices of the Department's Division of Family and Children's Services for the purposes of determining Medicaid eligibility.

B. Staffing Requirements

C. Clinical Operations

D. Service Access

E. Additional Medicaid Requirements

Not a Medicaid Rehabilitation Option "service." Medicaid recipients may access the general Medicaid pharmacy program as prescribed by the Department of Community Health.

F. Reporting & Billing Requirements

All applicable MICP and other DBHDD reporting requirements must be met.

Psychiatric Treatment

HIPAA Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Individual Psychotherapy, insight oriented, behavior-modifying and/or supportive in an office or outpatient facility, approximately <u>20-30 minutes</u> face-to-face with patient with medical evaluation and management services.	Practitioner Level 1, In-Clinic	90805	U1	U6			97.02
	Practitioner Level 1, Out-of-Clinic	90805	U1	U7			123.48
	Practitioner Level 2, In-Clinic	90805	U2	U6			64.95
	Practitioner Level 2, Out-of-Clinic	90805	U2	U7			77.93
Individual Psychotherapy, insight oriented, behavior-modifying and/or supportive in an office or outpatient facility, approximately <u>45-50 minutes</u> face-to-face with patient with medical evaluation and management services.	Practitioner Level 1, In-Clinic	90807	U1	U6			174.63
	Practitioner Level 1, Out-of-Clinic	90807	U1	U7			222.26
	Practitioner Level 2, In-Clinic	90807	U2	U6			116.90
	Practitioner Level 2, Out-of-Clinic	90807	U2	U7			140.28
Pharma-	Practitioner Level 1, In-Clinic	90862	U1	U6			58.21

cological Management	Practitioner Level 1, Via interactive audio and video telecommunication systems	90862	GT	U1		58.21
	Practitioner Level 1, Out-of-Clinic	90862		U1	U7	74.09
	Practitioner Level 2, In-Clinic	90862		U2	U6	38.97
	Practitioner Level 2, Via interactive audio and video telecommunication systems	90862	GT		U2	38.97
	Practitioner Level 2, Out-of-Clinic	90862		U2	U7	46.76

Definition of Service: The provision of specialized medical and/or psychiatric services that include, but are not limited to:

- a. Psychotherapeutic services with medical evaluation and management including evaluation and assessment of physiological phenomena (including co-morbidity between behavioral and physical health care issues);
- b. Assessment and monitoring of an individual's status in relation to treatment with medication,
- c. Assessment of the appropriateness of initiating or continuing services.

Individuals must receive appropriate medical interventions as prescribed and provided by a physician (or physician extender) that shall support the individualized goals of recovery as identified by the individual and their Individualized Recovery Plan (within the parameters of the person's informed consent).

Target Population	Individuals with Mental Illness or Substance Related Disorders
Benefit Information	Available to all Core Customers. Requires a MICP Registration or a MICP New Episode.
Utilization Criteria	<u>Available to those with LOCUS scores:</u> 1: Recovery Maintenance and Health Management 2: Low Intensity Community-Based Services 3: High Intensity Community-Based Services 4: Medically Monitored Non-Residential 5: Medically Monitored Community Residential 6: Medically Managed Residential
Ordering Practitioner	Physician, Physician's Assistant, Advanced Practice Registered Nurse (Clinical Nurse Specialist or Nurse Practitioner)
Unit Value	Unit=1 encounter
Initial Authorization*	12 units
Re-Authorization*	12 units
Maximum Daily Units	1 unit (see qualifier in definition below)
Authorization Period*	180 days
UAS: Budget and Expense Categories	<u>Core Services Provider</u> 122 – Adult Mental Health 722 – Adult Addictive Diseases

Admission Criteria	<ol style="list-style-type: none"> 1. Individual is determined to be in need of psychotherapy services and has confounding medical issues which interact with behavioral health diagnosis, requiring medical oversight; or 2. Individual has been prescribed medications as a part of the treatment array
Continuing Stay Criteria	<ol style="list-style-type: none"> 1. Individual continues to meet the admission criteria; or 2. Individual exhibits acute disabling conditions of sufficient severity to bring about a significant impairment in day-to-day functioning; or 3. Individual continues to present symptoms that are likely to respond to pharmacological interventions; or 4. Individual continues to demonstrate symptoms that are likely to respond or are responding to medical interventions; or 5. Individual continues to require management of pharmacological treatment in order to maintain symptom remission.
Discharge Criteria	<ol style="list-style-type: none"> 1. An adequate continuing care plan has been established; and one or more of the following: 2. Individual has withdrawn or been discharged from service; or 3. Individual no longer demonstrates symptoms that need pharmacological interventions.
Service Exclusions	Not offered in conjunction with ACT
Clinical Exclusions	Services defined as a part of ACT

**(unless authorized as a part of a specific "package" which changes the authorization parameters)*

Additional Service Criteria:

A. Required Components

1. Telemedicine may be utilized for an initial Psychiatric Diagnostic Examination as well as for ongoing Psychiatric Diagnostic Examination via the use of appropriate procedure codes with the GT modifier.
2. Any diagnosis given to an individual must come from persons identified in O.C.G.A Practice Acts as qualified to provide a diagnosis. These practitioners include a licensed psychologist, a physician or a Physician's Assistant (PA) or Advanced Practice Registered Nurse (APRN: Nurse Practitioner or Clinical Nurse Specialist—Psychiatry & Mental Health) working in conjunction with a physician with an approved job description or protocol.
3. "Out-of-Clinic" may only be billed when:
 - Travel by the practitioner is to a non-contiguous location; and/or
 - Travel by the practitioner is to a facility not owned, leased, controlled or named as a service site by the agency who is billing the service(excepting visits to Shelter Plus sites); and/or
 - Travel is to a facility owned, leased or controlled by the agency billing the service, but no more than 6 individuals are being served in the course of that day by a single practitioner in non-group services; and/or
 - Travel is to a facility owned, leased, controlled or named as a service site by the agency, but no more than 24 individuals are being served in groups at that site in the course of a day.

If the service does not qualify to be billed as "out of clinic," then the "in-clinic" rate may still be billed.

B. Staffing Requirements

1. The following individuals can provide individual psychotherapy face to face with medical evaluation and management services:
 - Practitioner Level 1: Physician/Psychiatrist
 - Practitioner Level 2: CNS-PMH (Clinical Nurse Specialist in Psychiatric/Mental Health)
2. The following individuals can provide pharmacological management:
 - Practitioner Level 1: Physician/Psychiatrist
 - Practitioner Level 2: PA or APRN (if authority to perform this task is delegated by physician through approved job description or protocol)

C. Clinical Operations

1. In accordance with recovery philosophy, it is expected that individuals will be treated as full partners in the treatment regimen/services planned and received. As such, it is expected that practitioners will fully discuss treatment options with individuals and allow for individual choice when possible. Discussion of treatment options should include a full disclosure of the pros and cons of each option (e.g. full disclosure of medication/treatment regimen potential side effects, potential adverse reactions--including potential adverse reaction from not taking medication as prescribed, and expected benefits). If such full discussion/disclosure is not possible or advisable according to the clinical judgment of the practitioner, this should be documented in the individual's chart (including the specific information that was not discussed and a compelling rationale for lack of discussion/disclosure).
2. Assistive tools, technologies, worksheets, etc. can be used by the served individual to facilitate communication about treatment, symptoms, improvements, etc. with the treating practitioner.

D. Service Access

1. Telemedicine is the use of medical information exchanged from one site to another via electronic communications to improve a patient's health. Electronic communication means the use of interactive telecommunications equipment that includes, at a minimum, audio and video equipment permitting two-way, real time interactive communication between the patient, and the physician or practitioner at the distant site.
2. Psychiatric Treatment may **not** be provided in an Institution for Mental Diseases (IMD, e.g. state or private psychiatric hospital or Crisis Stabilization Unit with greater than 16 beds), jail, or prison system.
3. This service may not be provided and billed for individuals who are involuntarily detained awaiting criminal proceedings, penal dispositions, or other involuntary detention proceedings.

E. Additional Medicaid Requirements

1. The daily maximum within a CSU for Pharmacologic Management is 1 unit/day.
2. Even if a physician also has his/her own Medicaid number, the physician providing behavioral health treatment and care through this code should bill via the approved provider agency's Medicaid number through the Medicaid Category of Service (COS) 440.

F. Reporting & Billing Requirements

1. Within this service group, a second unit with a U1 modifier may be used in the event that a Telemedicine Psychiatric Treatment unit is provided and it indicates a need for a face-to-face assessment (e.g. 90862GTU1 is billed and it is clinically indicated that a face-to-face by an on-site physician needs to immediately follow based upon clinical indicators during the first intervention, then 90862U1, can also be billed in the same day).
2. Within this service group, there is an allowance for when a U2 practitioner conducts an intervention and, because of clinical indicators presenting during this intervention, a U1 practitioner needs to provide another unit due to the concern of the U2 supervisee (e.g. Physician's Assistant provides and bills 90805U2U6 and because of concerns, requests U1 intervention following his/her billing of U2 intervention). The use of this practice should be rare and will be subject to additional utilization review scrutiny.
3. All applicable Medicaid, MICP, ERO, and other DBHDD reporting requirements must be met.

G. Documentation Requirements

Providers must document services in accordance with the specifications for documentation requirements specified in Part II, Section V of the Provider Manual.

Psychological Testing							
HIPAA Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Psychological Testing – Psycho-diagnostic assessment of emotionality, intellectual abilities, personality and psycho-pathology e.g. MMP, Rorschach, WAIS (per hour of psychologist's or physician's time, both face-to-face with the patient and time interpreting test results and preparing the report)	Practitioner Level 2, In-Clinic	96101	U2	U6			155.87
	Practitioner Level 2, Out-of-Clinic	96101	U2	U7			187.04
Psychological Testing – Psycho-diagnostic assessment of emotionality, intellectual abilities, personality and psycho-pathology e.g. MMP, Rorschach, WAIS) with qualified healthcare professional interpretation and report, administered by technician, per hour of technician time, face-to-face	Practitioner Level 3, In-Clinic	96102	U3	U6			120.04
	Practitioner Level 3, Out-of-Clinic	96102	U3	U7			146.71
	Practitioner Level 4, In-Clinic	96102	U4	U6			81.18
	Practitioner Level 4, Out-of-Clinic	96102	U4	U7			97.42

Definition of Service: Psychological testing consists of a face-to-face assessment of emotional functioning, personality, cognitive functioning (e.g. thinking, attention, memory) or intellectual abilities using an objective and standardized tool that has uniform procedures for administration and scoring and utilizes normative data upon which interpretation of results is based.

Psychological tests are only administered and interpreted by those who are properly trained in their selection and application. The practitioner administering the test ensures that the testing environment does not interfere with the performance of the examinee and ensures that the environment affords

adequate protections of privacy and confidentiality.

This service covers both the face-to-face administration of the test instrument(s) by a qualified examiner as well as the time spent by a psychologist or physician (with the proper education and training) interpreting the test results and preparing a written report.

Target Population	Individuals with a known or suspected mental health diagnosis and/or Substance-Related Disorder
Benefit Information	Requires a MICP Registration or MICP New Episode.
Utilization Criteria	<u>Available to those with LOCUS scores:</u> 1: Recovery Maintenance and Health Management 2: Low Intensity Community-Based Services 3: High Intensity Community-Based Services 4: Medically Monitored Non-Residential 5: Medically Monitored Community Residential 6: Medically Monitored Inpatient Residential
Ordering Practitioner	Physician, Psychologist, Physician's Assistant, Advanced Practice Registered Nurse (Clinical Nurse Specialist or Nurse Practitioner), LPC, LMFT, LCSW
Unit Value	1 hour
Initial Authorization	5 units
Re-Authorization	5 units
Maximum Daily Units	5 units
Authorization Period	180 days
UAS: Budget and Expense Categories	<u>Core Services Provider</u> 132 – Adult Mental Health 732 – Adult Addictive Diseases
Admission Criteria	1. A known or suspected mental illness or substance-related disorder; and 2. Initial screening/intake information indicates a need for additional undetermined supports and recovery/resiliency planning; and 3. Individual meets Core Customer eligibility.
Continuing Stay Criteria	The Individual's situation/functioning has changed in such a way that previous assessments are outdated.
Discharge Criteria	Each intervention is intended to be a discrete time-limited service that modifies treatment/support goals or is indicated due to change in illness/disorder.
Service Exclusions	None
Clinical Exclusions	None

Additional Service Criteria:

A. Required Components

1. There may be no more than one comprehensive battery of 96101 and 96102 provided to one individual within a year.
2. There may be no more than 10 combined hours of 96101 and 96012 provided to one individual within a year.

3. Any diagnosis given to an individual must come from persons identified in O.C.G.A Practice Acts as qualified to provide a diagnosis. These practitioners include a licensed psychologist, a physician or a PA or APRN (NP and CNS-PMH) working in conjunction with a physician with an approved job description or protocol.
4. "Out-of-Clinic" may only be billed when:
 - Travel by the practitioner is to a non-contiguous location; and/or
 - Travel by the practitioner is to a facility not owned, leased, controlled or named as a service site by the agency who is billing the service(excepting visits to Shelter Plus sites); and/or
 - Travel is to a facility owned, leased or controlled by the agency billing the service, but no more than 6 individuals are being served in the course of that day by a single practitioner in non-group services; and/or
 - Travel is to a facility owned, leased, controlled or named as a service site by the agency, but no more than 24 individuals are being served in groups at that site in the course of a day.If the service does not qualify to be billed as "out of clinic," then the "in-clinic" rate may still be billed.

B. Staffing Requirements

The following practitioners can perform Psychological Testing:

- Practitioner Level 2: Psychologist
- Practitioner Level 3: LCSW, LPC, LMFT in conjunction with Psychologist
- Practitioner Level 4: Psychologist's supervisee/trainee with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology, functioning within the scope of the practice acts of the state.

C. Clinical Operations

The individual consumer (and caregiver/responsible family members etc as appropriate) must actively participate in the assessment processes.

D. Service Access

1. Psychological Testing may **not** be provided in an Institution for Mental Diseases (IMD, e.g. state or private psychiatric hospital or Crisis Stabilization Unit with greater than 16 beds), jail, or prison system.
2. This service may not be provided and billed for individuals who are involuntarily detained awaiting criminal proceedings, penal dispositions, or other involuntary detention proceedings.

E. Additional Medicaid Requirements

These services are performed in accordance with GA Practice Acts.

F. Reporting & Billing Requirements

All other applicable Medicaid, MICP, ERO, and other DBHDD reporting requirements must be followed.

G. Documentation Requirements

1. Providers must document services in accordance with the specifications for documentation requirements specified in Part II, Section V of the Provider Manual.

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2. In addition to the authorization produced through this service, documentation of clinical assessment findings from this service should also be completed and placed in the individual's chart.

Service Plan Development							
HIPAA Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Service Plan Development	Practitioner Level 2, In-Clinic	H0032	U2	U6			\$38.97
	Practitioner Level 3, In-Clinic	H0032	U3	U6			\$30.01
	Practitioner Level 4, In-Clinic	H0032	U4	U6			\$20.30
	Practitioner Level 5, In-Clinic	H0032	U5	U6			\$15.13
	Practitioner Level 2, Out-of-Clinic	H0032	U2	U7			\$46.76
	Practitioner Level 3, Out-of-Clinic	H0032	U3	U7			\$36.68
	Practitioner Level 4, Out-of-Clinic	H0032	U4	U7			\$24.36
	Practitioner Level 5, Out-of-Clinic	H0032	U5	U7			\$18.15

Definition of Service: Individuals access this service when it has been determined through an assessment that the individual has mental health or addictive disease concerns. The Individualized Recovery Plan results from the Diagnostic and Behavioral Health Assessments and is required within the first 30 days of service, with ongoing plans completed as demanded by individual consumer need and/or by service policy.

Information from a comprehensive assessment should ultimately be used to develop with the individual an Individualized Recovery Plan that supports resilience and that is based on goals identified by the individual. Friends, family and other natural support resources may be included at the discretion and direction of the individual for whom services and supports are being planned. Also, as indicated, medical, nursing, peer support, community support, school, nutritional staff, etc. should provide information from records, and various multi-disciplinary assessments for the development of the Individualized Recovery Plan (IRP).

The Individualized Recovery Planning process includes the individual's perspective, and should include family and/or significant others as well as collateral agencies/treatment providers/relevant individuals.

The cornerstone component of the adult Individualized Recovery Plan (IRP) involves a discussion with the individual regarding what recovery means to him/her personally (e.g. getting/keeping a job, having more friends/improved relationships, improvement of behavioral health symptoms, etc.), and the development of goals (i.e. outcomes) and objectives that are defined by and meaningful to the individual based upon the individual's articulation of their recovery hopes. Concurrent with the development of the IRP, the individual should be offered the opportunity to develop an Advanced Directive for behavioral healthcare with the individual guiding the process through the free expression of their wishes and through his/her assessment of the components developed for the Advanced Directive as being realistic for him/her.

The entire process should involve the individual as a full partner and should focus on service and recovery goals/outcomes as identified by the individual.

Recovery planning shall set forth the course of care by:

- Prioritizing problems and needs;
- Stating goals which will honor achievement of stated hopes, choice, preferences and desired outcomes of the individual;
- Assuring goals/objectives are related to the assessment;
- Defining goals/objectives that are individualized, specific, and measurable with achievable timeframes;
- Defining discharge criteria and desired changes in levels of functioning and quality of life to objectively measure progress;
- Transition planning at onset of service delivery;
- Selecting services and interventions of the right duration, intensity, and frequency to best accomplish these objectives;
- Assuring there is a goal/objective that is consistent with the service intent; and
- Identifying qualified staff who are responsible and designated for the provision of services.

Target Population	Individuals with a known or suspected Mental Illness or Substance Related Disorders
Benefit Information	Available to all known or suspected Core Customers. Requires a MICP Registration or a MICP New Episode.
Utilization Criteria	<u>Available to those with LOCUS scores:</u> 1: Recovery Maintenance and Health Management 2: Low Intensity Community-Based Services 3: High Intensity Community-Based Services 4: Medically Monitored Non-Residential 5: Medically Monitored Community Residential 6: Medically Managed Residential
Ordering Practitioner	Physician, Psychologist, Physician's Assistant, Advanced Practice Registered Nurse (Clinical Nurse Specialist or Nurse Practitioner), LPC, LMFT, LCSW
Unit Value*	15 minutes
Initial Authorization*	32 units (Combined with H0031 – Behavioral Health Assessment)
Re-Authorization*	32 units (Combined with H0031 – Behavioral Health Assessment)
Maximum Daily Units*	24 units (Combined with H0031 – Behavioral Health Assessment)
Authorization Period*	180 days
UAS: Budget and Expense Categories	<u>Core Services Provider</u> 131 – Adult Mental Health 731 – Adult Addictive Diseases
Admission Criteria	1. A known or suspected mental illness or substance-related disorder; and 2. Initial screening/intake information indicates a need for additional undetermined supports and recovery/resiliency planning; and 3. Individual meets Core Customer eligibility.
Continuing Stay Criteria	The individual's situation/functioning has changed in such a way that previous assessments are outdated.

Discharge Criteria	Each intervention is intended to be a discrete time-limited service that modifies treatment/support goals or is indicated due to change in illness/disorder.
Service Exclusions	Assertive Community Treatment
Clinical Exclusions	None

**(unless authorized as a part of a specific “package” which changes the authorization parameters)*

Additional Service Criteria:

A. Required Components

1. The service plan must include elements articulated in the Documentation Guideline chapter in this Provider Manual.
2. “Out-of-Clinic” may only be billed when:
 - Travel by the practitioner is to a non-contiguous location; and/or
 - Travel by the practitioner is to a facility not owned, leased, controlled or named as a service site by the agency who is billing the service(excepting visits to Shelter Plus sites); and/or
 - Travel is to a facility owned, leased or controlled by the agency billing the service, but no more than 6 individuals are being served in the course of that day by a single practitioner in non-group services; and/or
 - Travel is to a facility owned, leased, controlled or named as a service site by the agency, but no more than 24 individuals are being served in groups at that site in the course of a day.

If the service does not qualify to be billed as "out of clinic," then the "in-clinic" rate may still be billed.

B. Staffing Requirements

The following practitioners can perform Service Planning:

- Practitioner Level 2: Psychologist, APRN, PA
- Practitioner Level 3: LCSW, LPC, LMFT, RN
- Practitioner Level 4: LMSW; LAPC; LAMFT; Psychologist/LCSW/LPC/LMFT’s supervisee/trainee with at least a Bachelor’s degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology, functioning within the scope of the practice acts of the state; MAC, CAC-II, CADC, CCADC, GCADC(II, III); CAC-I or Addiction Counselor Trainee with at least a Bachelor’s degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology (addictions counselors may only perform these functions related to treatment of addictive diseases).
- Practitioner Level 5: CAC-I, RADT (I, II, or III), Addiction Counselor Trainees with high school diploma/equivalent (practitioners at this level may only perform these functions related to treatment of addictive diseases).

C. Clinical Operations

1. The individual consumer (and any other consumer-identified natural supports) should actively participate in planning processes.

2. The Individualized Recovery Plan should be directed by the individual's personal recovery goals as defined by that individual.
3. Advanced Directive/crisis planning shall be directed by the individual served and their needs/wishes to the extent possible and clinically appropriate. Plans should not contain elements/components that are not agreeable to, meaningful for, or realistic for the youth/family and that the youth/family is, therefore, not likely to follow through with.
4. The Multipurpose Informational Consumer Profile (MICP) format for treatment planning does not meet the requirements for a comprehensive Individualized Recovery Plan and should not be used as such. Guidelines for treatment planning are contained in the "Documentation Guidelines" in Part II, Section V of this Manual and in the DBHDD Standards for Community Providers contained in this Provider Manual.

D. Service Access

1. Service Plan Development may **not** be provided in an Institution for Mental Diseases (IMD, e.g. state or private psychiatric hospital or Crisis Stabilization Unit with greater than 16 beds), jail, or prison system.
2. This service may not be provided and billed for individuals who are involuntarily detained awaiting criminal proceedings, penal dispositions, or other involuntary detainment proceedings.

E. Additional Medicaid Requirements

The daily maximum within a CSU for combined Behavioral Health Assessment and Service Plan Development is 24 units/day.

F. Reporting & Billing Requirements

All other applicable Medicaid, MICP, ERO, and other DBHDD reporting requirements must be followed.

G. Documentation Requirements

1. Providers must document services in accordance with the specifications for documentation requirements specified in Part II, Section V of the Provider Manual
2. The initial authorization/IRP and each subsequent authorization/IRP must be completed within the time-period specified by DBHDD.
3. Every record must contain an IRP in accordance with these Service Guidelines and with the DBHDD Standards contained in this Provider Manual.

Mental Health and Addictive Disease Services

Adults' SPECIALTY Benefit Package

Ambulatory Substance Abuse Detoxification							
HIPAA Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Alcohol And/Or Drug Services; Ambulatory Detoxification	Practitioner Level 2, In-Clinic	H0014	U2	U6			38.97
	Practitioner Level 3, In-Clinic	H0014	U3	U6			30.01
	Practitioner Level 4, In-Clinic	H0014	U4	U6			20.30

Definition of Service: This service is the medical monitoring of the physical process of withdrawal from alcohol or other drugs in an outpatient setting for those individuals with an appropriate level of readiness for behavioral change and level of community/social support. It is indicated when the individual experiences physiological dysfunction during withdrawal, but life or significant bodily functions are not threatened.

This service must reflect ASAM (American Society of Addiction Medication) Levels I-D (Ambulatory Without Extended On-Site Monitoring) and II-D (Ambulatory With Extended Onsite Monitoring) and focuses on rapid stabilization and entry into the appropriate level of care/treatment based upon the ASAM guidelines placement criteria. These services may be provided in traditional Outpatient, Intensive Outpatient, Day Treatment, Intensive Day Treatment or other ambulatory settings.

Target Population	Adults and Older Adolescents with a diagnosis of one of the following: 303.00 291.81 291.0 292.89 292.0
Benefit Information	Available to Core Customers in need of Ongoing Services Requires MICP New Episode Request or Update Request (to add as a single service to an existing authorization).
Utilization Criteria	<u>Available to those with LOCUS scores:</u> 4: Medically-monitored Non-Residential
Ordering Practitioner	Physician, Physician's Assistant, Advanced Practice Registered Nurse (Clinical Nurse Specialist or Nurse Practitioner)
Unit Value	15 minutes
Initial Authorization	60 units
Re-Authorization	60 units
Maximum Daily Units	32 units
Authorization Period	30 days
UAS: Budget and Expense Categories	Addictive Disease Detoxification Services Provider 766 – Adult Addictive Diseases 866- C&A Addictive Diseases (for older adolescents)
Admission Criteria	Individual has a Substance Related Disorder (ASAM PPC-2, Dimension-1) that is incapacitating, destabilizing or distressing. If the severity is incapacitating, there must be sufficient optimization in other dimensions of

	<p>the individual's life to provide for safe detoxification in an outpatient setting, and individual meets the following three criteria:</p> <ol style="list-style-type: none"> 1. Individual is experiencing signs and symptoms of withdrawal, or there is evidence (based on history of substance intake, age, gender, previous withdrawal history, present symptoms, physical condition, and/or emotional/behavioral condition) that withdrawal is imminent; and the individual is assessed to be at minimal (Level I-D) to moderate (Level II-D) risk of severe withdrawal syndrome outside the program setting and can safely be managed at this service level; and 2. Individual has no incapacitating physical or psychiatric complications that would preclude ambulatory detoxification services; and 3. Individual is assessed as likely to complete needed detoxification and to enter into continued treatment or self-help recovery as evidenced by: 1) Individual or support persons clearly understand and are able to follow instructions for care, and 2) Individual has adequate understanding of and expressed interest to enter into ambulatory detoxification services, or 3) Individual has adequate support services to ensure commitment to completion of detoxification and entry into ongoing treatment or recovery, or 4) Individual evidences willingness to accept recommendations for treatment once withdrawal has been managed.
Continuing Stay Criteria	Individual's withdrawal signs and symptoms are not sufficiently resolved so that the individual can participate in self-directed recovery or ongoing treatment without the need for further medical or detoxification monitoring.
Discharge Criteria	<ol style="list-style-type: none"> 1. Adequate continuing care plan has been established; and one or more of the following; 2. Goals of the Individualized Recovery Plan have been substantially met; or 3. Individual/family requests discharge and individual is not imminently dangerous; or 4. Withdrawal signs and symptoms have failed to respond to treatment and have intensified (as confirmed by higher scores on CIWA-Ar or other comparable standardized scoring system) such that transfer to a more intensive level of detoxification service is indicated, or 5. Individual has been unable to complete Level I-D/II-D despite an adequate trial.
Service Exclusions	ACT, Nursing Assessment and Medication Administration (Medication administered as a part of Ambulatory Detoxification is not to be billed separately as Medication Administration.)
Clinical Exclusions	<ol style="list-style-type: none"> 1. Substance Abuse issue has incapacitated the individual in all aspects of daily living, there is resistance to treatment as in ASAM Dimension 4, relapse potential is high (Dimension 5), and the recovery environment is poor (Dimension 6). 2. Concomitant medical condition and/or other behavioral health issues warrant inpatient/residential treatment. 3. This service code does not cover detoxification treatment for cannabis, amphetamines, cocaine, hallucinogens and phencyclines.

Additional Service Criteria:

A. Required Components

1. This service must be licensed by DCH/HFR under the Rules and Regulations for Drug Abuse Treatment Programs, 290-4-2.
2. A physician's order in the individual's record is required to initiate ambulatory detoxification services. Verbal orders or those initiated by a Physician's Assistant or Clinical Nurse Specialist are acceptable provided the physician signs them within 24 hours or the next working day.
3. Programmatic philosophy must reflect emphasis on the development of a Plan of Care, which provides services in the least restrictive most empowering setting. This is an essential consideration for each individual's plan of care. This empowers individuals by fostering independence.

B. Staffing Requirements

1. Services must be provided under supervision of a physician.
 - a. The following individuals can provide Alcohol and/or drug services, Ambulatory Detoxification:
 - Practitioner Level 1: Physician/Psychiatrist (may be billed at the Level 2 rate or under any evaluation service encompassed under the Psychiatric Treatment service group)
 - Practitioner Level 2: PA or APRN
 - Practitioner Level 3: Registered Nurse (RN)
 - Practitioner Level 4: Licensed Practical Nurse (LPN)

C. Clinical Operations

1. The severity of the individual's symptoms, level of supports needed, and the physician's authorization for the service will determine the setting, as well as the amount of nursing and physician supervision necessary during the withdrawal process. The individual may or may not require medication, and 24-hour nursing services are not required. However, there is a contingency plan for "after hours" concerns/emergencies.
2. Individuals receiving this service must have a qualifying diagnosis present in the medical record prior to the initiation of services. The diagnosis must be given by persons identified in O.C.G.A Practice Acts as qualified to provide a diagnosis. These practitioners include a licensed psychologist, a physician or a PA or APRN (NP and CNS-PMH) working in conjunction with a physician with an approved job description or protocol.
3. In order for this service to have best practice impact, the Individualized Recovery/Resiliency Plan should consider group and individual counseling and training to fully support recovery.

D. Service Access

E. Additional Medicaid Requirements

Currently, there are no additional Medicaid requirements to be added to the requirements above when billing Medicaid for this service.

F. Reporting & Billing Requirements

All applicable Medicaid, MICP, ERO, and other DBHDD reporting requirements must be met.

G. Documentation Requirements

Providers must document services in accordance with the specifications for documentation requirements specified in Part II, Section V of the Provider Manual.

Assertive Community Treatment							
HIPAA Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Assertive Community Treatment	Practitioner Level 1, In-Clinic	H0039	U1	U6			\$32.46
	Practitioner Level 2, In-Clinic	H0039	U2	U6			\$32.46
	Practitioner Level 3, In-Clinic	H0039	U3	U6			\$32.46
	Practitioner Level 4, In-Clinic	H0039	U4	U6			\$32.46
	Practitioner Level 5, In-Clinic	H0039	U5	U6			\$32.46
	Practitioner Level 1, Out-of-Clinic	H0039	U1	U7			\$32.46
	Practitioner Level 2, Out-of-Clinic	H0039	U2	U7			\$32.46
	Practitioner Level 3, Out-of-Clinic	H0039	U3	U7			\$32.46
	Practitioner Level 4, Out-of-Clinic	H0039	U4	U7			\$32.46
	Practitioner Level 5, Out-of-Clinic	H0039	U5	U7			\$32.46
	Practitioner Level 1, Via interactive audio and video telecommunication systems	H0039	GT	U1			\$32.46
	Practitioner Level 2, Via interactive audio and video telecommunication systems	H0039	GT	U2			\$32.46
	Multidisciplinary Team Meeting	H0039	HT				\$0

Definition of Service: As described in the NAMI Manual for ACT, this is an Evidence Based Practice that is client-centered, recovery-oriented, and a highly intensive community based service for individuals who have severe and persistent mental illness. The individual's mental illness has significantly impaired his or her functioning in the community. The individual has been unsuccessfully treated in the traditional mental health service system because of his/her high level of mental health acuity. The use of the traditional clinic based services for the individual in the past or present have usually been greater than 8 hours of service per month. The recipient may have experienced chronic homelessness and/or criminal justice involvement; and may have had multiple and/or extended stays in state psychiatric/public hospitals. ACT provides a variety of interventions twenty-four (24) hours, seven days a week. The service utilizes a multidisciplinary mental health team from the fields of psychiatry, nursing, psychology, social work, substance abuse, and vocational rehabilitation; additionally, a Certified Peer Specialist is an active member of the ACT Team providing assistance with the development of natural supports, promoting socialization, and the strengthening of community living skills. The ACT Team works as one organizational unit providing community based interventions that are rehabilitative, intensive, integrated, and stage specific. Services emphasize social inclusiveness through relationship building and the active involvement in assisting individuals to achieve a stable and structured life style. The service providers must develop programmatic goals that clearly articulate the use of best/evidence-based practices for

ACT recipients using co-occurring and trauma-informed service delivery and support. Practitioners of this service are expected to maintain knowledge and skills according to the current research trends in best/evidence-based practices. ACT is a unique treatment model in which the majority of mental health services are directly provided internally by the ACT program in the recipient's natural environment. ACT services are individually tailored with each consumer to address his/her preferences and identified goals, which are the basis of the Individualized Recovery Plan. Based on the needs of the individual, services may include (in addition to those services provided by other systems):

1. Assistance to facilitate the individual's active participation in the development of the Individualized Recovery Plan (IRP);
2. Psycho educational and instrumental support to individuals and their identified family;
3. Crisis planning, Wellness Recovery Action Plan (WRAP), assessment, support and intervention;
4. Psychiatric assessment and care; nursing assessment and care; psychosocial and functional assessment which includes identification of strengths, skills, resources and needs;
5. Curriculum-based group treatment;
6. Individualized interventions, which may include:
 - a. Identification, with the consumer, of barriers that impede the development of skills necessary for independent functioning in the community; as well as existing strengths which may aid the individual in recovery and goal achievement;
 - b. Support to facilitate recovery (including emotional/therapeutic support/assistance with defining what recovery means to the individual in order to assist individual with recovery-based goal setting and attainment);
 - c. Service and resource coordination to assist the individual with the acquisition and maintenance of recovery capital (i.e. gaining access to necessary internal and external rehabilitative, medical and other services) required for recovery initiation and self-maintenance;
 - d. Family counseling/training for individuals and their families (as related to the person's IRP);
 - e. Assistance to develop both mental illness and physical health symptom monitoring and illness self-management skills in order to identify and minimize the negative effects of symptoms which interfere with the individual's daily living (may include medication administration and/or observation and assistance with self- medication motivation and skills) and to promote wellness;
 - f. Assistance with accessing entitlement benefits and financial management skill development;
 - g. Motivational assistance to develop and work on goals related to personal development and school or work performance;
 - h. Substance abuse counseling and intervention (e.g. motivational interviewing, stage based interventions, refusal skill development, cognitive behavioral therapy, psycho educational approaches, instrumental support such as helping individual relocate away from friends/neighbors who influence drug use, relapse prevention planning and techniques etc);
 - i. Individualized, restorative one-to-one psychosocial rehabilitation and skill development, including assistance in the development of interpersonal/social and community coping and functional skills (i.e. adaptation/functioning in home, school and work environments);
 - j. Psychotherapeutic techniques involving the in depth exploration and treatment of interpersonal and intrapersonal issues, including trauma issues; and

- k. Any necessary monitoring and follow-up to determine if the services accessed have adequately met the individual's needs.

Individuals receiving this intensive level of community support are expected to experience increased community tenure and decreased frequency and/or duration of hospitalization/crisis services. Through individualized, team-based supports, it is expected that individuals will achieve housing stability, decreased symptomatology (or a decrease in the debilitating effects of symptoms), improved social integration and functioning, and increased movement toward self-defined recovery.

Target Population	Adults with Serious and Persistent Mental Illness, Adult with Co-Occurring Substance Related Disorders and Serious and Persistent Mental Illness Adults with Co-Occurring Serious and Persistent Mental Illness and MR/DD
Benefit Information	Available to Core Customers in need of Ongoing Services Requires MICP New Episode Request or Update Request (to add as a single service to an existing authorization).
Utilization Criteria	<u>Available to those with LOCUS scores:</u> 4: Medically Monitored Non-Residential 5: Medically Monitored Community Residential (transition) 6: Medically Managed Residential (transition)
Ordering Practitioner	Physician, Physician's Assistant, Advanced Practice Registered Nurse (Clinical Nurse Specialist or Nurse Practitioner)
Unit Value	15 minutes
Initial Authorization	240 units
Re-Authorization	240 units
Maximum Daily Units	96 units
Authorization Period	180 days
UAS: Budget and Expense Categories	<u>Intensive Treatment Services Provider</u> 152 – Adult Mental Health
Admission Criteria	<ol style="list-style-type: none"> 1. Individuals with severe and persistent mental illness that seriously impairs the ability to live in the community. Priority is given to people recently discharged from an institutional setting with schizophrenia, other psychotic disorders, or bipolar disorder, because these illnesses more often cause long-term psychiatric disability. <li style="text-align: center;">and 2. Individuals with significant functional impairments as demonstrated by the need for assistance in 3 or more of the following areas which despite support from a care giver or behavioral health staff continues to be an area that the individual cannot complete: <ol style="list-style-type: none"> a. Maintaining personal hygiene; b. Meeting nutritional needs; c. Caring for personal business affairs; d. Obtaining medical, legal, and housing services; e. Recognizing and avoiding common dangers or hazards to

	<p>self and possessions;</p> <ul style="list-style-type: none"> f. Persistent or recurrent failure to perform daily living tasks except with significant support or assistance from others such as friends, family, or relatives; g. Employment at a self-sustaining level or inability to consistently carry out homemaker roles (e.g., household meal preparation, washing clothes, budgeting or childcare tasks and responsibilities); h. Maintaining a safe living situation (e.g., evicted from housing, or recent loss of housing, or imminent risk of loss of housing). <p style="text-align: center;">and</p> <ul style="list-style-type: none"> 3. Past (within 180 days of admission) or current response to other community-based intensive behavioral health treatment has shown minimal effectiveness (e.g. Psychosocial Rehabilitation, CSI, etc).[*] Admission documentation must include evidence to support this criterion. 4. Individuals with two or more of the following issues that are indicators of continuous high-service needs (i.e., greater than 8 hours of service per month): <ul style="list-style-type: none"> a. High use of acute psychiatric hospitals or crisis/emergency services including mobile, in-clinic or crisis residential (e.g., 3 or more admissions in a year) or extended hospital stay (60 days in the past year) or psychiatric emergency services. b. Persistent, recurrent, severe, or major symptoms that place the individual at risk of harm to self or others (e.g., command hallucinations, suicidal ideations or gestures, homicidal ideations or gestures, self harm). c. Coexisting substance use disorder of significant duration (e.g., greater than 6 months) or co-diagnosis of substance abuse. d. High risk for or a recent history of criminal justice involvement related to mental illness (e.g., arrest and incarceration). e. Chronically homeless (e.g., 1 extended episode of homelessness for a year, or 4 episodes of homelessness within 3 years). f. Residing in an inpatient bed (i.e., state hospital, community hospital, CSU) or in a supervised community residence, but clinically assessed to be able to live in a more independent living situation if intensive services are provided, or requiring a residential or institutional placement if more intensive services are not available. g. Inability to participate in traditional clinic-cased services (must provide evidence of multiple agency trials if this is the only requirement met on the list). <p>[*] If the individual meets one or more of the criteria below, criteria #3 above is waived. All other requirements (criterion 1, 2, & 4) must be met:</p> <ul style="list-style-type: none"> a. Individual is transitioning from a state forensic unit or group home on a Conditional Release order; or b. Within the last 180 days, the individual has been incarcerated 2 or more times related to a behavioral health condition; or c. Within the last 180 days, individual has been admitted to a psychiatric hospital or crisis stabilization unit 2 or more times.
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<p>Continuing Stay Criteria</p>	<p>Individual meets two (2) or more of the requirements below:</p> <ol style="list-style-type: none"> 1. Individual has been admitted to an inpatient psychiatric hospital and/or received crisis intervention services one or more times in the past six (6) months; 2. Individual has had contact with Police/Criminal Justice System due to behavioral health problems in the past six (6) months; 3. Individual has displayed inability to maintain stable housing in the community due to behavioral health problems during the past six (6) months; 4. Individual continues to demonstrate significant functional impairments and/or difficulty developing a natural support system which allows for consistent maintenance of medical, nutritional, financial, and legal responsibilities without incident in the past six (6) months; 5. Individual has displayed persistent, recurrent, severe, or major symptoms that place him/her at risk of harm to self or others (e.g. command hallucinations, suicidal ideation or gestures, homicidal ideation or gestures, self harm) in the past six (6) months.
<p>Discharge Criteria</p>	<ol style="list-style-type: none"> 1. An adequate continuing care plan has been established; and one or more of the following: <ol style="list-style-type: none"> a. Individual no longer meets admission criteria; or b. Goals of the Individualized Recovery Plan have been substantially met; or c. Individual requests discharge and is not in imminent danger of harm to self or others, or d. Transfer to another service/level of care is warranted by a change in individual's condition, or e. Individual requires services not available in this level of care.
<p>Service Exclusions</p>	<ol style="list-style-type: none"> 1. ACT is a comprehensive team intervention and most services are excluded, with the exceptions of <ul style="list-style-type: none"> • Peer Supports, • Residential Supports, • Community Transition Planning (to be utilized as a person is transitioning to/from an inpatient setting, jail, or CSP) • Group Training/Counseling (within parameters listed in Section A), and • Supported Employment • Psychosocial Rehabilitation 2. On an individual basis, up to four (4) weeks of some services may be provided to ACT consumers to facilitate a smooth transition from ACT to these other community services. A transition plan must be adequately documented in the Individualized Recovery Plan and clinical record. These services are: <ul style="list-style-type: none"> • Community Support • Behavioral Health Assessment • Service Plan Development

	<ul style="list-style-type: none"> • Diagnostic Assessment • Physician Assessment (specific to engagement only) • Individual Counseling (specific to engagement only) <p>3. ACT recipients who also receive a DBHDD Residential Service may not receive ACT-provided skills training which is a part of the “residential” service. The ACT provider shall be in close coordination with the Residential provider such that there is no duplication of services supports/efforts.</p> <p>4. Those receiving Medicaid DD Waivers are excluded from the service.</p>
Clinical Exclusions	<p>Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of psychiatric condition overlaying the primary diagnosis: mental retardation, autism, organic mental disorder, substance-related disorder.</p>

Additional Service Criteria:

A. Required Components

1. Assertive Community Treatment must include a comprehensive and integrated set of medical and psychosocial services provided in non-office settings 80% of the time by a mobile multidisciplinary team. The team must provide community support services interwoven with treatment and rehabilitative services and regularly scheduled team meetings which will be documented in the served individual’s medical record.
2. Ideally, and in accordance with the Dartmouth Assertive Community Treatment Scale (DACTS), the Treatment Team Meeting must be held a minimum of 4 times a week with time dedicated to discussion of support to a specific individual, and documentation in the log of the Treatment Team Meetings as indicated in Section G. Each consumer must be discussed, even if briefly, in each Treatment Team Meeting. The Treatment Team Meetings are to review the status of all consumers and the outcome of the most recent staff contacts, develop a master staff work schedule for the day’s activities, and all ACT team members are expected to attend; exception of nonattendance can be made and documented by the Team Leader. Effective 7/1/11, the psychiatrist must participate at least one time/week in the ACT team meetings.
3. In accordance with NAMI ACT best practice, each ACT team will identify an Individual Treatment Team (ITT) for each enrolled ACT consumer.
4. Services and interventions must be individually tailored to the needs, goals, preferences and assets of the individual with the goals of maximizing independence and recovery as defined by the consumer.
5. At least 80% of all service units must involve face-to-face contact with consumers. Eighty percent (80%) or more of face-to-face service units must be provided outside of program offices in locations that are comfortable and convenient for consumers (including the individual’s home, based on individual need and preference and clinical appropriateness).
6. During the course of treatment, it is recommended that the ACT Team provide for some individuals at least 5 face-to-face contacts per week based on the persons mental health acuity. However, all individuals participating in ACT must receive a minimum of 12 face-to-face contacts per month. The Team must see each individual at least once a month for symptom assessment/management and management of medications.
7. During discharge transition, it is recommended that the ACT Team provide at least 3 face-to-face contacts per week for most individuals on an ongoing basis. All individuals participating in ACT

transitioning must receive a minimum of 4 face-to-face contacts per month. The Team must see each individual at least once a month for symptom assessment/management and medication management.

8. Service may be delivered by a single team member to 2 ACT consumers at the same time if their goals are compatible, however, this cannot be a standard practice. Services cannot be offered to more than 2 individuals at a time (exception: Item A.8.).
9. ACT recipients can receive limited Group Training/Counseling (up to 8 units/week) when a curriculum-based therapeutic group is offered such as Dialectical Behavioral Therapy (DBT), Motivational Enhancement, or Integrative Dual Diagnosis Treatment (IDDT). For this to be allowable, the ACT participants must have clinical needs and recovery goals that justify intervention by staff trained in the implementation of the specific curriculum-based therapy.
 - a. This group may be offered to no more than 10 ACT participants at one time and must be directed by no fewer than 2 staff in order to be billed as a Group.
 - b. This group contains no less than 3 consumers and no more than 10 consumers.
 - c. Only ACT consumers are permitted to attend these group services.
 - d. Acceptable group practitioners are those on the ACT team who meet the practitioner levels as follows:
 - Practitioner Level 1: Physician/Psychiatrist
 - Practitioner Level 2: Psychologist, CNS-PMH
 - Practitioner Level 3: LCSW, LPC, LMFT, RN
 - Practitioner Level 4: LMSW; LAPC; LAMFT; Psychologist/LCSW/LPC/LMFT's supervisee/trainee with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology, functioning within the scope of the practice acts of the state; MAC, CAC-II, CADC, CCADC, GCADC (II, III); CAC-I or Addiction Counselor Trainees with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology (may only perform these functions related to treatment of addictive diseases).
 - Practitioner Level 5: CAC-I, RADT (I, II, or III), Addiction Counselor Trainees with high school diploma/equivalent (practitioners at this level may only perform these functions related to treatment of addictive diseases).
 - e. ACT groups must be led by more than one practitioner.
 - i. If there are 2 practitioners leading the group who are the same practitioner level (i.e. two U3 practitioners), then each may split the responsibility for documentation and singly sign a note. In this situation, there must be evidence in the note of who was the co-leader of that group to document the compliance expectations for two practitioners.
 - ii. If a group is facilitated by two practitioners who are not the same U-level (i.e. one is a U3 and one is a U4), then these co-leaders may split the responsibility for documenting group progress notes. If the lower-leveled practitioner writes the progress note, the upper level person's practitioner level can be billed if the higher practitioner-leveled person co-signs the note. If the higher level practitioner writes the note, then he/she shall document the co-leaders participation and can solely sign that note.
9. "Out-of-Clinic" may only be billed when:

- Travel by the practitioner is to a non-contiguous location; and/or
 - Travel by the practitioner is to a facility not owned, leased, controlled or named as a service site by the agency who is billing the service(excepting visits to Shelter Plus sites); and/or
 - Travel is to a facility owned, leased or controlled by the agency billing the service, but no more than 6 individuals are being served in the course of that day by a single practitioner in non-group services; and/or
 - Travel is to a facility owned, leased, controlled or named as a service site by the agency, but no more than 24 individuals are being served in groups at that site in the course of a day.
- If the service does not qualify to be billed as "out of clinic," then the "in-clinic" rate may still be billed.

A. Staffing Requirements

1. The following practitioners can provide Assertive Community Treatment:
 - Practitioner Level 1: Physician/Psychiatrist
 - Practitioner Level 2: Psychologist, APRN, PA
 - Practitioner Level 3: LCSW, LPC, LMFT, RN
 - Practitioner Level 4: LMSW; LAPC; LAMFT; Psychologist/LCSW/LPC/LMFT's Supervisee/trainee with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology, functioning within the scope of the practice acts of the state; MAC, CAC-I, CAC-II, CADC, CCADC, GCADC (II, III); PP, CPRP, CPS, or Addiction Counselor Trainees with Master's or Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology (addictions counselors may only perform counseling functions related to treatment of addictive diseases).
 - Practitioner Level 5: CPS, PP, CPRP, CAC-I, RADT (I, II, or III), Addiction Counselor Trainees with high school diploma/equivalent under supervision of one of the licensed/credentialed professionals above
2. Assertive Community Treatment Team members must include:
 - (1 FT Employee required) A fulltime Team Leader who is the clinical and administrative supervisor of the team and also functions as a practicing clinician on the team; this individual must have at least 2 years of documented experience working with adults with a SPMI and one of the following qualifications to be an "independently licensed practitioner." It is expected that the practicing ACT Team Leader provides direct services at least 50% of the time. The Team Leader must be a FT employee and dedicated to only the ACT team.
 - Physician
 - Psychologist
 - Physician's Assistant
 - APRN
 - RN with a 4-year BSN
 - LCSW
 - LPC
 - LMFT
 - (Variable:.4-1.0 FTE required) Depending on consumer enrollment, a full or part time Psychiatrist who:
 - provides clinical and crisis services to all team consumers with emphasis in delivering services in the recipient's natural environment,
 - works with the team leader to monitor each individual's clinical and medical status and response to treatment, and

- directs psychopharmacologic and medical treatment (at a minimum, must provide monthly medication management for each consumer),
- must provide a minimum of 16 hours per week of direct support to the ACT team/ACT consumers
- the psychiatrist must participate in at least one time/week in the ACT team meetings

The psychiatrist to ACT consumer ratio must not be greater than 1:100 and the psychiatrist. Thus, with 1-50 consumers, the requirement for the agency is to have a Psychiatrist at least 16 hours per week providing support to the team consumers. Effective 01/01/12, with 51-75 consumers, the ACT agency must have .75 FTE psychiatrist providing support to the team and with 76-100 consumers, the ACT agency must have 1 FTE psychiatrist providing support to the team.

- (1 Fulltime Employee) One Registered Nurse per 1-50 consumers who provides nursing services for all consumers, including health and psychiatric assessments, education on adherence to treatment, prevention of medical issues, rehabilitation, nutritional practices, and works with the team to monitor each individual's overall physical health and wellness, clinical status and response to treatment. Effective 01/01/12, the ACT agency must employ a second RN in order to meet full-fidelity. The second RN is expected to work .75 FTE when the agency serves 51-75 consumers and, with 76- 100 consumers, the second RN is expected to work 1 FTE.
 - (1/2 FTE minimum) A 1/2 to fulltime equivalent substance abuse practitioner who holds a CACI (or an equally recognized SA certification equivalent or higher) and assesses the need for and provides and/or accesses substance abuse treatment and supports for team consumers. If any single team serves 50 or more individuals with a co-occurring SA issue, then there must be 1 FTE on the team.
 - (1 FT employee) A full-time practitioner licensed to provide psychotherapy/counseling under the practice acts or a person with an associate license who is supervised by a fully licensed clinician, and provides individual and group support to team consumers (this position is in addition to the Team Leader).
 - (1 FTE) One FTE Certified Peer Specialist who is fully integrated into the team and promotes consumer self-determination and decision-making and provides essential expertise and consultation to the entire team to promote a culture in which each client's point of view and preferences are recognized, understood, respected and integrated into treatment, rehabilitation and community self-help activities.
 - (2 FTEs) Two paraprofessional mental health workers who provide rehabilitation and support services under the supervision of a Licensed Clinician. The sum of the FTE counts for the following two bullets must equal 2 FTEs.
 - (1/2 to 1 FTE) One of these staff must be a Vocational Rehabilitation Specialist. A VRS is a person with a minimum of one year verifiable vocational rehabilitation experience. This person may be a ½ FTE if the team serves less than 50 individuals.
 - (1 to 1 ½) FTE Other Paraprofessional
3. It is critical that ACT team members build a sound relationship with and fully engage in supporting the served individuals. To that end, no more than 1/3 of the team can be "contracted"/1099 team members.
4. The ACT team maintains a small consumer-to-clinician ratio, of no more than 10 consumers per staff member. This does not include the psychiatrist, program assistant/s, transportation staff, or

administrative personnel. Staff-to-consumer ratio takes into consideration evening and weekend hours, needs of special populations, and geographical areas to be served.

5. Documentation must demonstrate that all team members are engaged in the support of each consumer served by the team including the "time-in" and "time-out" for each staff intervention (excluding the SAP if substance related issues have been ruled out).
6. At least one ACT RN must be dedicated to a single ACT team. "Dedicated" means that the RN works with only one team at least 32 hours/week (up to 40 hours/week) and is a full-time employee of the agency (not a subcontractor/1099 employee). The Team RN must be dedicated to a single ACT team. "Dedicated" means that the team leader works with only one team at least 32 hours/week (up to 40 hours/week) and is a full-time employee of the agency (not a subcontractor/1099 employee). See also B.2., bullet 3.

B. Clinical Operations

1. Individuals receiving this service must have a qualifying diagnosis present in the medical record prior to the initiation of services. The verified diagnosis must be given by persons identified in O.C.G.A Practice Acts as qualified to provide a diagnosis. These practitioners include a licensed psychologist, a physician or a PA or APRN (NP and CNS-PMH) working in conjunction with a physician with an approved job description or protocol.
2. ACT Teams must incorporate assertive engagement techniques to identify, engage, and retain the most difficult to engage consumers which include using street outreach approaches and legal mechanisms such as outpatient commitment and collaboration with parole and probation officers.
3. Because ACT-eligible individuals may be difficult to engage, the initial treatment/recovery plan for an individual may be more generic at the onset of treatment/support. It is expected that the treatment plan be individualized and recovery-oriented after the team becomes engaged with the individual and comes to know the individual. The allowance for "generic" content of the IRP shall not extend beyond one initial authorization period.
4. Because many individuals served may have a mental illness and co-occurring addiction disorder, the ACT team may not discontinue services to any individual based solely upon a relapse in his/her addiction recovery.
5. ACT Teams must be designed to deliver services in various environments, such as homes, schools, homeless shelters, and street locations. The provider should keep in mind that individuals may prefer to meet staff at a community location other than their homes or other conspicuous locations (e.g. their place of employment or school), especially if staff drive a vehicle that is clearly marked as a state or agency vehicle, or if staff must identify themselves and their purpose to gain access to the individual in a way that may potentially embarrass the individual or breach the individual's privacy/confidentiality. Staff should be sensitive to and respectful of individuals' privacy/confidentiality rights and preferences in this regard to the greatest extent possible (e.g. if staff must meet with an individual during their work time, mutually agree upon a meeting place nearby that is the least conspicuous from the individual's point of view).
6. The organization must have policies that govern the provision of services in natural settings and can document that it respects consumers' and/or families' right to privacy and confidentiality when services are provided in those settings.
7. Each ACT provider must have policies and procedures governing the provision of outreach services, including methods for protecting the safety of staff that engage in outreach activities.
8. The organization must have established procedures/protocols for handling emergency and crisis situations that describe methods for supporting and handling individuals who require psychiatric hospitalization and/or crisis stabilization.

9. The organization must have an Assertive Community Treatment Organizational Plan that addresses the following descriptions:
 - a. Particular rehabilitation, recovery and resource coordination models utilized, types of intervention practiced, and typical daily schedule for staff
 - b. Staffing pattern and how staff are deployed to assure that the required staff-to-consumer ratios are maintained, including how unplanned staff absences, illnesses, and emergencies are accommodated
 - c. Hours of operation, the staff assigned, and types of services provided to consumers, families, and/or guardians
 - d. How the plan for services is modified or adjusted to meet the needs specified in the Individualized Recovery Plan
 - e. Inter-team communication plan regarding consumer support (e.g., e-mail, team staffings, staff safety plan such as check-in protocols etc.)
 - f. A physical health management plan
 - g. How the organization will integrate consumers into the community including assisting consumers in preparing for employment
 - h. How the organization (team) will respond to crisis for individuals served.
10. The ACT team is expected to work with informal support systems at least 2 to 4 times a month with or without the consumer present to provide support and skill training as necessary to assist the consumer in his or her recovery (i.e., family, landlord, employers, probation officers). If the consumer is not an engaged participant in this contact, the service shall not be billed.
11. For the individuals which the ACT team supports, the ACT team must be involved in all hospital admissions and hospital discharges. The agency will be reviewed for fidelity by the standard that the ACT team will be involved with 95% of all hospital admissions and hospital discharges. This is evidenced by documentation in the clinical record for the individual.
12. The entire ACT team is responsible for completing the ACT Comprehensive Assessment for newly enrolled consumers. The ACT Comprehensive Assessment results from the information gathered and analyzed are used to establish immediate and longer-term service needs with each consumer and to set goals and develop the first individualized treatment plan. Because of the complexity of the mental illness and the need to build trust with the served individual, the comprehensive mental health, addiction, and functional assessments may take up to 60 days. Enrolled consumers will be re-assessed at 6 month intervals from date of completion of the comprehensive assessment. It is expected that when a person identifies and allows his/her natural supports to be partners in recovery that they will be fully involved in assessment activities and ACT team documentation will demonstrate this participation. The ACT Comprehensive Assessment shall (at a minimum) include:
 - a. Psychiatric History, Mental Status/Diagnosis
 - b. Physical Health
 - c. Substance Abuse assessment
 - d. Education and Employment
 - e. Social Development and Functioning
 - f. Family Structure and Relationships
13. Treatment and recovery support to the individual is provided in accordance with a Treatment Plan. Treatment Planning shall be in accordance with the following:
 - a. The Individual Treatment Team (ITT) is responsible for providing much of the consumer's treatment, rehabilitation, and support services and is charged with the development and continued adaptation of the person's recovery plan (along with that person as an active participant). The ITT is a group or combination of three to five ACT staff members who

together have a range of clinical and rehabilitation skills and expertise. The ITT members are assigned by the team leader to work collaboratively with a consumer and his/her family and/or natural supports in the community by the time of the first treatment planning meeting or thirty days after admission. The core members are the primary practitioner and at least one clinical or rehabilitation staff person who shares case coordination and service provision tasks for each consumer. ITT members are assigned to take separate service roles with the consumer as specified by the consumer and the ITT in the treatment plan.

- b. The Treatment Plan Review is a thorough, written summary describing the consumer's and the ITT's evaluation of the consumer's progress/goal attainment, the effectiveness of the interventions, and satisfaction with services since the last person-centered treatment plan.
 - c. Treatment Planning Meeting is a regularly scheduled meeting conducted under the supervision of the team leader and the psychiatric prescriber. The purpose of these meetings is for the staff, as a team, and the consumer and his/her family/natural supports, to thoroughly prepare for their work together. The group meets together to present and integrate the information collected through assessment in order to learn as much as possible about the consumer's life, his/her experience with mental illness, and the type and effectiveness of the past treatment they have received. The presentations and discussions at these meetings make it possible for all staff to be familiar with each consumer and his/her goals and aspirations and for each consumer to become familiar with each ITT staff person. The treatment plan shall be reevaluated and adjusted accordingly via the Treatment Planning Meeting prior to each reauthorization of service (Documentation is guided by elements G.2. and G.3. below).
14. Effective July 1, 2011, each ACT team shall stagger consumer admissions from (e.g., 4-6 consumers per month) to gradually build up capacity to serve no more than 70-100 consumers.
 15. It is expected that 90% or more of the consumers have face to face contact with more than one staff member in a 2 week period.

C. Service Accessibility

1. Services must be available by ACT Team staff skilled in crisis intervention 24 hours a day, 7 days a week with emergency response coverage, including psychiatric services. Answering devices/services/Georgia Crisis and Access Line do not meet the expectation of "emergency response."
2. The team must be able to rapidly respond to early signs of relapse and decompensation and must have the capability of providing multiple contacts daily to individuals in acute need.
3. An ACT staff member must provide this on-call coverage.
4. There must be documented evidence that service hours of operation include evening, weekend and holiday hours.
5. Telemedicine is the use of medical information exchanged from one site to another via electronic communications to improve a patient's health. Electronic communication means the use of interactive telecommunications equipment that includes, at a minimum, audio and video equipment permitting two-way, real time interactive communication between the patient, and the physician or practitioner at the distant site. The ACT Physician may use telemedicine to provide this service by using the code above with the GT modifier. Telemedicine is not to be utilized as the primary means of delivery of psychiatric services for ACT consumers.

D. Additional Medicaid Requirements

1. Currently, there are no additional Medicaid requirements to be added to the requirements above when billing Medicaid for this service.

E. Billing/Reporting Requirements

1. All applicable Medicaid, MICP, and other DBHDD reporting requirements must be met.
2. All time spent between 2 or more team practitioners discussing a served individual must be reported as H0039HT. While this claim/encounter is reimbursed at \$0, it is imperative that the team document these encounters (see Section G. below) to demonstrate program integrity AND submit the claim/encounter for this so this service can be included in future rate setting.
3. The following elements (at a minimum) shall be documented in the clinical record and shall be accessible to the DBHDD monthly as requested:
 - Served individual's employment status;
 - Served individual's residential status (including homelessness);
 - Served individual's involvement with criminal justice system/s;
 - Served individual's interactions with crisis support services (including acute psychiatric hospitals, emergency room visits, crisis stabilization program interactions, etc.).
4. ACT may **not** be provided in an Institution for Mental Diseases (IMD, e.g. state or private psychiatric hospital or crisis stabilization program with greater than 16 beds), jail, or prison system.
5. The ACT team can provide and bill for Community Transition Planning as outlined in the Guideline for this service. This includes supporting individuals who are eligible for ACT and are transitioning from Jail/Prison.
6. When group services are provided via an ACT team to an enrolled ACT-recipient, then the encounter shall be submitted as a part of the ACT package defined in the **Orientation to Services** section of Part I, Section 1 of this manual.
7. Each ACT program shall provide monthly outcomes data as defined by the DBHDD. The outcomes form will be emailed by the 10th of every month to dbhddACT@dhr.state.ga.us.

G. Documentation Requirements

1. Providers must document services in accordance with the specifications for documentation requirements specified in Part II, Section IV of the Provider Manual and in keeping with this section G.
2. All time spent between 2 or more team practitioners discussing a served individual must be documented in the medical record as H0039HT. While this claim/encounter is reimbursed at \$0, it is imperative that the team document these encounters to demonstrate program integrity AND submit the claim/encounter for this so this service can be included in future rate setting. HT documentation parameters include:
 - a. If the staff interaction is specific to a single consumer for 15 minutes, then the H0039HT code shall be billed to that consumer (through claims or encounters).
 - b. If the staff interaction is for multiple consumers served and is for a minimum single 15 minute unit and:
 - 1) the majority of time is for a single individual served, then the claim/encounter shall be submitted attached to the individual's name who was the focus of this staffing conversation; or
 - 2) the time is spent discussing multiple consumers (with no one consumer being the focus of the time), then the team should create a rotation list (see below) in which

- a different consumer would be selected for each of these staffing notes in order to submit claims and account for this staffing time, and
- c. An agency is not required to document every staff-to-staff conversation in the individual's medical record; however every attempt should be made to accurately document the time spent in staffing or case conferencing for individual consumers. The exceptions (which shall be documented in a medical record) are:
- when the staffing conversation modifies an individual's treatment planning or intervention strategy,
 - when observations are discussed that may lead to treatment or intervention changes, and/or that change the course of treatment
3. The ACT team must have documentation (e.g., notebook, binder, file, etc.) which contains all H0039HT staffing interactions (which shall become a document for audit purposes, and by which claims/encounters can be revoked-even though there are no funds attached). In addition to the requirements in Section G.2.above, a log of staff meetings is required to document staff meetings as outlined in Section A.2. The documentation notebook shall include:
- 1) the team's protocol for submission of H0039HT encounters (how the team is accounting for the submissions of H0039HT in accordance with the above);
 - 2) the protocol for staffings which occur ad hoc (e.g. team member is remote supporting a consumer and calls a clinical supervisor for a consult on support, etc.);
 - 3) date of staffing;
 - 4) time start/end for the "staffing" interaction;
 - 5) if a regular team meeting, names of team participants involved in staffing (signed/certified by the team leader or team lead designee in the absence of the team leader);
 - 6) if ad hoc staffing note, names of the team participants involved(signed by any one of the team members who is participating);
 - 7) name all of individuals discussed/planned for during staffing;
 - 8) minimal documentation of content of discussion specific to each consumer (1-2 sentences is sufficient).
4. All expectations set forth in this "Additional Service Components" section shall be documented in the record in a way which demonstrates compliance with the said items.

Community Based Inpatient Psychiatric and Substance Detoxification Services							
HIPAA Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Psychiatric Health Facility Service, Per Diem		H2013					Per negotiation

Definition of Service: A short-term stay in a licensed and accredited community-based hospital for the treatment or habilitation of a psychiatric and/or substance related disorder. Services are of short duration and provide treatment for an acute psychiatric or behavioral episode. This service may also include Medically Managed Inpatient Detoxification at ASAM Level IV-D.

Target Population	Adults with a serious mental illness Adults with a Substance Related Disorder Adults with Co-occurring SMI and a Substance Related Disorder
Benefit Information	Available to Core Customers in need of Ongoing Services Requires MICP New Episode Request or Update Request (to add as a single service to an existing authorization).
Utilization Criteria	<u>Available to those with LOCUS scores:</u> 6: Medically Managed Residential
Ordering Practitioner	
Unit Value	1 day
Initial Authorization	5 days
Re-Authorization	3 days
Maximum Daily Units	1 unit
Authorization Period	5 days
UAS: Budget and Expense Categories	Adult Crisis Services Provider 135 – Adult Mental Health 735 – Adult Addictive Diseases
Admission Criteria	<ol style="list-style-type: none"> Individual with serious mental illness/SED that is experiencing serious impairment; persistent, recurrent, severe, or major symptoms (such as psychoses); or who is experiencing major suicidal, homicidal or high risk tendencies as a result of the mental illness; or Individual's need is assessed for 24/7 supports which must be one-on-one and may not be met by any service array which is available in the community; or Individual is assessed as meeting diagnostic criteria for a Substance Related Disorder according to the latest version of the DSM; and one or more of the following: <ol style="list-style-type: none"> Individual is experiencing signs of severe withdrawal, or there is evidence (based on history of substance intake, age, gender, previous withdrawal history, present symptoms, physical condition, and/or emotional/behavioral condition) that severe

	<p>withdrawal syndrome is imminent; or</p> <p>B. Level IV-D is the only available level of service that can provide the medical support and comfort needed by the individual, as evidenced by:</p> <ul style="list-style-type: none"> i. A detoxification regimen or individual's response to that regimen that requires monitoring or intervention more frequently than hourly, or ii. The individual's need for detoxification or stabilization while pregnant, until she can be safely treated in a less intensive service.
Continuing Stay Criteria	<ol style="list-style-type: none"> 1. Individual continues to meet admission criteria; and 2. Individual's withdrawal signs and symptoms are not sufficiently resolved to the extent that they can be safely managed in less intensive services;
Discharge Criteria	<ol style="list-style-type: none"> 1. An adequate continuing care plan has been established; and one or more of the following: 2. Individual no longer meets admission and continued stay criteria; or 3. Individual requests discharge and individual is not imminently dangerous to self or others; or 4. Transfer to another service/level of care is warranted by change in the individual's condition; or 5. Individual requires services not available in this level of care.
Service Exclusions	<p>This service may not be provided simultaneously to any other service in the service array excepting short-term access to services that provide continuity of care or support planning for discharge from this service.</p>
Clinical Exclusions	<p>Individuals with any of the following unless there is clearly documented evidence of an acute psychiatric/addiction episode overlaying the primary diagnosis:</p> <ul style="list-style-type: none"> a. Autism b. Mental Retardation/Developmental Disabilities c. Organic Mental Disorder; or d. Traumatic Brain Injury

Additional Service Criteria:

A. Required Components

1. This service must be licensed by DCH/HFR under the Rules and Regulations for Drug Abuse Treatment Programs, 290-4-2
2. A physician's order in the individual's record is required to initiate detoxification services. Verbal orders or those initiated by a Physician's Assistant or Clinical Nurse Specialist are acceptable provided the physician signs them within 24 hours or the next working day.

B. Staffing Requirements

Detoxification services must be provided only by nursing or other licensed medical staff under supervision of a physician.

C. Clinical Operations

Individuals receiving this service must have a qualifying diagnosis present in the medical record prior to the initiation of services. The diagnosis must be given by persons identified in O.C.G.A Practice Acts as qualified to provide a diagnosis. These practitioners include a licensed psychologist, a physician or a PA or APRN (NP and CNS-PMH) working in conjunction with a physician with an approved job description or protocol.

D. Service Access

E. Additional Medicaid Requirements

Not applicable. Not a Medicaid billable service.

F. Reporting & Billing Requirements

All applicable MICP and other DBHDD reporting requirements must be met.

G. Documentation Requirements

Providers must document services in accordance with the specifications for documentation requirements specified in Part II, Section V of the Provider Manual.

Community Transition Planning							
Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Community Transition Planning	Community Transition Planning (State Hospital)	T2038	ZH				\$20.92
	Community Transition Planning (Crisis Stabilization Unit)	T2038	ZC				\$20.92
	Community Transition Planning (Jail / Youth Detention Center)	T2038	ZJ				\$20.92
	Community Transition Planning(Other)	T2038	ZO				\$20.92

If you are an ACT provider, you may also bill this service. Please refer to the Core Guidelines for the detail.

Consumer/Family Assistance							
HIPAA Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Mental Health Services, Not Otherwise Specified		H0046					Variable in accordance with Items C.6. below

Definition of Service: Individuals may need a range of goods and community support services to fully benefit from mental health and addictive disease services. This time-limited service consists of goods and services purchased/procured on behalf of the consumer (e.g. purchase of a time-limited mentor, a utility deposit to help an individual move into the community and/or their own housing, environmental modification to the individual's home to enhance safety and ability to continue living independently etc) that will help promote individual functional enhancement to the benefit of the individual and his/her behavioral health stability. The goods/services procured must provide a *direct and critical* benefit to the individualized needs of the consumer, in accordance with the IRP, and lead to an enhancement of specific positive behaviors/skills/resources that will allow the individual to leave an institution and/or achieve a more independent living status, or prevent an imminent crisis or out-of-home placement (e.g. eviction, homelessness, loss of independent living, loss of ability or resources needed to maintain the individual's living in the home, etc). This service is intended to be of short duration and is not intended to pay for/provide ongoing service programming through the provider agency.

Target Population	Adults defined as Core Customers of Ongoing Services who are diagnosed with: Mental Illness Substance Related Disorders Co-Occurring Mental Illness and Substance Related Disorders Co-Occurring Mental Illness/Substance Related Disorders and Mental Retardation/Developmental Disabilities
Benefit Information	Available to Core Customers in need of Ongoing Services. Requires a MICP New Episode Request or Update Request (to add as a single service to an existing authorization).
Utilization Criteria	<u>Available to those with LOCUS scores:</u> 2: Low Intensity Community-Based Services 3: High Intensity Community-Based Services 4: Medically Monitored Non-Residential 5: Medically Monitored Community Residential 6: Medically Managed Residential
Ordering Practitioner	Physician, Psychologist, Physician's Assistant, Advanced Practice Registered Nurse (Clinical Nurse Specialist or Nurse Practitioner), LPC, LMFT, LCSW
Unit Value	Variable in accordance with Items C.6. below
Initial Authorization	While the actual assistance should be very short-term in nature, this service can be authorized as part of a 180 day Recovery plan. Financial max \$2000/\$5000 (see Clinical Operations section below)

Re-Authorization	One within a single fiscal year.
Maximum Daily Units	
Authorization Period	180 days
UAS: Budget and Expense Categories	Adult Consumer/Family Support Services Provider 137 – Adult Mental Health 737 – Adult Addictive Diseases
Admission Criteria	<ol style="list-style-type: none"> 1. Individual must meet Core Customer criteria for Ongoing services, and 2. Individual must be in need of a specific good or service that will directly improve functioning (e.g. directly lead to an enhancement of specific positive behaviors/skills/resources that will allow the individual to leave an institution and/or achieve a more independent living status), or prevent a crisis or out-of home placement (e.g. eviction, homelessness, loss of independent living, loss of ability or resources needed to maintain the individual's living in the home, etc.), and 3. Individual or provider must exhaust all other possible resources for obtaining the needed goods/services—this service provides payment of last resort, and 4. Individual has not received this service for more than one other episode of need during the current fiscal year.
Continuing Stay Criteria	<ol style="list-style-type: none"> 1. Individual must continue to meet Core Customer criteria for Ongoing services, and 2. Individual must continue to be in need of the same specific good or service as when enrolled in Consumer/Family Assistance, that will directly improve functioning (e.g. directly lead to an increase in specific positive behaviors/skills/resources that will allow the individual to leave an institution and/or obtain more independent living), or prevent a crisis or out-of home placement (e.g. eviction, homelessness, loss of independent living, loss of ability or resources needed to maintain the individual's living in the home, etc.), and 3. Individual or provider must continue to lack any other possible resources for obtaining the needed goods/services.
Discharge Criteria	<ol style="list-style-type: none"> 1. Individual no longer meets Core Customer criteria for Ongoing services, or 2. Individual no longer continues to be in need of the good or service, or 3. Individual has received the good in the allotted amount or service for the allotted timeframe as described below in "Additional Service Criteria" # 3, or 4. The individual requests discontinuance of the service.
Service Exclusions	<ol style="list-style-type: none"> 1. Goods and services that are included as a part of other services the individual is enrolled in or could be enrolled in are excluded.
Clinical Exclusions	

Additional Service Criteria:

A. Required Components

B. Staffing Requirements

1. This service must not pay for the regular staffing of specific programs or services in the provider's agency.
2. Service may pay for a 1:1 mentor, etc for an individual consumer, within the following limits:
 - a. Other means are not available to pay for the mentor, etc., such as state funding, Medicaid, self-pay or private insurance.
 - b. The mentor, etc. cannot be used to supplement the staffing of any program or service in the provider agency.
 - c. The mentor, etc. cannot be used as a 1:1 staff for the consumer during the times the consumer is attending other programming/services offered by the provider agency.

C. Clinical Operations

1. This service must not pay for transportation to MH/DD/AD services.
2. Individuals receiving this service must have a qualifying diagnosis present in the medical record prior to the initiation of services. The diagnosis must be given by persons identified in O.C.G.A Practice Acts as qualified to provide a diagnosis. These practitioners include a licensed psychologist, a physician or a PA or APRN (NP and CNS-PMH) working in conjunction with a physician with an approved job description or protocol.
3. This service must not pay for the operating, programmatic, or administrative expenses of any other program or service offered by the provider agency.
4. Individual cannot receive this service for more than two episodes of need per fiscal year.
5. Services obtained (e.g. a mentor, etc.) are intended to be of short duration and must be provided through this service for no longer than 3 months, or until the direct consumer benefit is realized, whichever occurs sooner.
6. Each type of necessary good obtained through this service is intended to be of short duration and must be purchased for no longer/in no greater amount than is reasonably necessary to avoid/resolve the immediate crisis or achieve the targeted increase in functioning. Some items have specific limits that cannot be surpassed during a single episode of need. The least duration and/or amount necessary of such items should be provided. Except for individuals leaving institutions as described below, up to:
 - one month's rental/mortgage assistance;
 - one month's assistance with utilities and/or other critical bills;
 - one housing deposit;
 - one month's supply of groceries (for the individual);
 - one month of medications;
 - one assistive device (unless a particular device is required in multiple according to commonly understood definition/practice such as a hearing aide for each ear, a one month supply of diabetic supplies etc);
 - one to two weeks' worth of clothing.

Similar guidelines should be used with other items not on this list.

* Individuals leaving an institution after a stay of at least 60 days who have had their benefits suspended or who do not yet have income or other benefits established may need greater assistance than the allowances indicated above for rent, bills, groceries and other items/services.

7. The maximum yearly monetary limit for this service is \$2000 per individual per fiscal year except for individuals who have left an institution after a 60-day stay. For such individuals, multiple months of rent, bills, groceries, services etc may be purchased, at a maximum yearly monetary

limit of \$5000 per individual per fiscal year. This amount will be controlled by the Third Party Administrator (when operational) and the availability of funds.

8. Eligibility for the Consumer/Family Assistance service does not equate to an entitlement to the service. Prioritizing eligible individuals to receive services is the responsibility of the service provider. A standard protocol must be utilized by the service provider to assess and approve the individual's needs in regard to 1) the criticalness of the need(s) in terms of the individual's functioning and ability to return to/remain in the community, and 2) the individual's or provider's ability to obtain the needed goods or services through other viable means.

D. Service Access

E. Additional Medicaid Requirements

Not applicable. Not a Medicaid billable service.

F. Reporting & Billing Requirements

1. The agency must submit a monthly report on expenditures in a specified format (and upon request at anytime) to the DBHDD.
2. All applicable DBHDD reporting requirements.

G. Documentation Requirements

1. Documentation that authorized goods/services are not available through other viable means must be made in the individual's chart.
2. Details regarding the goods/services procured and resulting benefit to the individual consumer must be documented in the individual's chart.

H. Documentation Requirements

Providers must document services in accordance with the specifications for documentation requirements specified in Part II, Section V of the Provider Manual.

Crisis Stabilization Unit Services							
HIPAA Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Behavioral Health; Short-term Residential (Non-Hospital Residential Treatment Program Without Room & Board, Per Diem)		H0018	U2				Per negotiation and specific to Medicaid, see item E.2. below.
Behavioral Health; Short-term Residential (Non-Hospital Residential Treatment Program Without Room & Board, Per Diem)		H0018	TB	U2			Per negotiation

Definition of Service: This is a residential alternative to or diversion from inpatient hospitalization, offering psychiatric stabilization and detoxification services. The program provides medically monitored residential services for the purpose of providing psychiatric stabilization and substance detoxification services on a short-term basis. Specific services may include:

- 1) Psychiatric medical assessment;
- 2) Crisis assessment, support and intervention;
- 3) Medically Monitored Residential Substance Detoxification (at ASAM Level III.7-D).
- 4) Medication administration, management and monitoring;
- 5) Brief individual, group and/or family counseling; and
- 6) Linkage to other services as needed.

Services must be provided in a facility designated and certified by the DBHDD as an emergency receiving and evaluation facility

Target Population	Adults experiencing: Severe situational crisis Severe Mental Illness Substance-Related Disorders Co-Occurring Substance-Related Disorders and Mental Illness Co-Occurring Mental Illness and Mental Retardation Co-occurring Substance-Related Disorders and Mental Retardation,
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Benefit Information	Available to Core Customers in need of Ongoing Services. Requires a MICP New Episode Request or Update Request.
Utilization Criteria	<u>Available to those with LOCUS scores:</u> 4: Medically Monitored Non-Residential (residential detoxification only) 5: Medically Monitored Community Residential 6: Medically Managed Residential (with ERO Care Management Review)
Ordering Practitioner	Physician, Physician's Assistant, Advanced Practice Registered Nurse (Clinical Nurse Specialist or Nurse Practitioner)
Unit Value	1 day
Initial Authorization	20 units
Re-Authorization	
Maximum Daily Units	1 unit
Authorization Period	20 Days
UAS: Budget and Expense Categories	Adult Crisis Services Provider 134 – Adult Mental Health 734 – Adult Addictive Diseases
Admission Criteria	<ol style="list-style-type: none"> 1. Treatment at a lower level of care has been attempted or given serious consideration; and #2 and/or #3 are met: 2. Individual has a known or suspected illness/disorder in keeping with target populations listed above; or 3. Individual is experiencing a severe situational crisis which has significantly compromised safety and/or functioning; and one or more of the following: 4. Individual presents a substantial risk of harm to self, others, and/or property or is so unable to care for his or her own physical health and safety as to create a life-endangering crisis. Risk may range from mild to imminent; or 5. Individual has insufficient or severely limited resources or skills necessary to cope with the immediate crisis; or 6. Individual demonstrates lack of judgment and/or impulse control and/or cognitive/perceptual abilities to manage the crisis; or 7. For detoxification services, individual meets admission criteria for Medically Monitored Residential Detoxification.
Continuing Stay Criteria	This service may be utilized at various points in the individual's course of treatment and recovery; however, each intervention is intended to be a discrete time-limited service that stabilizes the individual.
Discharge Criteria	<ol style="list-style-type: none"> 1. Individual no longer meets admission guidelines requirements; or 2. Crisis situation is resolved and an adequate continuing care plan has been established; or 3. Individual does not stabilize within the evaluation period and must be transferred to a higher intensity service.
Service Exclusions	This is a comprehensive service intervention that is not to be provided with any other service(s), except for the following: <ul style="list-style-type: none"> • Methadone Administration

Clinical Exclusions	<ol style="list-style-type: none"> 1. Individual is not in crisis. 2. Individual does not present a risk of harm to self or others or is able to care for his or her own physical health and safety. 3. Severity of clinical issues precludes provision of services at this level of intensity.
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Additional Service Criteria:

A. Required Components

1. Crisis Stabilization Units (CSU) providing medically monitored short-term residential psychiatric stabilization and detoxification services shall be designated by the Department as both an emergency receiving facility and an evaluation facility and must be surveyed and certified by the DBHDD.
2. In addition to all service qualifications specified in this document, providers of this service must adhere to and be certified under the *Provider Manual for Community Mental Health, Developmental Disability and Addictive Disorders* "Core Requirements for All Providers" and DBHDD "Core Requirements for Crisis Stabilization Programs Operated by Community Service Boards."
3. Individual referred to a CSU must be evaluated by a physician within 24 hours of the referral.
4. The maximum length of stay in a crisis bed is 10 adjusted days (excluding Saturdays, Sundays and state holidays) for adults (an adult occupying a transitional bed may remain in the CSU for an unlimited number of additional days if the date of transfer and length of stay in the transitional bed is documented).
5. Individuals occupying transitional beds must receive services from outside the CSU (i.e. community-based services) on a daily basis.
6. Services must be provided in a facility designated as an emergency receiving and evaluation facility that is not also an inpatient hospital, a freestanding Institute for Mental Disease (IMD), or a licensed substance abuse detoxification facility.
7. All services provided within the CSU must be delivered under the direction of a physician. A physician must conduct an assessment of new admissions, address issues of care, and write orders as required.

B. Staffing Requirements

1. Crisis Stabilization Unit (CSU) Services must be provided by a physician or a staff member under the supervision of a physician, practicing within the scope of State law.
2. A CSU must employ a fulltime Nursing Administrator who is a Registered Nurse.
3. A CSU must have a Registered Nurse present at the facility at all times.
4. Staff-to-client ratios must be established based on the stabilization needs of clients being served and in accordance with the "Core Requirements for Crisis Stabilization Programs Operated by Community Service Boards."
5. Functions performed by Physician Assistants, Nurse Practitioners, Clinical Nurse Specialists, Registered Nurses, and Licensed Practical Nurses must be performed within the scope of practice allowed by State law and Professional Practice Acts.

C. Clinical Operations

1. CSU must have documented operating agreements and referral mechanisms for psychiatric disorders, addictive disorders, and physical healthcare needs that are beyond the scope of the CSU and that require inpatient treatment. Operating agreements must delineate the type and level

of service to be provided by the private or public inpatient hospital or treatment facility. These agreements must specifically address the criteria and procedures for transferring an individual to a designated treatment facility when the CSU is unable to stabilize the individual.

2. CSUs must follow the seclusion and restraint procedures included in the Department's "Core Requirements for Crisis Stabilization Programs operated by Community Service Boards."
3. For individuals with co-occurring diagnoses including mental retardation/developmental disabilities, this service must target the symptoms, manifestations, and skills-development related to the identified behavioral health issue.
4. Individuals served in transitional beds may access an array of community-based services in preparation for their transition out of the CSU, and are expected to engage in community-based services daily while in a transitional bed.

D. Service Access

E. Additional Medicaid Requirements

1. Effective July 1, 2007, Medicaid stopped paying a bundled daily rate for this service. Crisis Stabilization Units with 16 beds or less should bill individual services for Medicaid recipients.
2. The individual services listed below may be billed up to the daily maximum listed for services provided in a Crisis Stabilization Unit. Billable services and daily limits within CSUs are as follows:

Service	Daily Maximum Billable Units
Crisis Intervention	8 units
Diagnostic Assessment	2 units
Psychiatric Treatment	1 unit (Pharmacological Mgmt only)
Nursing Assessment and Care	5 units
Medication Administration	1 unit
Group Training/Counseling	4 units
Beh Health Assmnt & Serv. Plan Devel.	24 units
Medication Administration	1 unit

3. Medicaid claims for the services in E.2. above may **not** be billed for any service provided to

F. Reporting & Billing Requirements

1. Providers must report information on all consumers served in CSUs no matter the funding source:
 - a. The CSU shall submit MICPs for all individuals served (state-funded, Medicaid funded, private pay, other third party payor, etc);
 - b. The CSU shall submit per diem encounters (H0018HAU2 or H0018HATBU2) for all individuals served (state-funded, Medicaid funded, private pay, other third party payor, etc) even if sub-parts cited in E.2 above are also billed as a claim to Medicaid;
 - c. Providers must designate either CSU bed use or transitional bed use in encounter submissions through the presence or absence of the TB modifier. TB represents "Transitional Bed."
2. Unlike all other DBHDD residential services, the start date of a CSU span encounter submission may be in one month and the end date may be in the next. The span of reporting must cover continuous days of service and the number of units must equal the days in the span.
3. All other applicable Medicaid, MICP, ERO, and other DBHDD reporting requirements must be met.

G. Documentation Requirements

1. In order to report a per diem encounter, the consumer must have participated in the program for a minimum of 8 hours in the identified 12:00AM to 11:59PM day
2. For individuals transferred to transitional beds, the date of transfer must be documented in a progress note and filed in the individual's chart.
3. Specific to item F.1. above, the notes for the program must have documentation to support the per diem AND, if the program bills sub-parts to Medicaid (in accordance with E. above), each discrete service delivered must have documentation to support that sub-billable code (e.g. Group is provided for 1 hour, Group is billed for 1 hour, Group note is for 4 units at the 15 minute rate and meets all the necessary components of documentation for that sub-code).
4. Daily engagement in community-based services must also be documented in progress notes for those occupying transitional beds.
5. Providers must document services in accordance with the specifications for documentation requirements specified in Part II, Section V of the Provider Manual.

Housing Supplements							
HIPAA Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Housing Supplements		ROOM1					Actual cost

Definition of Service: This is a rental/housing subsidy that must be justified by a personal consumer budget. This may include a one-time rental payment to prevent eviction/homelessness.

Target Population	Adults experiencing: Severe and Persistent Mental Illness Substance-Related Disorders Co-Occurring Substance-Related Disorders and Mental Illness Co-Occurring Mental Illness and Mental Retardation Co-occurring Substance-Related Disorders and Mental Retardation
Benefit Information	Available to Core Customers in need of Ongoing Services and requires a MICP New Episode Request or Update Request (to add as a single service to an existing authorization).
Utilization Criteria	<u>Available to those with LOCUS scores:</u> 2: Low Intensity Community-Based Services 3: High Intensity Community-Based Services 4: Medically Monitored Non-Residential 5: Medically Monitored Community Residential 6: Medically Managed Residential
Ordering Practitioner	Physician, Psychologist, Physician's Assistant, Advanced Practice Registered Nurse (Clinical Nurse Specialist or Nurse Practitioner), LPC, LMFT, LCSW
Unit Value	Unit=1 day
Initial Authorization	180 days
Re-Authorization	180 days
Maximum Daily Units	
Authorization Period	180 days
UAS: Budget and Expense Categories	<u>Residential Services Provider</u> 148- Adult Mental Health 748 - Adult Addictive Diseases
Admission Criteria	1. Individual meets target population as identified above; and 2. Based upon a personal budget, individual has a need for financial support for a living arrangement.
Continuing Stay Criteria	1. Individual continues to meet admission criteria as defined above; and 2. Individual has developed a Recovery goal to develop natural supports that promote the family/caregiver-management of these needs.
Discharge Criteria	Individual requests discharge; or Individual has acquired natural supports that supplant the need for this service.
Service Exclusions	None

Clinical Exclusions	Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of psychiatric condition overlaying the primary diagnosis: mental retardation, autism, organic mental disorder, traumatic brain injury.
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A. Documentation Requirements

1. If the individual supported is sharing rent with another person, then the agency may only utilize and report the assistance provided to the identified served individual (rounded to the nearest dollar).
2. The individual clinical record must have documentation of the actual payment by the agency to the leaser/landlord. A receipt for this payment must also be kept in the clinical record.

Opioid Maintenance Treatment							
HIPAA Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Alcohol and/or Drug Services; Methadone Administration and/or Service (Provision of the drug by a licensed program)		H0020	U2	U6			33.40
		H0020	U3	U6			25.39
		H0020	U4	U6			17.40

Definition of Service: An organized, usually ambulatory, addiction treatment service for opiate-addicted individuals. (For Medicaid consumers, the actual administration of the opioid maintenance medication is conducted under the Medication Administration service code). The nature of the services provided (such as dose, level of care, length of service or frequency of visits) is determined by the patient's clinical needs, but such services always include regularly scheduled psychosocial treatment sessions and daily medication visits within a structured program. Services function under a defined set of policies and procedures, including admission, discharge and continued service criteria stipulated by state law and regulation and the federal regulations at FDA 21 CFR Part 291. Length of service varies with the severity of the individual's illness, as well as his or her response to and desire to continue treatment. Treatment with methadone or LAAM is designed to address the individual's need to achieve changes in his or her level of functioning, including elimination of illicit opiate and other alcohol or drug use. To accomplish such change, the Individualized Recovery/Resiliency Plan must address major lifestyle, attitudinal and behavioral issues that have the potential to undermine the goals of recovery and inhibit the individual's ability to cope with life. The Individualized Recovery/Resiliency Plan should also include individualized treatment, resource coordination, and personal health education specific to addiction recovery (including education about human immunodeficiency virus [HIV], tuberculosis [TB], and sexually transmitted diseases [STD]).

Target Population	Individuals with a diagnosis of Opioid Dependence.
Benefit Information	Available to all Ongoing Core Customers. Requires MICP New Episode Request or Update Request (to add as a single service to an existing authorization).
Utilization Criteria	<u>Available to those with LOCUS scores:</u> 1: Recovery Maintenance and Health Management 2: Low Intensity Community-Based Services 3: High Intensity Community-Based Services
Ordering Practitioner	Physician, Physician's Assistant, Advanced Practice Registered Nurse (Clinical Nurse Specialist or Nurse Practitioner)
Unit Value	1 encounter
Initial Authorization	With the submission of MICP New Episode: 180 units
Re-Authorization	180 units
Maximum Daily Units	1 unit
Authorization Period	180 days
UAS: Budget and Expense Categories	<u>Opioid Maintenance Treatment Provider</u> 763 – Adult Addictive Diseases

Admission Criteria	Must meet criteria established by the Georgia Regulatory body for opioid administration programs (Department of Human Resources, Office of Regulatory Services) and the Food and Drug Administration's guidelines for this service.
Continuing Stay Criteria	Must meet criteria established by the Georgia Regulatory body for opioid administration programs (Department of Human Resources, Office of Regulatory Services) and the Food and Drug Administration's guidelines for this service.
Discharge Criteria	Must meet criteria established by the Georgia Regulatory body for opioid administration programs (Department of Human Resources, Office of Regulatory Services) and the Food and Drug Administration's guidelines for this service.
Service Exclusions	
Clinical Exclusions	

Additional Service Criteria:

A. Required Components

1. This service must be licensed by DCH/HFR under the Rules and Regulations for Drug Abuse Treatment Programs, 290-4-2.
2. Must meet and follow criteria established by the Georgia regulatory body for opioid administration programs (Department of Human Resources, Office of Regulatory Services) and the Food and Drug Administration's guidelines for this service.

B. Staffing Requirements

C. Clinical Operations

D. Service Access

E. Additional Medicaid Requirements

Core providers who are approved to bill Medication Administration may bill H0020 for Medicaid recipients who receive this service.

F. Reporting & Billing Requirements

All applicable MICP and other DBHDD reporting requirements must be met.

G. Documentation Requirements

1. If medically necessary for the individual, the Individualized Recovery/Resiliency Plan should also include individualized treatment, resource coordination, and personal health education specific to addiction recovery (including education about human immunodeficiency virus [HIV], tuberculosis [TB], and sexually transmitted diseases [STD]).
2. Providers must document services in accordance with the specifications for documentation requirements specified in Part II, Section V of the Provider Manual.

Peer Support Services							
HIPAA Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Peer Support Services	Practitioner Level 4, In-Clinic	H0038	HQ	U4	U6		\$4.43
	Practitioner Level 5, In-Clinic	H0038	HQ	U5	U6		\$3.30
	Practitioner Level 4, Out-of-Clinic	H0038	HQ	U4	U7		\$5.41
	Practitioner Level 5, Out-of-Clinic	H0038	HQ	U5	U7		\$4.03

Definition of Service: This service provides structured activities within a peer support center that promote socialization, recovery, wellness, self-advocacy, development of natural supports, and maintenance of community living skills. Activities are provided between and among individuals who have common issues and needs, are consumer motivated, initiated and/or managed, and assist individuals in living as independently as possible. Activities must promote self-directed recovery by exploring consumer purpose beyond the identified mental illness, by exploring possibilities of recovery, by tapping into consumer strengths related to illness self-management (including developing skills and resources and using tools related to communicating recovery strengths, communicating health needs/concerns, self-monitoring progress), by emphasizing hope and wellness, by helping consumers develop and work toward achievement of specific personal recovery goals (which may include attaining meaningful employment if desired by the individual), and by assisting consumers with relapse prevention planning. A Consumer Peer Support Center may be a stand-alone center or housed as a "program" within a larger agency, and must maintain adequate staffing support to enable a safe, structured recovery environment in which consumers can meet and provide mutual support.

Target Population	Adults with serious mental illness or co-occurring mental illness and substance related disorders Adolescents transitioning into adulthood with SED or co-occurring SED and substance related disorders
Benefit Information	Available to all Ongoing Core Customers. Requires a MICP New Episode Request or Update Request (to add as a single service to an existing authorization).
Utilization Criteria	<u>Available to those with LOCUS scores:</u> 1: Recovery Maintenance and Health Management 2: Low Intensity Community-Based Services 3: High Intensity Community-Based Services 4: Medically Monitored Non-Residential
Ordering Practitioner	Physician, Psychologist, Physician's Assistant, Advanced Practice Registered Nurse (Clinical Nurse Specialist or Nurse Practitioner), LPC, LMFT, LCSW
Unit Value	15 minutes
Initial Authorization	3600 units
Re-Authorization	3600 units
Maximum Daily Units	96

Authorization Period	180 days
UAS: Budget and Expense Categories	<u>Peer Support Services Provider</u> 138 – Adult Mental Health 738 – Adult Addictive Diseases
Admission Criteria	<ol style="list-style-type: none"> 1. Individual must have a primary mental health issue; and one or more of the following: 2. Individual requires and will benefit from support of peer professionals for the acquisition of skills needed to manage symptoms and utilize community resources; or 3. Individual may need assistance to develop self-advocacy skills to achieve decreased dependency on the mental health system; or 4. Individual may need assistance and support to prepare for a successful work experience; or 5. Individual may need peer modeling to take increased responsibilities for his/her own recovery; or 6. Individual needs peer supports to develop or maintain daily living skills.
Continuing Stay Criteria	<ol style="list-style-type: none"> 1. Individual continues to meet admission criteria; and 2. Progress notes document progress relative to goals identified in the Individualized Recovery/Resiliency Plan, but treatment/recovery goals have not yet been achieved.
Discharge Criteria	<ol style="list-style-type: none"> 1. An adequate continuing care plan has been established; and one or more of the following: 2. Goals of the Individualized Recovery Plan have been substantially met; or 3. Consumer/family requests discharge; or 4. Transfer to another service/level is more clinically appropriate.
Service Exclusions	Crisis Stabilization Unit (however, those utilizing transitional beds within a Crisis Stabilization Unit may access this service).
Clinical Exclusions	<ol style="list-style-type: none"> 1. Individuals diagnosed with a Substance-Related Disorder and no other concurrent mental illness; or 2. Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of a psychiatric condition overlaying the primary diagnosis: mental retardation, autism, organic mental disorder, or traumatic brain injury

Additional Service Criteria:

A. Required Components

1. A Peer Supports service may operate as a program within:
 - A freestanding Peer Support Center
 - A Peer Support Center that is within a clinical service provider
 - A larger clinical or community human service provider administratively, but with complete programmatic autonomy.
2. A Peer Supports service must be operated for no less than 3 days a week, no less than 12 hours a week, no less than 4 hours per day, typically during day, evening and weekend hours. Any agency may offer additional hours on additional days in addition to these minimum requirements.

3. The governing board of a freestanding Peer Center must be composed of 75% consumers and represent the cultural diversity of the population of the community being served. The board is encouraged to have either board members or operating relationships with someone with legal and accounting expertise. For programs that are part of a larger organizational structure that is not consumer led and operated, the Peer Supports Program must have an advisory body with the same composition as a freestanding Peer Center's board. The board or advisory committee must have the ability to develop programmatic descriptions and guidelines (consistent with state and federal regulations, accreditation requirements, and sponsoring agency operating policies), review and comment on the Peer Support Program's budgets, review activity offerings, and participate in dispute resolution activities for the program.
4. Individuals participating in the service at any given time must have the opportunity to participate in and make decisions about the activities that are conducted or services offered within the Peer Supports program, and about the schedule of those activities and services, as well as other operational issues.
5. Regardless of organizational structure, the service must be directed and led by consumers themselves.
6. Peer Supports may include meals or other social activities for purpose of building peer relationships, but meals cannot be the central or core activity offered. The focus of the service must be skill maintenance and enhancement and building individual consumer's capacity to advocate for themselves and other consumers.
7. Peer Supports cannot operate in isolation from the rest of the programs within the facility or affiliated organization. The Program Leader must be able to call multidisciplinary team meetings regarding a participating individual's needs and desires, and a Certified Peer Specialist providing services for and with a participating individual must be allowed to participate in multidisciplinary team meetings.
8. "Out-of-Clinic" may only be billed when:
 - Travel by the practitioner is to a non-contiguous location; and/or
 - Travel by the practitioner is to a facility not owned, leased, controlled or named as a service site by the agency who is billing the service(excepting visits to Shelter Plus sites); and/or
 - Travel is to a facility owned, leased or controlled by the agency billing the service, but no more than 6 individuals are being served in the course of that day by a single practitioner in non-group services; and/or
 - Travel is to a facility owned, leased, controlled or named as a service site by the agency, but no more than 24 individuals are being served in groups at that site in the course of a day.If the service does not qualify to be billed as "out of clinic," then the "in-clinic" rate may still be billed.

B. Staffing Requirements

1. The following practitioners can provide Peer Support Services:
 - Practitioner Level 4: LMSW; LAPC; LAMFT; Psychologist/LCSW/LPC/LMFT's supervisee/trainee with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology, functioning within the scope of the practice acts of the state; and CPSs and PPs with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology.

- Practitioner Level 5: CPS and PP under supervision of a Physician, Psychologist, LCSW, LPC, LMFT, RN, APRN, PA, LMSW, LAPC, or LAMFT
2. The individual leading and managing the day-to-day operations of the program, the Program Leader, must be a Georgia-certified Peer Specialist, who is a CPRP or can demonstrate activity toward attainment of the CPRP credential.
 3. The Program Leader must be employed by the sponsoring agency at least 0.5 FTE.
 4. The Program Leader and Georgia-certified Peer Specialists in the Peer Supports program may be shared with other programs as long as the Program Leader is present at least 75% of the hours the Peer Supports program is in operation, and as long as the Program Leader and the Georgia-certified Peer Specialists are available as required for supervision and clinical operations, and as long as they are not counted in consumer to staff ratios for 2 different programs operating at the same time.
 5. Services must be provided and/or activities led by staff who are Georgia-certified Peer Specialists or other consumers under the supervision of a Georgia-certified Peer Specialist. A specific activity may be led by someone who is not a consumer but is an invited guest.
 6. There must be at least 2 Georgia-certified Peer Specialists on staff either in the Peer Supports Program or in a combination of Peer Supports and other programs and services operating within the agency.
 7. The maximum face-to-face ratio cannot be more than 30 consumers to 1 Certified Peer Specialist based on average daily attendance in the past three (3) months of consumers in the program.
 8. The maximum face-to-face ratio cannot be more than 15 consumers to 1 direct service/program staff, based on the average daily attendance in the past three (3) months of consumers in the program.
 9. All staff must have an understanding of recovery and psychosocial rehabilitation principles as defined by the Georgia Consumer Council and psychosocial rehabilitation principles published by USPRA and must possess the skills and ability to assist other consumers in their own recovery processes.

C. Clinical Operations

1. This service must operate at an established site approved to bill Medicaid for services. However, individual or group activities may take place offsite in natural community settings as appropriate for the Individualized Recovery Plan (IRP) developed by each consumer with assistance from the Program Staff.
2. Individuals receiving this service must have a qualifying diagnosis present in the medical record prior to the initiation of services. The diagnosis must be given by persons identified in O.C.G.A Practice Acts as qualified to provide a diagnosis. These practitioners include a licensed psychologist, a physician or a PA or APRN (NP and CNS-PMH) working in conjunction with a physician with an approved job description or protocol.
3. This service may operate in the same building as other day services; however, there must be a distinct separation between services in staffing, program description, and physical space during the hours the Peer Supports program is in operation except as noted above.
4. Adequate space, equipment, furnishings, supplies, and other resources must be provided in order to effectively provide services and so that the program environment is clean and in good repair. Space, equipment, furnishings, supplies, transportation, and other resources for consumer use within the Peer Supports program must not be substantially different from space provided for other uses for similar numbers of individuals.

5. Staff of the Peer Supports Program must be treated as equal to any other staff of the facility or organization and must be provided equivalent opportunities for training (both mandated and offered) and pay and benefits competitive and comparable to other staff based on experience and skill level.
6. When this service is used in conjunction with Psychosocial Rehabilitation and ACT, documentation must demonstrate careful planning to maximize the effectiveness of this service as well as appropriate reduction in service amounts. Utilization of this service in conjunction with these services is subject to review by the External Review Organization.
7. Consumers should set their own individualized goals and assess their own skills and resources related to goal attainment. Goals are set by exploring strengths and needs in the consumer's living, learning, social, and working environments. Goal attainment should be supported through a myriad of approaches (e.g. coaching approaches, assistance via technology, etc.)
8. Implementation of services may take place individually or in groups.
9. Each consumer must be provided the opportunity for peer assistance in the development and acquisition of needed skills and resources necessary to achieve stated goals.
10. A Peer Supports Program must offer a range of skill-building and recovery activities developed and led by consumers. These activities must include those that will most effectively support achievement of the consumer's rehabilitation and recovery goals.
11. The program must have a Peer Supports Organizational Plan addressing the following:
 - A service philosophy reflecting recovery principles as articulated by the Georgia Consumer Council, August 1, 2001. This philosophy must be actively incorporated into all services and activities and:
 - (a) View each individual as the director of his/her rehabilitation and recovery process
 - (b) Promote the value of self-help, peer support, and personal empowerment to foster recovery
 - (c) Promote information about mental illness and coping skills
 - (d) Promote peer-to-peer training of individual skills, social skills, community resources, and group and individual advocacy
 - (e) Promote the concepts of employment and education to foster self-determination and career advancement
 - (f) Support each individual to "get a life" using community resources to replace the resources of the mental health system no longer needed
 - (g) Support each individual to fully integrate into accepting communities in the least intrusive environment that promote housing of his/her choice
 - (h) Actively seek ongoing consumer input into program and service content so as to meet each individual's needs and goals and foster the recovery process
 - A description of the particular consumer empowerment models utilized, types of activities offered, and typical daily activities and schedule. If offered, meals must be described as an adjunctive peer relationship building activity rather than as a central activity.
 - A description of the staffing pattern, plans for staff who have or will have achieved Certified Peer Specialist and CPRP credentials, and how staff are deployed to assure that the required staff-to-consumer ratios are maintained, including how unplanned staff absences, illnesses, and emergencies are accommodated.
 - A description of how consumer staff within the agency are given opportunities to meet with or otherwise receive support from other consumers (including Georgia-certified Peer Specialists) both within and outside the agency.

- A description of how consumers are encouraged and supported to seek Georgia certification as a Peer Specialist through participation in training opportunities and peer or other counseling regarding anxiety following certification.
 - A description of test-taking skills and strategies, assistance with study skills, information about training and testing opportunities, opportunities to hear from and interact with consumers who are already certified, additional opportunities for consumer staff to participate in clinical team meetings at the request of a consumer, and the procedure for the Program Leader to request a team meeting.
 - A description of the hours of operation, the staff assigned, and the types of services and activities provided for and by consumers as well as for families, parents, and/or guardians.
 - A description of the program's decision-making processes including how consumers direct decision-making about both individual and program-wide activities and about key policies and dispute resolution processes.
 - A description of how consumers participating in the service at any given time are given the opportunity to participate in and make decisions about the activities that are conducted or services offered within the Peer Supports program, about the schedule of those activities and services, and other operational issues.
 - A description of the space, furnishings, materials, supplies, transportation, and other resources available for individuals participating in the Peer Supports services.
 - A description of the governing body and/or advisory structures indicating how this body/structure meets requirements for consumer leadership and cultural diversity.
 - A description of how the plan for services and activities is modified or adjusted to meet the needs specified in each IRP.
 - A description of how consumer requests for discharge and change in services or service intensity are handled.
12. Assistive tools, technologies, worksheets, etc. can be used by the Peer Support staff to work with the served individual to improve his/her communication about treatment, symptoms, improvements, etc. with treating behavioral health and medical practitioners.

D. Service Access

Peer Supports may **not** be provided in an Institution for Mental Diseases (IMD, e.g. state or private psychiatric hospital or Crisis Stabilization Unit with greater than 16 beds), jail, or prison system.

E. Additional Medicaid Requirements

Currently, there are no additional Medicaid requirements to be added to the requirements above when billing Medicaid for this service.

F. Reporting & Billing Requirements

All applicable Medicaid, MICP, ERO, and other DBHDD reporting requirements must be met.

G. Documentation Requirements

1. Providers must document services in accordance with the specifications for documentation requirements specified in Part II, Section V of the Provider Manual.
2. Each 15 minute unit of service provided must be documented within the individual's medical record. Although there is no single prescribed format for documentation (a log may be used), the following elements **MUST** be included for every unit of service provided:
 - a. the specific type of intervention must be documented

- b. the date of service must be named
- c. the number of unit(s) of service must be named
- d. the practitioner level providing the service/unit must be named

For example, a group led by a Practitioner Level 4 that lasts 1 hour should be documented as 4 units of H0038HQU4U6 and the intervention type should be noted (such as "Enhancement of Recovery Readiness" group).

3. Weekly progress notes must document the individual's progress relative to functioning and skills related to the person-centered goals identified in his/her IRP. This progress note aligns the weekly activities reported on the daily log or in daily notes to the stated interventions on the individualized recovery plan, and documents progress toward goals. The progress note may be written by any practitioner who provided services over the course of that week.
4. If a daily log format is utilized, the consumer and Program Supervisor are required to sign the log once per week. The Supervisor's signature is an attestation that the daily activities documented did indeed occur over the course of that week. The consumer should also sign the log (if the consumer refuses, documentation of his/her refusal would be indicated in the weekly summary).
5. While billed in increments, the Peer Support service is a program model. Daily time in/time out is tracked for while the person is present in the program, but due to time/in out not being required for each intervention, the time in/out may not correlate with the units billed as the time in/out will include breaks taken during the course of the program. However, the units noted on the log should be consistent with the units billed and, if noted, on the weekly progress note. If the units documented are not consistent, the most conservative number of units will be utilized and may result in a billing discrepancy.
6. A provider shall only record units in which the consumer was actively engaged in services. Meals and breaks must not be included in the reporting of units of service delivered. Should a consumer leave the program or receive other services during the range of documented time in/time out for Peer Support hours, the absence should be documented on the log.

Psychosocial Rehabilitation							
HIPAA Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Psychosocial Rehabilitation	Practitioner Level 4, In-Clinic	H2017	U4	U6			\$4.43
	Practitioner Level 5, In-Clinic	H2017	U5	U6			\$3.30
	Practitioner Level 4, Out-of-Clinic	H2017	U4	U7			\$5.41
	Practitioner Level 5, Out-of-Clinic	H2017	U5	U7			\$4.03

Definition of Service: A therapeutic, rehabilitative, skill building and recovery promoting service for individuals to gain the skills necessary to allow them to remain in or return to naturally occurring community settings and activities. Services include, but are not limited to:

- 1) Individual or group skill building activities that focus on the development of skills to be used by individuals in their living, learning, social and working environments,
- 2) Social, problem solving and coping skill development;
- 3) Illness and medication self-management;
- 4) Prevocational skills (for example: preparing for the workday; appropriate work attire and personal presentation including hygiene and use of personal effects such as makeup, jewelry, perfume/cologne etc as appropriate to the work environment; time management; prioritizing tasks; taking direction from supervisors; appropriate use of break times and sick/personal leave; importance of learning and following the policies/rules and procedures of the workplace; workplace safety; problem solving/conflict resolution in the workplace; communication and relationships with coworkers and supervisors; resume and job application development; on-task behavior and task completion skills such as avoiding distraction from work tasks, following a task through to completion, asking for help when needed, making sure deadlines are clarified and adhered to, etc; learning common work tasks or daily living tasks likely to be utilized in the workplace such as telephone skills, food preparation, organizing/filing, scheduling/participating in/leading meetings, computer skills etc) and
- 5) Recreational activities/leisure skills that improve self-esteem and recovery.

The programmatic goals of the service must be clearly articulated by the provider, utilizing a best/evidence based model for service delivery and support. These best/evidence based models may include: the Boston University Psychosocial Rehabilitation approach, the Lieberman Model, the International Center for Clubhouse Development approach, or blended models/approaches in accordance with current psychosocial rehabilitation research. Practitioners providing this service are expected to maintain knowledge and skills regarding current research trends in best/evidence based models and practices for psychosocial rehabilitation.

This service is offered in a group setting, though individual activities are allowable within the service when more circumstantially appropriate. Group activities and interventions should be made directly relevant to the needs, desires and IRP goals of the individual participants (i.e. an additional activity/group should be made available as an alternative to a particular group for those individuals who do not need or wish to be in that group, as clinically appropriate).

This service may be provided as a step-down from intensive day treatment. Services must be provided in a clinic or other facility-based setting and available at least 25 hours per week. This service is offered for a maximum of 5 hours per day.

Target Population	Adults with Serious Mental Illness Adults with a Co-Occurring Serious Mental Illness and Substance Related Disorder Adults with a Co-Occurring Serious Mental Illness and MR/DD
Benefit Information	Available to all Ongoing Core Customers. Requires a MICP New Episode Request or Update Request (to add as a single service to an existing authorization).
Utilization Criteria	<u>Available to those with LOCUS scores:</u> 3: High Intensity Community-Based Services 4: Medically Monitored Non-Residential (transition) 5: Medically Monitored Community Residential (transition)
Ordering Practitioner	Physician, Psychologist, Physician's Assistant, Advanced Practice Registered Nurse (Clinical Nurse Specialist or Nurse Practitioner), LPC, LMFT, LCSW
Unit Value	Unit=15 minutes
Initial Authorization	450 units
Re-Authorization	450 units
Maximum Daily Units	5 units
Authorization Period	180 days
UAS: Budget and Expense Categories	<u>MH Day Services Provider</u> 155 – Adult Mental Health
Admission Criteria	<ol style="list-style-type: none"> 1. Individual must have primary behavioral health issues (including those with a co-occurring substance abuse disorder or MR/DD) and present a low or no risk of danger to themselves or others; and one or more of the following: 2. Individual lacks many functional and essential life skills such as daily living, social skills, vocational/academic skills and/or community/family integration; or 3. Individual needs frequent assistance to obtain and use community resources.
Continuing Stay Criteria	<ol style="list-style-type: none"> 1. Primary behavioral health issues that continue to present a low or no imminent risk of danger to themselves or others (or is at risk of moderate to severe symptoms); and one or more of the following: 2. Individual improvement in skills in some but not all areas; or 3. If services are discontinued there would be an increase in symptoms and decrease in functioning

Discharge Criteria	<ol style="list-style-type: none"> 1. An adequate continuing care plan has been established; and one or more of the following: 2. Individual has acquired a significant number of needed skills; or 3. Individual has sufficient knowledge and use of community supports; or 4. Individual demonstrates ability to act on goals and is self sufficient or able to use peer supports for attainment of self sufficiency; or 5. Consumer/family need a different level of care; or 6. Consumer/family requests discharge.
Service Exclusions	<ol style="list-style-type: none"> 1. Cannot be offered in conjunction with SA Day Services. 2. Service can be offered while enrolled in a Crisis Stabilization Unit in a limited manner when documentation supports this combination as a specific need of the individual. Time and intensity of services in PSR must be at appropriate levels when PSR is provided in conjunction with other services. (This will trigger a review by the External Review Organization). This service cannot be offered in conjunction with Medicaid MR Waiver services.
Clinical Exclusions	<ol style="list-style-type: none"> 1. Individuals who require one-to-one supervision for protection of self or others. 2. Individual has primary diagnosis of substance abuse, developmental disability, autism, or organic mental disorder without a co-occurring DSM IV mental disorder diagnosis. 3. Legal status requiring a locked facility.

Additional Service Criteria:

A. Required Components

1. This service must operate at an established site approved to bill Medicaid for services. However, individual or group activities should take place offsite in natural community settings as is appropriate to the participating consumer's Individualized Recovery Plan.
2. This service may operate in the same building as other day-model services; however, there must be a distinct separation between services in staffing, program description, and physical space during the hours the PSR program is in operation except as described above.
3. Adequate space, equipment, furnishings, supplies and other resources must be provided in order to effectively provide services and so that the program environment is clean and in good repair. Space, equipment, furnishings, supplies, transportation, and other resources for consumer use within the PSR program must not be substantially different from that provided for other uses for similar numbers of individuals.
4. A PSR program must be operated for no less than 25 hours a week, typically during day, evening and weekend hours. No more than 5 hours per day may be billed for any one consumer.
5. A PSR program must operate to assist individuals in attaining, maintaining, and utilizing the skills and resources needed to aid in their own rehabilitation and recovery.
6. "Out-of-Clinic" may only be billed when:
 - Travel by the practitioner is to a non-contiguous location; and/or
 - Travel by the practitioner is to a facility not owned, leased, controlled or named as a service site by the agency who is billing the service(excepting visits to Shelter Plus sites); and/or

- Travel is to a facility owned, leased or controlled by the agency billing the service, but no more than 6 individuals are being served in the course of that day by a single practitioner in non-group services; and/or
- Travel is to a facility owned, leased, controlled or named as a service site by the agency, but no more than 24 individuals are being served in groups at that site in the course of a day. If the service does not qualify to be billed as "out of clinic," then the "in-clinic" rate may still be billed.

B. Staffing Requirements

1. The program must be under the direct programmatic supervision of a Certified Psychiatric Rehabilitation Practitioner (CPRP)¹, or staff who can demonstrate activity toward attainment of certification (an individual can be working toward attainment of the certification for up to one year under a non-renewable waiver which will be granted by the DBHDD Regional Coordinator). For purposes of this service "programmatic supervision" consists of the day-to-day oversight of the program as it operates (including elements such as maintaining the required staffing patterns, staff supervision, daily adherence to the program model, etc.)
2. Additionally, the program must be under the clinical oversight of an independently licensed practitioner (this should include meeting with the programmatic leadership on a regular basis to provide direction and support on whether the individuals in the program are clinically improving, whether the design of the program promotes recovery outcomes, etc.).
3. The following practitioners can provide psychosocial rehabilitation services:
 - Practitioner Level 1: Physician/Psychiatrist (reimbursed at Level 4 rate)
 - Practitioner Level 2: Psychologist, APRN, PA (reimbursed at Level 4 rate)
 - Practitioner Level 3: LCSW, LPC, LMFT, RN (reimbursed at Level 4 rate)
 - Practitioner Level 4: LMSW; LAPC; LAMFT; Psychologist/LCSW/LPC/LMFT's supervisee/trainee with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology, functioning within the scope of the practice acts of the state; MAC, CAC-II, CADC, CCADC, GCADC (II, III); CPS, PP, CPRP, CAC-I or Addiction Counselor Trainees with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology
 - Practitioner Level 5: CPS, PP, CPRP, CAC-I, RADT (I, II, or III), Addiction Counselor Trainees with high school diploma/equivalent under supervision of one of the licensed/credentialed professionals above
4. There must be a CPRP with a Bachelor's Degree present at least 80% of all time the service is in operation regardless of the number of consumers participating.
5. The maximum face-to-face ratio cannot be more than 12 consumers to 1 direct service/program staff (including CPRPS) based on average daily attendance of consumers in the program.

6. At least one CPRP (or someone demonstrating activity toward attainment of certification) must be onsite face-to-face at all times (either the supervising CPRP or other CPRP staff) while the program is in operation regardless of the number of consumers participating. All staff are encouraged to seek and obtain the CPRP credential. All staff must have an understanding of recovery and psychosocial rehabilitation principles as published by USPRA and must possess the skills and ability to assist individuals in their own recovery processes.
7. Basic knowledge necessary for all staff serving individuals with mental illness or substance abuse in "co-occurring capable" day services must include the content areas in Georgia DBHDD Suggested Best Practices: Principles and Staff Capabilities for Day Services Serving Adults with Co-Occurring Disorders of Substance Abuse and Mental Illness.
8. Programs must have documentation that there is one staff person that is "co-occurring capable." This person's knowledge must go beyond basic understanding and must demonstrate actual staff capabilities in using that knowledge for individuals with co-occurring disorders. Personnel documentation should demonstrate that this staff person has received a minimum of 4 hours of training in co-occurring treatment within the past 2 years.
9. If the program does not employ someone who meets the criteria for a MAC, CACII, and/or CADC, then the program must have documentation of access to an addictionologist and/or one of the above for consultation on addiction-related disorders as co-occurring with the identified mental illness.

C. Clinical Operations

1. Individuals receiving this service must have a qualifying diagnosis present in the medical record prior to the initiation of services. The diagnosis must be given by persons identified in O.C.G.A Practice Acts as qualified to provide a diagnosis. These practitioners include a licensed psychologist, a physician or a PA or APRN (NP and CNS-PMH) working in conjunction with a physician with an approved job description or protocol.
2. Rehabilitation services facilitate the development of an individual's skills in the living, learning, social, and working environments, including the ability to make decisions regarding: self-care, management of illness, life work, and community participation. The services promote the use of resources to integrate the individual into the community.
3. Rehabilitation services are consumer driven and are founded on the principles and values of individual choice and active involvement of individuals in their rehabilitation. Through the provision of both formal and informal structures consumers are able to influence and shape service development.
4. Rehabilitation services must include education on self-management of symptoms, medications and side effects; identification of rehabilitation preferences; setting rehabilitation goals; and skills teaching and development.
5. All individuals should participate in setting individualized goals for themselves and in assessing their own skills and resources related to goal attainment. Goals are set by exploring strengths and needs in the individual's living, learning, social, and working environments. Implementation of services may take place individually or in groups.
6. Each individual must be provided assistance in the development and acquisition of needed skills and resources necessary to achieve stated goals.
7. PSR programs must offer a range of skill-building and recovery activities from which individuals choose those that will most effectively support achievement of the individual's rehabilitation and recovery goals. These activities must be developed based on participating individual's input and

stated interests. Some of these activities should be taught or led by consumers themselves as part of their recovery process.

8. A PSR program must be capable of serving individuals with co-occurring disorders of mental illness and substance abuse utilizing integrated methods and approaches that address both disorders at the same time (e.g. groups and occasional individual interventions utilizing approaches to co-occurring disorders such as motivational interviewing/building motivation to reduce or stop substance use, stage based interventions, refusal skill development, cognitive behavioral techniques, psychoeducational approaches, relapse prevention planning and techniques etc). For those individuals whose substance abuse and dependence makes it difficult to benefit from the PSR program, even with additional or modified methods and approaches, the PSR program must offer co-occurring enhanced services or make appropriate referrals to specialty programs specifically designed for such individuals.
9. The program must have a PSR Organizational Plan addressing the following:
 - a. Philosophical principles of the program must be actively incorporated into all services and activities including²:
 - i. View each individual as the director of his/her rehabilitation process
 - ii. Solicit and incorporate the preferences of the individuals served
 - iii. Believe in the value of self-help and facilitate an empowerment process
 - iv. Share information about mental illness and teach the skills to manage it
 - v. Facilitate the development of recreational pursuits
 - vi. Value the ability of each individual with a mental illness to seek and sustain employment and other meaningful activities in a natural community environment
 - vii. Help each individual to choose, get, and keep a job (or other meaningful daily activity)
 - viii. Foster healthy interdependence
 - ix. Be able to facilitate the use of naturally occurring resources to replace the resources of the mental health system
 - b. Services and activities described must include attention to the following:
 - i. Engagement with others and with community
 - ii. Encouragement
 - iii. Empowerment
 - iv. Consumer Education and Training
 - v. Family Member Education and Training
 - vi. Assessment
 - vii. Financial Counseling
 - viii. Program Planning
 - ix. Relationship Development
 - x. Teaching
 - xi. Monitoring
 - xii. Enhancement of vocational readiness
 - xiii. Coordination of Services
 - xiv. Accommodations
 - xv. Transportation
 - xvi. Stabilization of Living Situation
 - xvii. Managing Crises
 - xviii. Social Life

² Adapted from Best Practices in Psychosocial Rehabilitation, edited by Hughes and Weinstein.

- xix. Career Mobility
 - xx. Job Loss
 - xxi. Vocational Independence
- c. A description of the particular rehabilitation models utilized, types of interventions practiced, and typical daily activities and schedule.
 - d. A description of the staffing pattern, plans for staff who will achieve CPRP credentials, and how staff are deployed to assure that the required staff-to-consumer ratios are maintained, including how unplanned staff absences, illnesses, and emergencies are accommodated.
 - e. A description of how the program will assure that it is co-occurring capable and how it will adjust or make appropriate referrals for individuals needing a co-occurring enhanced PSR program.
 - f. A description of the hours of operation, the staff assigned, and the types of services and activities provided for consumers, families, parents, and/or guardians including how consumers are involved in decision-making about both individual and program-wide activities.
 - g. A description of how the plan for services and activities will be modified or adjusted to meet the needs specified in each IRP.
 - h. A description of services and activities offered for education and support of family members.
 - i. A description of how consumer requests for discharge and change in services or service intensity are handled and resolved.

D. Service Access

1. A PSR program must be operated for no less than 25 hours a week, typically during day, evening and weekend hours. No more than 5 hours per day may be billed for any one consumer.
2. Psychosocial Rehabilitation may **not** be provided in an Institution for Mental Diseases (IMD, e.g. state or private psychiatric hospital or Crisis Stabilization Unit with greater than 16 beds), jail, or prison system.

E. Additional Medicaid Requirements

1. Currently, there are no additional Medicaid requirements to be added to the requirements above when billing Medicaid for this service.

F. Reporting & Billing Requirements

1. Units of service by practitioner level must be aggregated daily before claim submission
2. All applicable Medicaid, MICP, ERO, and other DBHDD reporting requirements must be met.

G. Documentation Requirements

1. Providers must document services in accordance with the specifications for documentation requirements specified in Part II, Section V of the Provider Manual.
2. Each 15 minute unit of service provided must be documented within the individual's medical record. Although there is no single prescribed format for documentation (a log may be used), the following elements **MUST** be included for every unit of service provided:
 - a. the specific type of intervention must be documented
 - b. the date of service must be named
 - c. the number of unit(s) of service must be named
 - d. the practitioner level providing the service/unit must be named

For example, a group led by a Practitioner Level 4 that lasts 1 hour should be documented as 4 units of H0017U4U6 and the intervention type should be noted (such as "Enhancement of Recovery Readiness" group).

3. Weekly progress notes must document the individual's progress relative to functioning and skills related to the person-centered goals identified in his/her IRP. This progress note aligns the weekly activities reported on the daily log or in daily notes to the stated interventions on the individualized recovery plan, and documents progress toward goals. The progress note may be written by any practitioner who provided services over the course of that week.
4. If a daily log format is utilized, the consumer and Program Supervisor are required to sign the log once per week. The Supervisor's signature is an attestation that the daily activities documented did indeed occur over the course of that week. The consumer should also sign the log (if the consumer refuses, documentation of his/her refusal would be indicated in the weekly summary).
5. While billed in increments, the PSR service is a program model. Daily time in/time out is tracked for while the person is present in the program, but due to time/in out not being required for each intervention, the time in/out may not correlate with the units billed as the time in/out will include breaks taken during the course of the program. However, the units noted on the log should be consistent with the units billed and, if noted, on the weekly progress note. If the units documented are not consistent, the most conservative number of units will be utilized and may result in a billing discrepancy.
6. A provider shall only record units in which the consumer was actively engaged in services. Meals and breaks must not be included in the reporting of units of service delivered. Should a consumer leave the program or receive other services during the range of documented time in/time out for PSR hours, the absence should be documented on the log.
7. When this service is used in conjunction with Crisis Stabilization Units, Peer Supports, and ACT (on a limited basis), documentation must demonstrate careful planning to maximize the effectiveness of this service as well as appropriate reduction in service amounts of PSR. Utilization of psychosocial rehabilitation in conjunction with these services is subject to additional review by the External Review Organization.

**Residential:
Independent Residential Services**

HIPAA Transaction Code	Code	Mod1	Mod2	Mod3	Mod4
Supported Housing (Mental Health)	H0043	R1			
Supported Housing (Addictive Diseases)	H0043	HF	R1		

Definition of Service: Independent Residential Service provides scheduled residential service to a consumer who requires a low level of residential structure to maintain stable housing, continue with their recovery, and increase self-sufficiency. This residential placement will be of the consumer's choice and may be fully integrated in the community in a scattered site individual residence.

Independent Residential Services may only be provided by a DBHDD Contracted Provider.

Target Population	Adults aged 18 or older with 1. Serious Mental Illness, Addictive Diseases or Co-occurring Mental Illness and Addictive Diseases Diagnoses and 2. Demonstrates the need for scheduled residential visits and mild assistance with residential responsibilities.
Utilization Criteria	Available to those eligible for core customer Ongoing Support and Recovery services.
Benefit Information	<u>Available to those with a LOCUS Level of Care:</u> 1: Recovery Maintenance and Health Management 2: Low Intensity Community Based Services 3: High Intensity Community Based Services 4: Medically Monitored Non-residential Services
Unit Value	Unit= 1 day
Reimbursement Rate	N/A
Initial Authorization	180 units
Re-Authorization	180 units
Maximum Daily Units	1 unit
Authorization Period	180 days
UAS: Budget and Expense Categories	<u>Residential Services Provider</u> 141– Adult Mental Health 744 – Adult Addictive Diseases
Admission Criteria	1. Individual must meet target population as indicated above, and 2. Individual demonstrates ability to live with minimal supports and 3. Individual, states a preference to live independently.
Continuing Stay Criteria	Consumer continues to benefit from and require minimal community supports.
Discharge Criteria	1. Consumer, or appropriate legal representative, no longer desires service, or 2. Consumer no longer meets program and/or housing criteria.

Service Exclusions	None.
Clinical Exclusions	1. Individuals with the following conditions are excluded from admission unless there is documented evidence of a psychiatric condition: developmentally disabled persons who do not have co-occurring mental illness or substance abuse issues, autism, organic mental disorder, or traumatic brain injury.

Additional Service Criteria:

A. Required Components

1. The organization must have an executive director or program director charged with the responsibility for day-to-day management of the organization.
2. If applicable, the organization must be licensed by the Georgia Office of Regulatory Services to provide residential services to consumers with mental illness and/or substance abuse diagnosis.
3. The Independent Residential Service provides scheduled visits to a consumer's apartment or home to assist with residential responsibilities.
4. Services must be provided at a time that accommodates consumers' needs, which may include during evenings, weekends, and holidays.
5. This service requires a minimum of 1 face-to-face contact with the consumer in their home each week (see also D. for an exception).
6. Independent Residential Services may only be provided within a supportive housing program or within the consumer's own apartment or home.
7. There must be a written Residential Crisis Response Plan that guides the residential provider's response to an individual's crisis episode while receiving residential services that diverts the loss of housing and promotes housing stability. This plan shall be developed in partnership with the individual and offer 24/7 access to a residential services specialist in the event of a crisis.

B. Staffing Requirements

1. Residential Managers may be persons with at least 2 years experience providing MH or AD services and with at least a high school diploma; however, this person must be supervised by a licensed staff member (including LMSW, LAMFT, LAPC or 4 year RN).
2. Persons with high school diplomas, GEDs, or higher degrees may provide direct support services under the supervision of a Residential Manager.
3. A staff person must be available 24/7 to respond to emergency calls within one hour.
4. A minimum of one staff per 35 consumers may not be exceeded.

C. Program Operations

1. The organization must have a written description of the Independent Residential Service offered that includes, at a minimum, the purpose of the service; the intended population to be served; service philosophy/model; level of supervision and oversight provided; and outcome expectations for its residents.
2. The focus of Independent Residential Service is to view each consumer as the director of his/her own recovery; to promote the value of self-help and peer support; to provide information about mental illness and coping skills; to promote social skills, community

- resources, and individual advocacy; to promote employment and education to foster self-determination and career advancement; to support each consumer in using community resources to replace the resources of the mental health system no longer needed; to support each consumer to fully integrate into scattered site residential placement or in housing of his or her choice; and to provide necessary support and assistance to the consumer that furthers recovery goals, including transportation to appointments and community activities that promote recovery.
3. The Goal of Independent Residential Supports is to fully integrate the consumer into an accepting community in the least intrusive environment that promotes housing of his/her choice.
 4. The outcomes of Independent Residential Supports will focus on recovery, housing, employment and meaningful life in the community. These outcomes will be measured based upon:
 - a. Reduction in hospitalizations;
 - b. Reduction in incarcerations;
 - c. Maintenance of housing stability;
 - d. Participation in education, vocational training or gainful employment, if this is a goal in the Individualized Recovery plan;
 - e. Participation in community meetings and other social and recreational activities;
 - f. Participation in activities that promote recovery and community integration.

D. Service Access

In addition to receiving Independent Residential Services, consumers should be linked to adult mental health and/or addictive disease services, as applicable, including Core or Private psychiatrist and Specialty services; however, individuals served shall not lose this support as a result of his/her choice to opt out of other behavioral health support/treatment services (unless these services are otherwise required by a federal program/fund source supporting a specific individual).

E. Additional Medicaid Requirements

This is not a Medicaid reimbursable service.

F. Reporting & Billing Requirements

1. All applicable MICP and other DBHDD reporting requirements must be met.
2. Each month, the provider must submit a Monthly Residential Service Report developed by the Department that identifies the actual utilization of independent residential services including amount spent, number of units occupied, and number of individuals served.

G. Documentation Requirements

1. Individuals receiving this service must have a qualifying diagnosis present in the medical record prior to the initiation of services. The diagnosis must be given by persons identified in O.C.G.A. Practice Acts as qualified to provide a diagnosis.
2. Providers must document services in accordance with the specifications for documentation found in "Documentation Guidelines" in Part II, Section IV of this manual.
3. The organization must develop and maintain sufficient written documentation to support the Independent Residential Services for which billing is submitted. This documentation, at a minimum, must confirm that the individual for whom billing is requested was enrolled in the Independent Residential Services on the billing date and that residential contact and support

- services are being provided at least once per week. The individual's record must also include each week's programming/service schedule in order to document the provision of the personal support activities.
4. Providers must provide documentation that demonstrates compliance with a minimum of 1 face-to-face contact per week, which includes date and time in/time out.
 5. Weekly progress notes must be entered in the individual's record to enable the monitoring of the individual's progress toward recovery goals and to reflect the Individualized Recovery Plan implementation. The individual's record should include health issues or concerns and how they are being addressed, appointments for psychiatric and medical care that are scheduled for the consumer, attendance at other treatments such as addictive diseases counseling that staff may be assisting the consumer to attend, assistance provided to the consumer to help him or her reach recovery goals and the consumer's participation in other recovery activities.
 6. Each note must be signed and dated and must include the professional designation of the individual making the entry.
 7. Documentation must be legible and concise and include the printed name and the signature of the treating practitioner. The name, title, and credentials of the individual providing the service must reflect the staffing requirements established for Independent Residential Services being delivered.

Residential: Intensive Residential Services

HIPAA Transaction Code	Code	Mod1	Mod2	Mod3	Mod4
Supported Housing (Mental Health)	H0043	R3			
Supported Housing (Addictive Diseases)	H0043	HF	R3		

Definition of Service: Intensive Residential Service provides around the clock assistance to consumers within a residential setting that assists them to successfully maintain housing stability in the community, continue with their recovery, and increase self-sufficiency.

Intensive Residential Service may only be delivered by a DBHDD Contracted Provider.

Target Population	Adults aged 18 or older with 1. Serious Mental Illness, Addictive Disease Issues, or Co-occurring Mental Illness and Addictive Diseases Diagnosis and 2. Frequent psychiatric hospitalizations, i.e., more than 2 admissions in the last year and/or lengthy admission in the last year (more than 30 days); or 3. Frequent incarcerations, i.e., more than 2 incarcerations in the last year or lengthy incarceration in the last year (more than 60 days) or 4. Those who require a highly supportive environment with 24/7 awake staff to divert from going to a more intensive level of care.
Utilization Criteria	Available to those eligible for Core Customer Ongoing Support and Recovery services.
Benefit Information	<u>Available to those with a LOCUS Level Of Care :</u> 3: High Intensity Community Based Services 4: Medically Monitored Non-Residential Services 5: Medically Monitored Residential Services
Unit Value	Unit= 1 day
Reimbursement Rate	N/A
Initial Authorization	180 units
Re-Authorization	180 units
Authorization Period	180 days
UAS: Budget and Expense Categories	<u>Residential Services Provider</u> 143 – Adult Mental Health 744 – Adult Addictive Diseases
Admission Criteria	Individual must meet target population as indicated above and have a Core Provider, ACT Provider, or private psychiatrist; and one or more of the following: 1. Individual's symptoms/behaviors indicate a need for continuous monitoring and supervision by 24/7 awake staff to ensure safety; or 2. Individual has insufficient or severely limited skills needed to maintain stable housing and had failed using less intensive residential supports.

Continuing Stay Criteria	Individual continues to meet Admission Criteria
Discharge Criteria	1. Individual can effectively and safely be supported with a more appropriate level of service due to change in individual's level of functioning; or 2. Individual or appropriate legal representative, requests discharge.
Service Exclusions	None
Clinical Exclusions	1. Individuals with the following conditions are excluded from admission unless there is documented evidence of psychiatric condition: developmentally disabled persons who do not have co-occurring mental illness or substance abuse issues, autism, organic mental disorder, or traumatic brain injury.

Additional Service Criteria:

A. Required Components

1. The organization must have an executive director or program director charged with the responsibility for day-to-day management of the organization.
2. If applicable, the organization must be licensed by the Georgia Office of Regulatory Services to provide residential services to consumers with mental illness and/or substance abuse diagnosis.
3. The residential program must provide a structured and supported living environment 24 hours a day, 7 days a week with AWAKE staff on-site at all times.
4. Intensive Residential Service must provide a minimum of 5 hours per week of skills training programming relevant to the consumer's Individual Recovery Plan (IRP).
5. There must be a written Residential Crisis Response Plan that guides the residential provider's response to an individual's crisis episode while receiving residential services that diverts the loss of housing and promotes housing stability. This plan shall be developed in partnership with the individual and offer 24/7 access to a residential services specialist in the event of a crisis.

B. Staffing Requirements

1. Residential Managers may be persons with at least 2 years experience providing MH or AD services and at least a high school diploma; however this person must be directly supervised by a licensed staff member (including LMSW, LAMFT, LAPC, or 4-year RN).
2. Persons with high school diplomas, GEDs or higher, who have completed the paraprofessional training required for DBHDD contracted organizations and under the supervision of a Residential Manager may perform residential services.
3. A minimum of at least one (1) awake on-site staff 24/7.

C. Program Operations

1. The organization must have a written description of the Intensive Residential Service offered that includes, at a minimum, the purpose of the service; the intended population to be served; service philosophy/model, level of supervision and oversight provided; and outcome expectations for its residents.
2. Intensive Residential Service assists those individuals with an intensive need for personal supports and skills training to restore, develop, or maintain skills in functional areas in order to live meaningful lives in the community; develop or maintain social relationships, and participate in social,

interpersonal, vocational, recreational or community activities. Services must be delivered to consumers relevant to their individualized Recovery Plan.

3. Intensive Residential Service must provide a minimum of 5 hours of skills training and/or support activities per week that relate to the individual's IRP.

Skills Training may include interpersonal skills training; coping skills/problem solving; symptom identification and management; cooking; maintaining a residence; using public transportation; shopping; budgeting and other needed skills training as identified in the IRP.

Support Activities may include daily contacts by Intensive Residential Service staff daily to monitor physical and mental health needs; crisis intervention when needed; assistance with scheduling of medical and mental health appointments; the supervision of the self-administration of medications; transportation to medical/dental/mental health/employment/recreational activities; participation in community activities; and other needed supports as identified in the IRP.

D. Service Access

In addition to receiving Intensive Residential Services, consumers will be linked to adult mental health services including Core or private psychiatrist or Specialty Services.

E. Additional Medicaid Requirements

This is not a Medicaid reimbursable service.

F. Reporting & Billing Requirements

1. All applicable MICP and other DBHDD reporting requirements must be met.
2. Each month, the provider must submit a Monthly Residential Service Report developed by the Department that identifies the actual utilization of intensive residential services including amount spent, number of units occupied, and number of individuals served.

G. Documentation Requirements

1. Individuals receiving this service must have a qualifying diagnosis present in the medical record prior to the initiation of services. The diagnosis must be given by persons identified in O.C.G.A. Practice Acts as qualified to provide a diagnosis.
2. Providers must document services in accordance with the specifications for documentation found in "Documentation Guidelines" in Part II, Section IV of this document.
3. The organization must develop and maintain sufficient written documentation to support the Intensive Residential Service for which billing is made. This documentation, at a minimum, must confirm that the individual for whom billing is requested was a resident of the Intensive Residential Service on the date of service. The individual's record must also include each week's programming/service schedule in order to document the provision of the required amount of skills training and support activities.
4. Weekly progress notes must be entered in the individual's record to enable the monitoring of the individual's progress toward IRP and recovery goals.
5. The record should include health issues and how they are being addressed; appointments for psychiatric and medical care that are scheduled for the consumer; attendance at other treatments such as addictive diseases counseling that staff may be assisting consumer to attend; assistance provided to the consumer to help him or her reach recovery goals; and the consumer's participation in other recovery activities.

6. Each note must be signed and dated and must include the professional designation of the individual making the entry.
7. Documentation must be legible and concise and include the printed name and the signature of the service provider. The name, title, and credentials of the individual providing the service must reflect the staffing requirements established for the Intensive Residential Service being delivered.

H. Facilities Management (applicable to traditional residential settings such as group homes, Treatment facilities, etc.)

1. Each resident facility must be arranged and maintained to provide adequate measures for the health, safety, access and well being of the residents.
2. Each resident facility must comply with all relevant safety codes.
3. All areas of the residential facility must be clean, safe, appropriately equipped, and furnished for the services delivered.
4. The facility must comply with the Americans with Disabilities Act.
5. The facility must maintain a written evacuation plan to be used in the case of fire or other disaster. An appropriate written certification of compliance must be obtained indicating that all applicable fire and safety code requirements have been satisfied. Periodic fire and other safety drills must be conducted.
6. Evacuation routes must be clearly marked by exit signs.
7. The program must be responsible for providing physical facilities that are structurally sound and that meet all applicable federal, state, and local regulations for adequacy of construction, safety, sanitation, and health.

**Residential:
Semi-Independent Residential Services**

HIPAA Transaction Code	Code	Mod1	Mod2	Mod3	Mod4
Supported Housing (Mental Health)	H0043	R2			
Supported Housing (Addictive Diseases)	H0043	HF	R2		

Definition of Service: Semi-Independent Residential Service on-site programming for consumers within a residential setting to assist them to successfully maintain stable housing, continue with their recovery, and increase self-sufficiency.

Semi Independent Residential Services may only be provided by a DBHDD Contracted Provider.

Target Population	Adults aged 18 or older with 1. Serious Mental Illness, Addictive Disease Issues, or Co-occurring Mental Illness and Addictive Diseases Diagnoses and 2. Demonstrates the need for 24/7 available staff support, daily contact, and moderate assistance with residential responsibilities.
Utilization Criteria	Available to those eligible for Core Customer Ongoing Support and Recovery services.
Benefit Information	<u>Available to those with a LOCUS Level Of Care:</u> 2. Low Intensity Community based Services 3: High Intensity Community-Based Services 4: Medically Monitored Non-Residential Services
Unit Value	Unit= 1 day
Reimbursement Rate	N/A
Initial Authorization	180 units
Re-Authorization	180 units
Authorization Period	180 days
UAS: Budget and Expense Categories	<u>Residential Services Provider</u> 142- Adult Mental Health 744 Adult Addictive Diseases
Admission Criteria	1. Individual must meet target population as indicated above; and one or more of the following: 2. Individual's symptoms/behaviors indicate a need for moderate skills training and personal supports; or 3. Individual has limited skills needed to maintain stable housing and has failed using a less intensive residential service; or 4. Individual requires frequent medication assistance to prevent relapse.
Continuing Stay Criteria	Individual continues to meet Admission Criteria
Discharge Criteria	1. Individual can effectively and safely be supported with a more appropriate level of service due to change in individual's level of functioning; or 2. Individual or appropriate legal representative requests discharge.

Service Exclusions	None
Clinical Exclusions	1. Individuals with the following conditions are excluded from admission unless there is documented evidence of psychiatric condition: developmentally disabled persons who do not have co-occurring mental illness or substance abuse issues, autism, organic mental disorder, or traumatic brain injury.

Additional Service Criteria:

A. Required Components

1. The organization must have an executive director or program director charged with the responsibility for day-to-day management of the organization.
2. If applicable, the organization must be licensed by the Georgia Office of Regulatory Services to provide residential services to consumers with mental illness and/or substance abuse diagnosis.
3. The residential program must provide a supported living environment 24 hours, 7 days a week. Staff will be on-site for at least 36 hours each week to accommodate residents' needs. There must be an emergency response plan when staff is not scheduled on-site.
4. Within the required 36 hours of staffing coverage, Semi-Independent Residential Service must provide a minimum of 3 hours per week of skills training and/or personal support relevant to the consumer's Individualized Recovery Plan.
5. There must be a written Residential Crisis Response Plan that guides the residential provider's response to an individual's crisis episode while receiving residential services that diverts the loss of housing and promotes housing stability. This plan shall be developed in partnership with the individual and offer 24/7 access to a residential services specialist in the event of a crisis.

B. Staffing Requirements

1. Residential Managers may be persons with at least 2 years experience providing MH or AD services and at least a high school diploma; however, this person must be directly supervised by a licensed staff member (including LMSW, LAMFT, LAPC or 4 year RN).
2. Persons with high school diplomas, GEDs, or higher, who have completed the paraprofessional training required for DBHDD contracted organizations may provide direct support services under the supervision of a Residential Manager.
3. A staff person must be available 24/7 to respond to emergency calls within one (1) hour.
4. A staff person must be on site at least 36 hours a week.

C. Program Operations

1. The organization must have a written description of the Semi-Independent Residential Service offered that includes, at a minimum, the purpose of the service; the intended population to be served; level of supervision and oversight provided; and outcome expectations for its residents.
2. The focus of Semi-Independent Residential Service is to view each consumer as the director of his/her own recovery; to promote the value of self-help and peer support; to provide information about mental illness and coping skills; to promote social skills, community resources, and individual advocacy; to promote employment and education to foster self-determination and career advancement; to support each consumer in using community

- resources to replace the resources of the mental health system no longer needed; and to support each consumer to fully integrate into scattered site residential placement or in housing of his or her choice, and to provide necessary support and assistance to the consumer that furthers recovery goals, including transportation to appointments and community activities that promote recovery.
3. The Goal of Semi-Independent Residential Supports is to further integrate the consumer into an accepting community in the least intrusive environment that promotes housing of his/her choice.
 4. The outcomes of Semi-Independent Residential Supports will focus on recovery, housing, employment, and meaningful life in the community. These outcomes will be measured based upon:
 - a. Reduction in hospitalizations;
 - b. Reduction in incarcerations;
 - c. Maintenance of housing stability;
 - d. Participation in education, vocational training or gainful employment, if this is a goal in the Individualized Recovery Plan;
 - e. Participation in community meetings and other social and recreational activities;
 - f. Participation in activities that promote recovery and community integration.
 5. Semi-Independent Residential Service assists those individuals who will benefit from a moderate level of personal support and skill training to restore, develop, or maintain skills in functional areas in order to live meaningful lives in the community; develop or maintain social relationships; and participate in social, interpersonal, recreational or community activities. Services must be delivered to individuals according to their IRP.
 6. Semi-Independent Residential Service provides at least 36 hours of on-site residential service and a minimum of 3 hours of direct skills training and/or individual support each week. This level of residential service shall include:

Skill Training Activities such as budgeting, shopping, menu planning and food preparation, leisure skill development, maintaining a residence, using public transportation, symptom identification and management, medication self-administrating training, and other needed skills training as identified in the IRP.

AND

Personal Support Activities such as daily face-to-face contact with the consumer by Residential Service staff to ensure needs are being met; supportive counseling; crisis intervention as needed; tracking of appointments, assistance with transportation to appointments, shopping, employment, academics, recreational and support activities, and other needed supports as identified in the IRP

D. Service Access

In addition to receiving Semi Independent Residential Services, consumers will be linked to adult mental health and/or addictive disease services including Core or private Psychiatrist or Specialty services.

E. Additional Medicaid Requirements

This is not a Medicaid reimbursable service.

F. Reporting & Billing Requirements

1. All applicable MICP and other DBHDD reporting requirements must be met.

2. Each month, the provider must submit a Monthly Residential Service Report developed by the Department that identifies the actual utilization of semi-independent residential services including amount spent, number of units occupied, and number of individuals served.

G. Documentation Requirements

1. Individuals receiving this service must have a qualifying diagnosis present in the medical record prior to the initiation of services. The diagnosis must be given by persons identified in O.C.G.A. Practice Acts as qualified to provide a diagnosis.
2. Providers must document services in accordance with the specifications for documentation found in "Documentation Guidelines" in Part II, Section IV of this manual.
3. The organization must develop and maintain sufficient written documentation to support that Semi-Independent Residential Services were provided to the individual, as defined herein and according to billing. This documentation must confirm that the individual for whom billing is requested was a resident of the Semi-Independent Residential Services on the date billed. The individual's record must also include each week's programming/ service schedule in order to document provision of the required amount of skill training and personal support activities.
4. Providers must provide documentation that demonstrates compliance with a minimum of 3 hours each week of skills training and personal support activities, which include date, and time in/time out of contact.
5. Weekly progress notes must be entered in the individual's record to enable the monitoring of the individual's progress toward meeting treatment and rehabilitation goals and to reflect the Individualized Recovery Plan implementation.
6. The record should include health issues or concerns and how they are being addressed, appointments for psychiatric and medical care that are scheduled for the consumer, attendance at other treatments, such as addictive diseases counseling that staff may be assisting the consumer to attend, assistance provided to the consumer to help him or her reach recovery goals, and the consumer's participation in other recovery activities.
7. Each note must be signed and dated and must include the professional designation of the individual making the entry.
8. Documentation must be legible and concise and include the printed name and the signature of the treating practitioner. The name, title, and credentials of the individual providing the service must reflect the staffing requirements established for Semi-Independent Residential Services being delivered.

H. Facilities Management (applicable to traditional residential settings such as group homes, Treatment facilities, etc.)

1. Each resident facility must be arranged and maintained to provide adequate measures for the health, safety, access and well being of the residents.
2. Each resident facility must comply with all relevant safety codes.
3. All areas of the residential facility must be clean, safe, appropriately equipped, and furnished for the services delivered.
4. The facility must comply with the Americans with Disabilities Act.
5. The facility must maintain a written evacuation plan to be used in the case of fire or other disaster. An appropriate written certification of compliance must be obtained indicating that all applicable fire and safety code requirements have been satisfied. Periodic fire and other safety drills must be conducted.
6. Evacuation routes must be clearly marked by exit signs.

7. The program must be responsible for providing physical facilities that are structurally sound and that meet all applicable federal, state, and local regulations for adequacy of construction, safety, sanitation, and health.

Residential Substance Detoxification							
HIPAA Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Alcohol and/or Other Drug Services; Sub-acute Detoxification (Residential Addiction Program Outpatient)		H0012					\$85.00

Definition of Service: Residential Substance Detoxification is an organized and voluntary service that may be delivered by appropriately trained staff who provide 24-hour per day, 7 day per week supervision, observation and support for individuals during detoxification. Residential detoxification is characterized by its emphasis on medical monitoring and/or on peer/social support, and should reflect a range of residential detoxification service intensities from ASAM (American Society of Addiction Medication) Level III.2D to III.7D. These levels provide care for individuals whose intoxication/withdrawal signs and symptoms may only require 24-hour supervision, observation and support by appropriately trained staff with an emphasis on peer/social support that cannot be provided by the individual's natural support system, or that are sufficiently severe enough to require 24-hour medically monitored withdrawal management and support from medical and nursing professionals in a permanent facility with inpatient beds. All programs at these levels rely on established clinical protocols to identify individuals who are in need of medical services beyond the capacity of the facility and to transfer such individuals to more appropriate levels of service.

Target Population	Adults and Older Adolescents with a diagnosis of one of the following: 303.00 291.81 291.0 292.89 292.0
Benefit Information	Available to all Ongoing Core Customers. Requires a MICP New Episode Request or Update Request (to add as a single service to an existing authorization).
Utilization Criteria	<u>Available to those with LOCUS scores:</u> 3: High Intensity Community-Based Services 4: Medically Monitored Non-Residential 5: Medically Monitored Community Residential 6: Medically Managed Residential
Ordering Practitioner	Physician, Physician's Assistant, Advanced Practice Registered Nurse (Clinical Nurse Specialist or Nurse Practitioner)
Unit Value	Unit=1 day (per diem)
Initial Authorization	30 days
Maximum Daily Units	1 unit
Re-Authorization	
Authorization Period	30 days

UAS: Budget and Expense Categories	<u>Addictive Diseases Detoxification Services Provider</u> 765 – Adult Addictive Diseases 865 – C&A Addictive Diseases
Admission Criteria	<ol style="list-style-type: none"> 1. Individual has a Substance Related Disorder as defined in the latest version of the DSM (ASAM PPC-2, Dimension-1 and is experiencing signs of severe withdrawal, or there is evidence (based on history of substance intake, age, gender, previous withdrawal history, present symptoms, physical condition, and/or emotional/behavioral condition) that severe withdrawal syndrome is imminent; and is assessed as manageable at this level of service; and 2. There is strong likelihood that the individual will not complete detoxification at another level of service and enter into continued treatment or self-help recovery as evidenced by one of the following: <ol style="list-style-type: none"> a. individual requires medication and has recent history of detoxification at a less intensive service level, marked by past and current inability to complete detoxification and enter continuing addiction treatment; individual continues to lack skills or supports to complete detoxification, or b. individual has a recent history of detoxification at less intensive levels of service marked by inability to complete detoxification or enter into continuing addiction treatment and continues to have insufficient skills to complete detoxification, or c. individual has co-morbid physical or emotional/behavioral condition that is manageable in a Level III.7-D setting but which increases the clinical severity of the withdrawal and complicates detoxification.
Continuing Stay Criteria	Individual's withdrawal signs and symptoms are not sufficiently resolved so that the individual can be managed in a less intensive service.
Discharge Criteria	<ol style="list-style-type: none"> 1. An adequate continuing care plan has been established; and one or more of the following: 2. Goals of the Individualized Recovery Plan have been substantially met; or 3. Individual requests discharge and individual is not in imminent danger of harm to self or others; or 4. Individual's signs and symptoms of withdrawal have failed to respond to treatment and have intensified (as confirmed by higher scores on the CIWA-Ar or other comparable standardized scoring system), such that transfer to a Level IV-D detoxification service is indicated.
Service Exclusions	ACT, Nursing Assessment and Medication Administration (Medication administered as a part of Residential Detoxification is not to be billed as Medication Administration.)
Clinical Exclusions	Concomitant medical condition and/or other behavioral health issues warrant inpatient treatment or Crisis Stabilization Unit admission.

Additional Service Criteria:

A. Required Components

1. This service must be licensed by DCH/HFR under the Rules and Regulations for Drug Abuse Treatment Programs, 290-4-2.
2. A physician's order in the individual's record is required to initiate a detoxification regimen.
3. Medication administration may be initiated only upon the order of a physician.
4. Verbal orders or those initiated by a Physician's Assistant or Clinical Nurse Specialist are acceptable provided they are signed by the physician within 24 hours or the next working day.

B. Staffing Requirements

1. Services must be provided by a combination of nursing, other licensed medical staff, and other residential support under supervision of a physician.
2. In programs that are designed to target older adolescents, staffing patterns must reflect staff expertise in the delivery of services to that age population. In addition, higher staffing ratios would be expected in these programs related to supervision.

C. Clinical Operations

1. Individuals receiving this service must have a qualifying diagnosis present in the medical record prior to the initiation of services. The diagnosis must be given by persons identified in O.C.G.A Practice Acts as qualified to provide a diagnosis. These practitioners include a licensed psychologist, a physician or a PA or APRN (NP and CNS-PMH) working in conjunction with a physician with an approved job description or protocol.

D. Service Access

E. Additional Medicaid Requirements

1. For Medicaid recipients, certain individual services may be billed to Medicaid if the individual is receiving this service as a part of a Crisis Stabilization Unit (see CSU service description for billable services).
2. For those CSUs that bill Medicaid, the program bed capacity is limited to 16 beds.

F. Reporting & Billing Requirements

All applicable MICP and other DBHDD reporting requirements must be met.

G. Documentation Requirements

Providers must document services in accordance with the specifications for documentation requirements specified in Part II, Section V of the Provider Manual.

Respite							
HIPAA Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Respite Care Services, Not in the Home (Out of Home), Per Diem		H0045					\$56.00
Unskilled Respite Care, Not Hospice (In Home), Per Diem		S5151					\$56.00

Definition of Service: Respite services are brief periods of support or relief from current debilitating situations for individuals with mental illnesses and/or substance related disorders. Respite is provided: (1) when an individual is experiencing a psychiatric, substance related or behavioral crisis and needs structured, short-term support; (2) consumer-identified natural supports are unable to provide necessary illness-management support and thus the individual is in need of additional support or relief; or (3) when the individual and his/her identified natural supports experience the need for therapeutic relief from the stresses of their mutual cohabitation. Respite may be provided in-home (i.e. provider delivers service in individual's home) or out-of-home (individual receives service outside of their home), and may include day activities as well as overnight activities/accommodations as appropriate to the situation.

Target Population	Adults experiencing: Severe and Persistent Mental Illness Substance-Related Disorders Co-Occurring Substance-Related Disorders and Mental Illness Co-Occurring Mental Illness and Mental Retardation Co-occurring Substance-Related Disorders and Mental Retardation
Benefit Information	Available to all Ongoing Core Customers. Requires a MICP New Episode Request or Update Request (to add as a single service to an existing authorization).
Utilization Criteria	<u>Available to those with LOCUS scores:</u> 2: Low Intensity Community-Based Services 3: High Intensity Community-Based Services 4: Medically Monitored Non-Residential
Ordering Practitioner	Physician, Psychologist, Physician's Assistant, Advanced Practice Registered Nurse (Clinical Nurse Specialist or Nurse Practitioner), LPC, LMFT, LCSW
Unit Value	1 day
Initial Authorization	While the actual respite should be very short-term in nature, this service can be authorized as part of a 180 day Recovery/Resiliency plan. A maximum of 30 days may be provided to a single individual in a single authorization period.
Re-Authorization	180 days
Maximum Daily Units	1 unit
Authorization Period	180 days

UAS: Budget and Expense Categories	<u>Consumer/Family Support Services Provider</u> 136 – Adult Mental Health 736 – Adult Addictive Diseases
Admission Criteria	<ol style="list-style-type: none"> 1. Individual meets target population as identified above; and 2. Individual has a need for short-term support which could delay or prevent the need for out-of-home placement or higher levels of service intensity (such as acute hospitalization); and one or more of the following: 3. Individual has a circumstance which destabilizes his/her current living arrangement and the provision of this service would provide short-term relief and support of the individual; or 4. The consumer-identified natural supports network has an immediate need for support and relief from its role of supporting the individual in his/her behavioral health crises 5. The consumer-identified natural supports network has an immediate need to participate in an emergency event during which lack of support may cause the individual a setback in his/her Recovery plan.
Continuing Stay Criteria	<ol style="list-style-type: none"> 1. Individual continues to meet admission criteria as defined above; and 2. Individual has developed a Recovery goal to develop natural supports that promote the self/family-management of these needs.
Discharge Criteria	<ol style="list-style-type: none"> 1. Individual requests discharge; or 2. Individual has acquired natural supports that supplant the need for this service.
Service Exclusions	Traditional 24/7 Residential Supports
Clinical Exclusions	<ol style="list-style-type: none"> 1. Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of psychiatric condition overlaying the primary diagnosis: mental retardation, autism, organic mental disorder, traumatic brain injury. 2. Individual is actively using unauthorized drugs or alcohol (which should not indicate a need for discharge, but for a review of need for more intensive services).

Additional Service Criteria:

A. Required Components

B. Staffing Requirements

C. Clinical Operations

Individuals receiving this service must have a qualifying diagnosis present in the medical record prior to the initiation of services. The diagnosis must be given by persons identified in O.C.G.A Practice Acts as qualified to provide a diagnosis. These practitioners include a licensed psychologist, a physician or a PA or APRN (NP and CNS-PMH) working in conjunction with a physician with an approved job description or protocol.

D. Service Access

A maximum of 30 days may be provided to a single individual in a single authorization period.

E. Additional Medicaid Requirements

Not applicable. Not a Medicaid-billable service.

F. Reporting & Billing Requirements

All other applicable MICP and DBHDD reporting requirements must be met.

G. Documentation Requirements

Providers must document services in accordance with the specifications for documentation requirements specified in Part II, Section V of the Provider Manual.

Substance Abuse Intensive Outpatient (SA Day Treatment)

HIPAA Transaction Code	Code	Mod1	Mod2	Mod3	Mod4
See Item E.1. Below					

Definition of Service: A time limited multi-faceted approach treatment service for adults who require structure and support to achieve and sustain recovery from substance related disorders. These services are available during the day and evening hours to enable individuals to maintain residence in their community, continue to work or go to school and to be a part of their family life. The following elements of this service model will include:

1. Behavioral Health Assessment
2. Psychiatric Treatment
3. Nursing Assessment
4. Diagnostic Assessment
5. Community Support
6. Individual Counseling
7. Group Counseling (including psycho-educational groups focusing, relapse prevention and recovery)
8. Family Counseling/Training (including psychoeducation) for Family Members

The SA Intensive Outpatient Package emphasizes reduction in use and abuse of substances and/or continued abstinence; the negative consequences of substance abuse; development of social support network and necessary lifestyle changes; educational skills; vocational skills leading to work activity by reducing substance abuse as a barrier to employment; social and interpersonal skills; improved family functioning; the understanding of addictive disease; and the continued commitment to a recovery and maintenance program.

Services are provided according to individual needs and goals as articulated in the treatment plan. The programmatic goal of the service must be clearly articulated by the provider, utilizing the best/evidenced based practices for the service delivery and support that are based on the population(s) and issues to be addressed. Practitioners providing this service are expected to maintain knowledge and skills regarding current research trends in best/evidence based practices.

Target Population	Adult Core Customers with substance abuse disorders, including those with co-occurring mental illness, or Developmental Disabilities
Benefit Information	Requires a MICP New Episode Request or Update request (to add as a single service to an existing authorization)

Utilization Criteria	<p><u>Available to those with LOCUS scores:</u> 3: High Intensity Community-Based Services 4: Medically Monitored Non-Residential (transition) 5: Medically Monitored Community Residential (transition) 6: Medically Managed Residential (transition)</p>
Ordering Practitioner	Physician, Physician's Assistant, Advanced Practice Registered Nurse (Clinical Nurse Specialist or Nurse Practitioner)
Unit Value	See Authorization Package/Service Group Detail
Initial Authorization	See Authorization Package/Service Group Detail
Re-Authorization	See Authorization Package/Service Group Detail
Authorization Period	180 days
UAS: Budget and Expense Categories	<p><u>Addictive Disease Day Services Provider</u> Report UAS Codes as associated with unbundled services in Item E1 below.</p>
Admission Criteria	<ol style="list-style-type: none"> 1. A DSM IV diagnosis of Substance Abuse or Dependence or substance-related disorder with a co-occurring DSM IV diagnosis of mental illness or DD; and 2. The individual is able to function in a community environment even with impairments in social, medical, family, or work functioning; and 3. The individual is sufficiently motivated to participate in treatment; and 4. One or more of the following: <ol style="list-style-type: none"> a. The substance use is incapacitating, destabilizing or causing the individual anguish or distress and the individual demonstrates a pattern of alcohol and/or drug use that has resulted in a significant impairment of interpersonal, occupational and/or educational functioning; or b. The individual's substance abuse history after previous treatment indicates that provision of outpatient services alone (without an organized program model) is not likely to result in the individual's ability to maintain sobriety; or c. There is a reasonable expectation that the individual can improve demonstrably within 3-6 months; or d. The individual is assessed as needing ASAM Level II or III.1; or e. The individual has no significant cognitive and/or intellectual impairments that will prevent participation in and benefit from the services offered and has sufficient cognitive capacity to participate in and benefit from the services offered; or f. The individual is not actively suicidal or homicidal, and the individual's crisis, and/or inpatient needs (if any) have been met prior to participation in the program.
Continuing Stay Criteria	<ol style="list-style-type: none"> 1. The individual's condition continues to meet the admission criteria. 2. Progress notes document progress in reducing use and abuse of substances; developing social networks and lifestyle changes; increasing educational, vocational, social and interpersonal skills; understanding addictive disease; and/or establishing a commitment to a recovery and maintenance program, but the overall goals of the treatment plan have not

	<p>been met.</p> <p>3. There is a reasonable expectation that the individual can achieve the goals in the necessary reauthorization time frame.</p>
Discharge Criteria	<p>An adequate continuing care or discharge plan is established and linkages are in place; and one or more of the following:</p> <ol style="list-style-type: none"> 1. Goals of the treatment plan have been substantially met; or 2. Consumer recognizes the severity of his/her drug/alcohol usage and is beginning to apply the skills necessary to maintain recovery by accessing appropriate community supports 3. Clinical staff determines that consumer no longer needs ASAM Level II and is now eligible for aftercare and/or transitional services <p>Transfer to a higher level of service is warranted by change in the</p> <ol style="list-style-type: none"> 1. Individual's condition or nonparticipation; or 2. The individual refuses to submit to random drug screens; or 3. Consumer exhibits symptoms of acute intoxication and/or withdrawal or 4. The individual requires services not available at this level or 5. Consumer has consistently failed to achieve essential treatment objectives despite revisions to the treatment plan and advice concerning the consequences of continues alcohol/drug use to such an extent that no further process is likely to occur
Service Exclusions	<p>Services cannot be offered with Mental Health Intensive Outpatient Package or Psychosocial Rehabilitation. When offered with ACT, documentation must indicate efforts to minimize duplication of services and effectively transition the individual to the appropriate services. This combination of services is subject to review by the External Review Organization</p>

Additional Service Criteria:

A. Required Components

1. This service must be licensed by DCH/HFR under the Rules and Regulations for Drug Abuse Treatment Programs, 290-4-2.
2. The program provides structured treatment or therapeutic services, utilizing activity schedules as part of its operational method, i.e., plans or schedules of days or times of day for certain activities.
3. These services should be scheduled and available at least 5 hours per day, 4 days per week (20 hrs/week), with no more than 2 consecutive days without service availability for high need individuals (ASAM Level II.5). For programs that have a lower intensity program Level, it should be at least ASAM Level II.1 which includes 9 hours of programming per week.
4. The program utilizes methods, materials, settings, and outside resources appropriate to the developmental and cognitive levels, capabilities, age, gender, and culture of participants.
5. The program utilizes methods, materials, approaches, activities, settings, and outside resources appropriate for and targeted to individuals with co-occurring disorders of mental illness and substance abuse and targeted to individuals with co-occurring developmental disabilities and substance abuse when such individuals are referred to the program.

6. The program conducts random drug screening and uses the results of these tests for marking participant's progress toward goals and for service planning.
7. The program is provided over a period of several weeks or months and often follows detoxification or residential services.
8. This service must operate at an established site approved to bill Medicaid for services. However, limited individual or group activities may take place off-site in natural community settings as is appropriate to each individual's treatment plan. (Narcotics Anonymous (NA) and/or Alcoholics Anonymous (AA) meetings offsite may be considered part of these limited individual or group activities for billing purposes only when time limited and only when the purpose of the activity is introduction of the participating individual to available NA and/or AA services, groups or sponsors. NA and AA meetings occurring during the SA Intensive Outpatient package may not be counted toward the billable hours for any individual outpatient services, nor may billing related to these meetings be counted beyond the basic introduction of an individual to the NA/AA experience.).
9. This service may operate in the same building as other services; however, there must be a distinct separation between services in staffing, program description, and physical space during the hours the SA Intensive Outpatient Services is in operation.
10. Adequate space, equipment, furnishings, supplies, and other resources must be provided in order to effectively provide services and so that the program environment is clean and in good repair. Space, equipment, furnishings, supplies, transportation, and other resources for participating individuals' use within the Substance Abuse Intensive Outpatient package must not be substantially different from that provided for other uses for similar numbers of individuals.

B. Staffing Requirements

1. The program must be under the clinical supervision of a **Level 4 or above** who is onsite a minimum of 50% of the hours the service is in operation.
2. Services must be provided by staff who are:
 - a. Level 4 (LAPC, LMSW, CACII, CADC, CCADC and Addiction Counselor Trainee with supervision)
 - b. Level 5 (Paraprofessionals, high school graduates) under the supervision of an Level 4 or above
3. It is necessary for all staff who provide this "co-occurring capable" service to have basic knowledge in the Georgia DBHDD content areas in the Suggested Best Practices Principles and Staff Capabilities for Services Serving Individuals with Co-Occurring Disorders document included in this Provider Manual
4. Programs must have documentation that there is one Level 4 staff (excluding Addiction Counselor Trainee) that is "co-occurring capable." This person's knowledge must go beyond basic understanding and must demonstrate actual staff capabilities in using that knowledge for individuals with co-occurring disorders. Personnel documentation should demonstrate that this staff person has received a minimum of 4 hours of training in co-occurring treatment within the past 2 years.
5. There must be at least a Level 4 practitioner on-site at all times the service is in operation, regardless of the number of individuals participating.
6. The maximum face-to-face ratio cannot be more than 12 individuals to 1 direct program staff based on average daily attendance of individuals in the program.
7. The maximum face-to-face ratio cannot be more than 20 individuals to 1 SAP based on average daily attendance of individuals in the program.

8. A physician and/or a Registered Nurse or a Licensed Practical Nurse with appropriate supervision must be available to the program either by a physician and/or nurse employed by the agency, through a contract with a licensed practitioner, or by written referral or affiliation agreement with another agency or agencies that offer such services.
 - a. The physician is responsible for addiction and psychiatric consultation, assessment, and care (including but not limited to ordering medications and/or laboratory testing) as needed.
 - b. The nurse is responsible for nursing assessments, health screening, medication administration, health education, and other nursing duties as needed.
9. Level 4 staff may be shared with other programs as long as they are available as required for supervision and clinical operations and as long as their time is appropriately allocated to staffing ratios for each program.

C. Clinical Operations

1. It is expected that the transition planning for less intensive service will begin at the onset of these services. Documentation must demonstrate this planning.
2. Consumers receiving the Substance Abuse Intensive Outpatient Package must have a qualifying diagnosis present in the medical record prior to the initiation of services. The diagnosis must be given by persons identified in O.C.G.A Practice Acts as qualified to provide a diagnosis (Level 1).
3. A consumer may have variable length of stay. The level of care should be determined as a result of consumers' multiple assessments. It is recommended that individuals attend at a frequency appropriate to their level of need. Ongoing clinical assessment should be conducted to determine step down in level of care.
4. Each consumer should participate in setting individualized goals for themselves and in assessing their own skills and resources related to sobriety, use/abuse, and maintaining recovery. Goals are set by exploring strengths and needs in the consumer's living, learning, social, and working environments. Implementation of services may take place individually or in groups.
5. Each consumer must be provided assistance in the development and acquisition of needed skills and resources necessary to achieve sobriety and/or reduction in abuse and maintenance of recovery.
6. Substance Abuse Intensive Outpatient Package must offer a range of skill-building and recovery activities within the program.
7. The following the services must be included in the SA Intensive Outpatient Package. Many of these activities are reimbursable through Medicaid.

The activities include but not limited to:

a. Group Outpatient Services:

- I. Psycho-educational activities focusing on the disease of addiction prevention, the health consequences of addiction, and recovery
- II. Therapeutic group treatment and counseling
- III. Leisure and social skill-building activities without the use of substances
- IV. Linkage to natural supports and self-help opportunities

b. Individual Outpatient Services

- I. Individual counseling
- II. Individualized treatment, service, and recovery planning
- III. Linkage to health care

c. Family Outpatient Services

- I. Family education and engagement

- d. **Community Support**
 - I. Vocational readiness and support
 - II. Service coordination unless provided through another service provider
 - e. **Behavioral Health Assessment & Service Plan Development and Diagnostic Assessment**
 - I. Assessment and reassessment
 - f. **Services not covered by Medicaid**
 - I. Drug screening/toxicology examinations
8. In addition to the above required activities within the program, the following must be offered as needed either within the program or through referral to/ or affiliation with another agency or practitioner, and may be billed in addition to the billing for Substance Abuse Intensive Outpatient Package:
 - a. Community Support– for housing, legal and other issues
 - b. Individual counseling in exceptional circumstances for traumatic stress and other mental illnesses for which special skills or licenses are required
 - c. Physician assessment and care
 - d. Psychological testing
 - e. Health screening.
 9. The program must have a Substance Abuse Intensive Outpatient Services Organizational Plan addressing the following:
 - a. The philosophical model of the program and the expected outcomes for program participants (i.e., harm reduction, abstinence, beginning of or maintaining individually defined recovery, employment readiness, relapse prevention, stabilization and treatment of those with co-occurring disorders).
 - b. The schedule of activities and hours of operations.
 - c. Staffing patterns for the program.
 - d. How the activities listed above in Items 4 and 5 will be offered and/or made available to those individuals who need them, including how that need will be determined.
 - e. How assessments will be conducted.
 - f. How staff will be trained in the administration of addiction services and technologies.
 - g. How staff will be trained in the recognition and treatment of co-occurring disorders of mental illness and substance abuse pursuant to the Georgia Best Practices
 - h. How services for individuals with co-occurring disorders will be flexible and will include services and activities addressing both mental health and substance abuse issues of varying intensities and dosages based on the symptoms, presenting problems, functioning, and capabilities of such individuals.
 - i. How individuals with co-occurring disorders who cannot be served in the regular program activities will be provided and/or referred for time-limited special integrated services that are co-occurring enhanced as described in the Georgia Suggested Best Practices
 - j. How services will be coordinated with the substance abuse array of services including assuring or arranging for appropriate referrals and transitions.
 - k. How the requirements in these service guidelines will be met.

D. Service Access

The package is offered at least 5 hours per day at least 4 days per week with no more than 2 consecutive days between offered services, and distinguishes between those individuals needing between 9 and 20 hours per week of structured services per week (ASAM Level II.1) and those

needing 20 hours or more of structured services per week (ASAM Level II.5 or III.1) in order to begin recovery and learn skills for recovery maintenance. The program may offer services a minimum of only 3 hours per day for only 3 days per week with no more than 2 consecutive days between offered services if only individuals at ASAM Level II.1 are served.

E. Additional Medicaid Requirements

1. Effective July 1, 2009 Medicaid stopped paying a bundled daily rate for Substance Abuse Day Services. These services now will be unbundled and billed per service. As mentioned above Substance Abuse Intensive Outpatient Package allows providers to select all services that will be offered in a substance abuse outpatient setting. Billable services and daily limits within SA Intensive Outpatient Package are as follows:

Service	Maximum Authorization Units	Maximum Daily Units
Behavioral Health Assessment & Service Plan Development	32	24
Diagnostic Assessment	4	2
Psychiatric Treatment	12	1
Nursing Assessment & Care	48	16
Community Support	600	96
Individual Outpatient Services	36	1
Group Outpatient Services	1170	20
Family Outpatient Services	100	8

F. Reporting/Billing Requirements

1. All applicable Medicaid, MICP, ERO, and other DBHDD reporting requirements must be met.
2. The maximum number of units that can be billed differs depending on the individual service. Please refer to the table below or in the Mental Health and Addictive Disease Orientation to Authorization Packages Section of this manual.
3. Approved providers of this service may submit claims/encounters for the unbundled services listed in the package, up to the daily maximum amount for each service. Program expectations are that this model follow the content of this Service Guideline as well as the clearly defined service group elements.

G. Documentation Requirements

1. Provider must document services in accordance with the specifications for documentation requirements specified in Part II, Section V of the Provider Manual.
2. Every admission and assessment must be documented.
3. Progress notes must include written daily documentation of important occurrences; level of functioning; acquisition of skills necessary for recovery; progress on goals identified in the IRP including acknowledgement of addiction, progress toward recovery and use/abuse reduction and/or abstinence; use of drug screening results by staff; and evaluation of service effectiveness.
4. Daily attendance of each individual participating in the program must be documented showing the number of hours in attendance for billing purposes.
5. This service may be offered in conjunction with ACT or Crisis Residential Services for a limited time to transition consumers from one service to the more appropriate one. When this service is

used in conjunction with ACT or Crisis Residential services, documentation must demonstrate careful planning to maximize the effectiveness of this service as well as an appropriate reduction in service amounts of the service to be discontinued. Utilization of Substance Abuse Day Services in conjunction with these services is subject to review by the External Review Organization.

Supported Employment					
HIPAA Transaction Code	Code Detail	Code	Mod1	Mod2	Rate
Supported Employment		H2024			\$410.00

Definition of Service: In line with current best practice, this service emphasizes that a rapid job search and placement approach be prioritized above traditional prevocational training or traditional vocational rehabilitation. Job development, placement and training are for people who, due to the severity of their disabilities, need support to locate, choose, obtain, learn and maintain a job. Services include supports to choose and obtain paid employment in competitive wage, individual-based community jobs, as well as brief training support to learn the specific job skills/tasks necessary to perform and retain a particular job. Services are provided to any individual interested in obtaining employment, regardless of the degree of disability, and with particular attention and consideration to the individual's interests, strengths, needs, capabilities, priorities, concerns, previous work experiences and informed choice (**i.e. job placement should be individualized**).

Once a job is obtained, brief on-the-job training and support is available through this service to assist individuals in learning the job-specific skills/tasks necessary to successfully performing the new job.

It is expected that service staff will maintain regular, meaningful collaboration with the individual's mental health/substance abuse treatment team.

Managers and staff are encouraged to become familiar with evidence-based practice on Supported Employment such as the SAMHSA (Substance Abuse and Mental Health Services Administration Supported Employment Toolkit that provides guidelines and practices that enhance outcomes for consumers). Website for SAMHSA toolkit is:

<http://mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/employment>

Services may be provided in a variety of settings and must meet the following specific service criteria:

- 1) Employment is paid;
- 2) Employment provides opportunities to interact with people who do not have disabilities;
- 3) Training includes brief teaching/modeling of the specific skills/tasks necessary to perform the job; and
- 4) Regular, meaningful collaboration with the mental health/substance abuse treatment team is maintained.

Moreover, the service should maintain a focus on the individual's long-term career goals if a career is important to the individual, and attempt to place the individual in a job accordingly, rather than simply placing the individual in the easiest, lowest requirement job available. Jobs may be full or part time, and frequent opportunities for individuals to interact with non-disabled co-workers during the performance of their jobs or during breaks, working hour meals or travel to and from work is an important benefit. More than one individual consumer with a disability could work for the same employer and still be considered to receive this service, as long as consumers are not grouped within the work site. Wages must be paid in compliance with all applicable Department of Labor requirements.

The programmatic goals of this service must be clearly articulated by the provider, utilizing best/evidence based practices for employment services. Practitioners providing this service are expected to maintain knowledge and skills regarding current research trends in best/evidence based practices.

Target Population	Adults and Older Adolescents with a: Mental Illness Substance Related Disorder Co-Occurring Substance-Related Disorder and Mental Illness, Co-Occurring Mental Illness and Mental Retardation/Developmental Disabilities Co-Occurring Substance-Related Disorder and Mental Retardation/Developmental Disabilities
Benefit Information	Available to all Ongoing Core Customers. Requires a MICP New Episode Request or Update Request (to add as a single service to an existing authorization).
Utilization Criteria	<u>Available to those with LOCUS scores:</u> 2: Low Intensity Community-Based Services* 3: High Intensity Community-Based Services *Those who enter this service with a LOCUS score of 2 may continue to receive the service at LOCUS level 1 with ERO approval.
Ordering Practitioner	Physician, Psychologist, Physician's Assistant, Advanced Practice Registered Nurse (Clinical Nurse Specialist or Nurse Practitioner), LPC, LMFT, LCSW
Unit Value	1 month – Weekly documentation via daily attendance or weekly time sheet.
Initial Authorization	180 days
Re-Authorization	180 days
Authorization Period	180 days
UAS: Budget and Expense Categories	<u>Employment Services Provider</u> 139 – Adult Mental Health 739 – Adult Addictive Diseases
Admission Criteria	1. Individuals who meet the target population criteria and indicate an interest through Recovery Planning in establishing or enhancing work skills; and 2. Individuals for whom behavioral health issues have caused unemployment or underemployment.
Continuing Stay Criteria	1. Individuals who meet the target population criteria and indicate an interest through Recovery Planning in establishing or enhancing work skills; and 2. Individuals for whom behavioral health issues have caused unemployment or underemployment; and 3. Individual demonstrates documented progress relative to goals identified in the Individualized Recovery Plan for employment, but employment goals have not yet been achieved.
Discharge Criteria	1. Goals of the Individualized Recovery Plan related to employment have been substantially met; or

	2. Individual requests a discharge from this support.
Service Exclusions	
Clinical Exclusions	Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of a psychiatric condition overlaying the primary diagnosis: mental retardation, autism, organic mental disorder.

Additional Service Criteria:

A. Required Components

1. The programmatic goals of this service must be clearly articulated by the provider, utilizing best/evidence based practices for employment services.
2. Wages must be paid in compliance with all applicable Department of Labor requirements.

B. Staffing Requirements

Practitioners providing this service are expected to maintain knowledge and skills regarding current research trends in best/evidence based practices.

C. Clinical Operations

1. Individuals should be encouraged to be as involved and self-directed in the job location and placement process as possible (e.g. the individual should call a potential employer to inquire about a job rather than staff calling when possible (which may entail coaching the individual), and the individual should be offered assistance—though not advice-- from staff in making the personal decision about whether or not to disclose his or her disability to a potential employer).
2. Individuals receiving this service must have a qualifying diagnosis present in the medical record prior to the initiation of services. The diagnosis must be given by persons identified in O.C.G.A Practice Acts as qualified to provide a diagnosis. These practitioners include a licensed psychologist, a physician or a PA or APRN (NP and CNS-PMH) working in conjunction with a physician with an approved job description or protocol

D. Service Access

E. Additional Medicaid Requirements

Not Applicable. Not a Medicaid-billable service.

F. Reporting & Billing Requirements

1. All applicable MICP and other DBHDD reporting requirements must be met.
2. A monthly, standardized report may be required by the DBHDD to monitor outcomes.

G. Documentation Requirements

1. Providers must document services in accordance with the specifications for documentation requirements specified in Part II, Section V of the Provider Manual.

GEORGIA DBHDD – BEST PRACTICE SUGGESTIONS

PRINCIPLES AND STAFF CAPABILITIES FOR SERVICES FOR ADULTS WITH CO-OCCURRING DISORDERS – April 17, 2002

Principles

11. Services for persons with co-occurring disorders should be integrated, rather than sequential. That is, they should be structured to deal with both disorders at once rather than requiring one disorder and one set of symptoms to be dealt with before services for the other can begin.
12. Psychosocial Rehabilitation (PSR) programs and Substance Abuse (SA) Day Services programs will be initially encouraged and eventually required to work toward becoming “co-occurring capable,” that is, able to deal flexibly with the issues of persons with co-occurring disorders.
13. “Co-occurring enhanced” services are time limited and go beyond co-occurring capable services and programs. They are characterized by the following:
 - Additional or special assessments requiring additional training or competencies, perhaps utilizing additional or specialized assessment tools;
 - Special training, experience, licensure, certification, or other qualifications of staff beyond basic recognition and general capabilities of addressing the needs of persons with co-occurring disorders within a larger program (see recommended staff capabilities below);
 - Availability of addictionologist and/or MAC, CACII, or CADC consultation;
 - Availability of psychiatric consultation and/or medication management;
 - Availability of crisis services if needed, either directly or through an interagency agreement with a mobile crisis service;
 - Additional staff to client ratio beyond the minimum requirements for a limited period of time, in order to deal effectively with individuals needing more intense or more frequent services than those offered in a co-occurring capable day services program; and
 - Additional programming intensity or specialized approaches or activities requiring significant adjustments to the usual day services activities to assure adequate dosing, frequency, and integration of services for individuals with co-occurring disorders.
14. Programs that provide PSR or SA Day Services will be required to either provide or arrange for co-occurring enhanced integrated services for adults with co-occurring disorders until those individuals can move back into regular co-occurring capable day services. Adults with co-occurring disorders should not be expected to simply adapt to usual or routine PSR or SA Day Services activities.
15. Co-occurring enhanced day services may be provided within a larger SA Day Services or PSR program, may be a separate day services program within a larger agency, or may be a stand-alone service provider.
16. An adult with serious and persistent mental illness and a co-occurring substance abuse disorder should be served in a co-occurring capable or co-occurring enhanced PSR program. Adults with substance abuse or dependence who also have a co-occurring mental health needs that do not rise to the level of serious and persistent mental illness should be served in a co-occurring capable or co-occurring enhanced SA Day Services.
17. An adult with serious and persistent mental illness whose symptoms are stable enough so that Intensive Day Treatment is not indicated; whose cognitive functioning is high enough to participate in and benefit from a co-occurring capable SA Day Services program without distraction; whose coping

skills and abilities are sufficiently intact to allow attention to his/her substance abuse; and who can understand the emotional concerns related to the negative consequences and effects of addiction should be allowed to choose service in a SA Day Services program. An adult with serious and persistent mental illness may not be refused service in an SA Day Services program simply because he/she is seriously and persistently mentally ill. Likewise, a seriously and persistently mentally ill adult may not be refused service in a PSR program simply because he/she is abusing or dependent on alcohol or other drugs.

18. Adults with serious and persistent mental illness whose symptoms, cognition, functioning, or coping skills are sufficiently impaired to prevent participation or benefit from a co-occurring capable day services program but who meet the admission criteria for either PSR or SA Day Services, must be served by a co-occurring enhanced PSR or SA Day Services program.
19. The service guidelines for PSR Services and for SA Day Services will include the same requirements about cross training and capabilities of staff to recognize and treat adults with co-occurring disorders.
20. DBHDD will work to ensure that there is no financial disincentive to serving individuals with co-occurring disorders in any particular day services program.
14. Basic knowledge necessary for all staff serving persons with mental illness or substance abuse in "co-occurring capable" day services must include the content areas below. For programs that are "co-occurring enhanced," this knowledge must go beyond basic understanding and must demonstrate actual staff competencies in using that knowledge to serve adults with co-occurring disorders.
15. PSR and SA Day Services Program Managers and staff are encouraged to become familiar with ASAM Patient Placement Criteria – 2R and current evidence-based practices literature about serving adults with co-occurring disorders.

GEORGIA DBHDD – BEST PRACTICES SUGGESTIONS

Staff Knowledge and Capabilities

About

Serving Persons with Co-Occurring Disorders

Necessary Capabilities for Substance Abuse Staff	Necessary Capabilities for Mental Health Staff
<ul style="list-style-type: none">• knowledge of mental illness diagnoses, symptoms, and cognitive impairments where applicable;• medications used to treat various types of mental illness and their effects, including undesired medication side effects and the effects of discontinuing these medications;• assessment of mental illness;• likely coping strategies of individuals with mental illness, including use and abuse of substances,• concept of role of family members and psychoeducational approaches for working collaboratively with them;• motivational counseling for clients who are not ready to take full responsibility for self-management and recovery from substance abuse;• behavioral counseling for those who are actively working on recovery;• denial about mental illness or its symptoms, while respecting and encouraging individual choice and responsibility;• individual strategies for preventing symptom exacerbation; and• difference between recovery and engagement concepts in mental health and in substance abuse.	<ul style="list-style-type: none">• knowledge of substances of abuse and how they affect mental illnesses;• symptoms of withdrawal from various types of substances of abuse;• complications of interactions between psychotropic medications and substances of abuse, especially in detoxification and withdrawal processes;• assessment of substance abuse;• special considerations in assessing substance abuse in adults who have symptoms associated with a mental illness or who are taking or are candidates for taking prescribed medications for a diagnosed mental illness;• motivational counseling to use with clients who appear to be unmotivated for substance abuse treatment;• behavioral substance abuse counseling for those who are motivated to work toward abstinence;• denial and its role in addiction;• methods for overcoming denial while respecting and encouraging individual choice and responsibility;• relapse prevention strategies for persons with addictions; and• difference between recovery and engagement concepts in substance abuse and in mental health.

Part I

Eligibility, Service Definitions and Requirements

SECTION II

***Eligibility, Service
Definitions and Service
Guidelines for
Developmental Disabilities
Services***

Fiscal Year 2012



**Georgia Department of Behavioral Health &
Developmental Disabilities**

April 2012

DBHDD

Eligibility for Developmental Disabilities Services

To be eligible for Developmental Disabilities Services, individuals must meet disability and financial criteria. One of the Department of Behavioral Health and Developmental Disabilities (DBHDD) Regional Offices determines disability eligibility for individuals residing in that region. The Department of Family and Children Services (DFCS) determines financial and Medicaid eligibility for services which are funded through Medicaid Waiver resources. Eligibility for the Medicaid waiver programs is determined by DBHDD Regional Offices in accordance with waiver policies.

To be eligible for **developmental disabilities services, an individual must meet the eligibility criteria below.** The contractor will deliver services to individuals who meet the following criteria:

A. Most in Need: The individual demonstrates:

1. Substantial risk of harm to self or others; or
2. Substantial inability to demonstrate community living skills at an age-appropriate level; or
3. Substantial need for supports to augment or replace insufficient or unavailable natural resources

AND

B. Diagnosis:

1. **Developmental Disability:** The individual meets the following diagnostic criteria for a developmental disability, which is a severe, chronic disability of the individual, as determined by a professional licensed to do so:
 1. Is attributable to a significant intellectual disability, or any combination of a significant intellectual disability and physical impairments;
 2. Is manifested before the individual attains age 22;
 3. Is likely to continue indefinitely;
 4. Results in substantial functional limitations in three or more of the following areas of major life activities:
 - a. Self-care;
 - b. Receptive and expressive language;
 - c. Learning;
 - d. Mobility;
 - e. Self-direction; and
 - f. Capacity for independent living; and
 5. Reflects the individual's need for a combination and sequence of special, interdisciplinary, or generic services, individualized supports, or other forms of assistance, which are of lifelong or extended duration and are individually planned and coordinated.

OR

- C. **Mental Retardation:** The individual has a diagnosis of mental retardation based on assessment findings of significantly subaverage general intellectual functioning and significantly impaired adaptive functioning.

Mental Retardation/Developmental Disabilities Services Definitions NOW & COMP Waiver Services¹

¹Individuals have the option to self-direct NOW services with the exception of Financial Support Services, Prevocational, and Support Coordination. The co-employer, participant-direction option is available under the NOW for Community Access, Community Guide, Community Living Support, Respite, Supported Employment, and Transportation.

Individuals have the option to self-direct COMP services with the exception of Community Residential Alternative, Financial Support Services, Prevocational, and Support Coordination. The co-employer, participant-direction option is available under the COMP for Community Access, Community Guide, Community Living Supports, Supported Employment, and Transportation.

Behavioral Supports Consultation

NOW & COMP Waiver

HIPAA Transaction Code	Code	Mod1 Self D	Mod2	Mod3	Mod4
Behavioral Supports Consultation	H2019	UC			

Definition of Service: Individuals can choose the self-direction option with Behavioral Supports Consultation Services.

Behavioral Supports Consultation Services are professional consultation services that assist the individual with significant, intensive challenging behaviors that interfere with activities of daily living, social interaction, work, or similar situations. These services consist of behavioral supports professional evaluation, training, and intervention services. Evaluation services by the Behavioral Supports professional consultant include functional assessment of behavior and other diagnostic assessment of behavior. Training and intervention services by the Behavioral Supports professional consultant comprise direct skills training of individuals as well as family education and training on Positive Behavioral Supports.

Behavioral Supports Consultation Services provide for the development of Behavior Supports plans for the acquisition or maintenance of appropriate behaviors for community living and behavioral intervention for the reduction of maladaptive behaviors. Intervention modalities described in plans must relate to the identified behavioral needs of the waiver individual, and specific criteria for remediation of the behavior must be established and specified in the plan. Behavioral Supports Consultation Services may not be provided to individuals receiving Community Residential Alternative Services in the Comprehensive Supports Waiver (COMP).

Behavioral Supports Consultation services are provided by appropriately qualified individuals with expertise in behavioral supports evaluation and services for people with developmental disabilities. These services may be provided in an individual's own or family home, the Behavioral Supports Consultant's office, outpatient clinics, facilities in which Community Access or Prevocational Services are provided, Supported Employment work sites, or other community settings specific to community-based behavioral supports goals specified in the Individual Service Plan.

ADDITIONAL SERVICE INFORMATION:

1. Providers of Behavioral Supports Consultation services must comply with the guidelines and requirements for the provision of behavioral supports to individuals with developmental disabilities in the DHR, MHDDAD Guidelines for Supporting Adults with Challenging Behaviors in Community Settings and Behavioral Supports Guidelines (see Guidelines in Appendix D) in the delivery of these services; providers rendering Behavioral Supports Consultation services to individuals under the age of eighteen years must comply with any guidelines and requirements in these DBHDD Guidelines that are applicable to children and adolescents with developmental disabilities.

Revised August 12, 2011

2. Providers can provide Behavioral Supports Consultation Services at facilities where Community Access and Prevocational Services are rendered; however, the services must be documented and billed separately, and any waiver individual receiving multiple services may not receive these services at the same time of the same day.

Community Access Services					
NOW & COMP Waiver					
HIPAA Transaction Code	Code	Mod1	Mod2 Self D	Mod3 Co Emp	Mod4
Community Access Group	T2025	HQ	UC	UA	
Community Access Individual	T2025	UB	UC	UA	

Definition of Service:

Community Access Services are designed to assist the individual in acquiring, retaining, or improving self-help, socialization, and adaptive skills required for active community participation and independent functioning *outside* the individual's home or family home. These services are interventions in the areas of social, emotional, physical, and intellectual development and may include training in the areas of daily living skills (including leisure/recreation skills); communication training; mobility training; programming to reduce inappropriate and/or maladaptive behaviors; and training in the use of common community resources.

The emphasis of training will be on assisting the individual in increasing self help, socialization skills, skills or daily living and adaptive skills required for active community participation and independent functioning outside the individual's home or family home. These activities include accompanying individuals to the grocery store, or eating establishments; teaching an individual how to participate in appropriate social and recreational activities; and assessing other activities of community living.

The services typically occur during the day but may also take place in the evenings and weekends. Community Access services are individually planned to meet the individual's needs and preferences for active community participation. These services are provided in either community-based or facility-based settings but not in the Individual's home, family home, or any other residential setting.

The intended outcome of these services is to improve the individual's access to the community through increased skills and/or less paid supports.

Community Access Group services are provided to individual individuals or to groups of individuals. Community Access Group services are provided to groups of individuals, with a staff to individual ratio of one to two or more. The staff to individual ratio for Community Access Group services cannot exceed one (1) to ten (10). Community Access Individual services are provided to an individual, with a one-to-one staff to individual ratio. Community Access Services Providers offer (or arrange when needed) any of the Community Access Services that are needed by the individuals served and specified in the individuals' Individual Service Plans.

The following Community Access Services are offered:

- Community Access Group**
- Community Access Individual**

ADDITIONAL SERVICE INFORMATION:

1. Service design is based on self-determination principles and evidenced based practices, which support individuals to express their choices and direct their services.
2. Service design and implementation encourage and build on existing social networks and natural sources of support and result in increased interdependence, contribution and inclusion in community life.
3. Services and planning meetings shall be scheduled to accommodate individual and family needs.
4. Provider shall collaborate with the Regional Office Intake and Evaluation and Planning List Administrators, and Support Coordination agencies in the development of the Individual Support Plan and implementation of the Support Intensity Scale for each individual in service. Contractor's direct support staff will directly participate in both the ISP and the SIS.
5. Provider shall have the capacity (by staff expertise or through contract) to support individuals with complex behavioral and or medical needs.
6. Service design shall be outcome based with focus on self-determination principles and evidence based practices that continually support individuals towards responsible citizenship.
7. Providers rendering facility-based Community Access and other services (e.g., Prevocational Services and adult therapy services) can provide these services in the same facility; however, the services must be documented and billed separately, and any waiver individual receiving multiple services may not receive these services at the same time of the same day.

Community Guide NOW & COMP Waiver					
HIPAA Transaction Code	Code	Mod1	Mod2	Mod3	Mod4
Community Guide Self Directed	H2015	UC			
Community Guide Co-Employer	H2015	UA			

Definition of Service: Community Guide Services are direct assistance to individuals in skills building and information in meeting participant-direction responsibilities. These services are available *only* for individuals who choose the participant-direction option for service delivery. The individual, with the Support Coordinator, determines the amount of Community Guide Services, if any, and the specific services that the Community Guide will provide. The specific Community Guide Services for the individual are specified in the Individual Service Plan. Individuals may elect to receive Community Guide Services, and when elected, individuals choose their Community Guide.

Community Guide Services are individualized services designed to assist individuals in meeting their responsibilities in the individual-direction option for service delivery. Community Guides provide information, direct assistance, and training to individuals in support of Individual direction. The intended outcome of these services is to improve the individual's knowledge and skills for individual direction.

Community Guides assist and train individuals to build the skills required for individual direction, such as exploring and brokering available community resources, problem solving, and decision-making, being an effective employer of support workers, developing and managing the individual budget, and record keeping. Information provided by the Community Guide helps the individual's understanding of provider qualifications, record keeping, and other individual-direction responsibilities.

The scope, intensity, and frequency of Community Guide Services may change over time, based on the needs of the Individual.

ADDITIONAL SERVICE INFORMATION:

1. Community Guide Services are only for individuals who opt for participant-direction.
2. The individual determines the amount of Community Guide Services, if any, and the specific services that the Community Guide will provide.
3. The specific Community Guide Services for the individual are specified in the Individual Service Plan.
4. Individuals may elect to receive Community Guide Services, and when elected, individuals choose their Community Guide.

Revised August 12, 2011

5. The need for Community Guide Services must be related to the individual disability and tied to a specific goal in the Intake and Evaluation Team approved Individual Service Plan (ISP).

Community Residential Alternative Services

COMP Waiver

HIPAA Transaction Code	Code	Mod1	Mod2	Mod3	Mod4
Community Residential Alternative	T2033				

Definition of Service:

Community Residential Alternative (CRA) services are targeted for Individuals who require intense levels of support. These services are a range of interventions with a particular focus on training and support in one or more of the following areas: eating and drinking, toileting, personal grooming and health care, dressing, communication, interpersonal relationships, mobility, home management, and use of leisure time. CRA Services are individually planned and tailored to meet the specific needs of the Individual and to accommodate fluctuations in his or her needs for various services.

CRA services include assistance with and/or training in activities of daily living, such as bathing, dressing, grooming, other personal hygiene, feeding, toileting, transferring, and other similar tasks. These services also include training and/or assistance in household care, such as meal preparation, clothes laundering, bed-making, housecleaning, simple home repair, yard care, and other similar tasks. CRA services consist of medically related services, such as basic first aid, arranging and transporting Individuals to medical appointments, assisting with therapeutic exercises, and assisting with or supervising self-administration of medication. These services also consist of implementing behavioral support plans designed for Individuals to reduce inappropriate and/or maladaptive behaviors and to acquire alternative adaptive skills and behaviors. CRA Services include transportation to all other waiver services specified in the Individual Service Plan and as needed to facilitate the individual's participation in personal shopping, recreation and other community activities.

Individuals receive CRA services in small group settings of four or less, in host home/life sharing situations for adults 19 years and above, or foster home for Individuals under the age of 19 years through an approved foster home operating under a licensed Child Placing Agency. CRA Services may not be provided to individuals living in their own or family homes.

Community Residential Alternative Services is provided to individuals who live in one of the following settings:

1. "Host Home" (Life sharing). A home where an individual, who receives services, resides in an owner occupied home where the owner/family is funded to include the individual with the disability into their household routines and provide training and supervision. **This is an unlicensed setting for two adults (19 years or above) receiving community residential alternative services.** For CRA services rendered in life sharing/host home settings to individuals under the age of 19 years, the provider agency must have a Department of Human Services, Office of Residential Child Care license from the Department of Community Health, Division of Healthcare Facility Regulations. These homes can only serve a maximum of two (2) individuals under the age of 19 years at a time and can only serve individuals receiving services through the COMP Waiver.

2. Community Living Arrangement (CLA). Agencies providing this community residential alternative service must have a Community Living Arrangement License from the Office of Regulatory Services. **If anyone in the home receives Medicaid Waiver funding no more than four people may reside in the home, unless granted an exception by the Office of DD.**
3. Personal Care Home (PCH) Agencies providing this community residential alternative service must have a Personal Care Home Permit from the Department of Community Health, Division of Healthcare Facility Regulation. PCH permits for the provision of CRA services are no longer accepted in applications to provide CRA services. PCH agencies enrolled to provide CRA services prior to January 1, 2011 may continue to provide CRA services. No more than four (4) individuals may reside in a PCH if anyone in the home receives Medicaid Waiver funding, unless an exception has been granted by the Division of Developmental Disabilities. New homes will not be granted this exception

The services provided, the frequency and intensity of services are specific to the individual receiving services as detailed in his/her Individual Services Plan (ISP).

ADDITIONAL SERVICE INFORMATION:

1. Service design and implementation encourage and build on existing social networks and natural sources of support and result in increased interdependence, contribution and inclusion in community life.
2. The selection of living environments shall include consideration of opportunities for community inclusion of individuals receiving services, individual choice (including preference to be close to family) and distance from other homes (e.g. apartments, house) of individuals receiving services to assure that individuals with developmental disabilities are not grouped in a conspicuous manner.
3. Daily and weekly rhythms and routines shall be directly related to individual's needs, interests and preferences.
4. Service design shall be outcome based with focus on self-determination principles and evidence based practices that continually support individuals towards responsible citizenship.
5. Provider shall collaborate with the Regional Office Intake and Evaluation staff and Planning List Administration staff and Support Coordination agencies in the development of the Individual Support Plan and implementation of the Support Intensity Scale for each individual in service. The Contractor's direct support staff will directly participate in both the ISP and the SIS.
6. The Provider **must** have Regional Office approval before moving individual(s) to a new address. Emergency relocation plans identified in the Individual Service Plans is acceptable as prior approval for moving to a new location in emergencies. Each individual Community Residential Alternative site must be individually enrolled.
7. Provider will adhere to Policy on Personal Spending and Protection of Funds for individuals receiving community residential alternative services. See Part IV.
8. Provider shall have the capacity (by staff expertise or through contract) to support individuals with complex behavioral and or medical needs.
9. A health exam is required for each individual in residential services on an annual basis. See Part I Section IV for the Annual Health Form to be used to document the annual health exam and maintained in the individual's record.

Community Living Support Services NOW & COMP Waiver					
HIPAA Transaction Code	Code	Mod1	Mod2 Self D	Mod3 Comp	Mod4
Community Living Support Services 15 Minutes	T2025	U5	UC	UA	
Community Living Supports Daily (COMP only)	T2025	U6	UC	UA	

Definition of Service: Individuals can choose the self-direction OR co-employer options with CLS services.

Community Living Support (CLS) Services are individually tailored supports that assist with the acquisition, retention, or improvement in skills related to an Individual's continued residence in his or her own or family home. Personal care/assistance may be a component part of CLS services but may not comprise the entirety of the services. CLS services are offered to Individuals who live in their own or family home.

CLS services include training and assistance with activities of daily living (ADLs), such as bathing, dressing, toileting, and transferring, and with instrumental activities of daily living (IADLs), such as personal hygiene, light housework, laundry, meal preparation, transportation, grocery shopping, using the telephone, and medication and money management. These services include transportation to facilitate the individual's participation in grocery or personal shopping, banking, and other community activities that support continued residence of the individual in his or her own or family home. CLS services may include medically related services, such as basic first aid, arranging and transporting individuals to medically appointments, accompanying individuals on medical appointments, documenting an individual's food and/or liquid intake or output, reminding individuals to take medication, and assisting with or supervising self-administration of medication.

Personal care/assistance may be a component part of CLS services but may not be the only service provided to an Individual. The amount of personal care/assistance is specific to the individual needs of the individual, as determined by the Supports Intensity Scale, the Health Risk Screening Tool, and other person-centered assessment data. The individual amount of personal care/assistance provided the individual is specified in the individual Service Plan.

A personal assistance retainer is a component of Community Living Support Services. This retainer allows continued payment to personal caregivers under the waiver for the following: (1) up to seven (7) days from the date of each admission to a general hospital or nursing facility, including ICF/MR and skilled nursing facilities; and (2) up to thirty (30) days per year for other absences of the individual from his or her home, such as vacations and family/relative visits.

CLS services are only for individuals who live in their own or family home. The types and intensity of services provided are specific to the individual and detailed in his or her Individual Service Plan.

ADDITIONAL SERVICE INFORMATION:

1. Service design and implementation encourage and build on existing social networks and natural sources of support and result in increased interdependence, contribution and inclusion in community life.
2. **Daily and weekly rhythms and routines shall be directly related to individual's needs, interests and preferences.**
3. Service design shall be outcome based with focus on self-determination principles and evidence based practices that continually support individuals towards responsible citizenship.
4. Provider shall collaborate with the Regional Office Intake and Evaluation and Planning List Administration staff and Support Coordination agencies in the development of the Individual Support Plan and implementation of the Support Intensity Scale for each individual in service. Provider's direct support staff will directly participate in both the ISP and the SIS.
5. Provider shall have the capacity (by staff expertise or through contract) to support individuals with complex behavioral and or medical needs.
6. **Personal Assistance Retainer Documentation:** Providers, except for providers of participant-directed services, must document the following in the record of each individual for whom a personal assistance retainer is a component of Community Living Support Services: (1) Beginning and end date of absence, (2) Reason for absence, (3) Scheduled days and units per day for Community Living Support Services as specified in the ISP.
7. **Provider agencies must have a Private Home Care Provider License from the Department of Community Health (DCH), Division of Healthcare Facility Regulations (HFR) if providing covered services as required by DCH/HFR.**

Financial Support Services					
NOW & COMP Waiver					
HIPAA Transaction Code	Code	Mod1	Mod2	Mod3	Mod4
Financial Support Services	T2040	UC			

Definition of Service:
 Financial Support Services (FSS) are designed to perform fiscal and related finance functions for the Individual or representative who elects the participant-direction option for service delivery and supports. FSS assure that the funds to provide services and supports, outlined in the Individual Service Plan (ISP) and to be implemented through a self-directed approach are managed and distributed as intended.

Additional Service Information:

1. Financial Support Services are provided by a Fiscal Intermediary Agency (FIA) established as a legally recognized entity in the United States, qualified and registered to do business in the state of Georgia, and approved as a Medicaid provider by the Department of Community Health (DCH.).
2. Financial Support Services are mandatory and integral to participant-direction through a fiscal intermediary.
3. Financial Support Services are not available to individuals who choose the Co-Employer model for self-directed services and supports.
4. Financial Support Services are provided by agencies that do not provide any other Medicaid services in Georgia.

Individual Directed Goods and Services NOW & COMP Waiver

HIPAA Transaction Code	Code	Mod1	Mod2 Self D	Mod3	Mod4
Individual Directed Goods and Services (NOW only)	T2025	U7	UC		

Definition of Service:

Individual Directed Goods and Services are goods and services not otherwise provided through the NOW or the Medicaid State Plan, but are identified by the waiver individual/representative who opts for -direction and the Support Coordinator or interdisciplinary team. These services are available **only** for individuals who choose the participant-direction option for service delivery. Individual Directed Goods and Services must be clearly linked to an assessed need of the individual due to his or her disability and be documented in the individual's Individual Service Plan.

Individual Directed Goods and Services are purchased from the participant-directed budget and cover services that include improving and maintaining the individual's opportunities for full membership in the community. Goods and services purchased under this coverage may not circumvent other restrictions on NOW services, including the prohibition against claiming for the costs of room and board. Individual Directed Goods and Services must be authorized by the operating agency prior to service delivery.

The Individual Directed Goods and Services must:

Decrease the need for other Medicaid services; AND

Not be available through another source, including the individual not having the funds to purchase the item or service; AND

Promote inclusion in the community; OR

Increase the individual's safety in the home environment.

The individual/representative must submit a request to the Support Coordinator for the goods or service to be purchased that includes the supplier/vendor name and identifying information and the cost of the service/goods. A paid invoice or receipt that provides clear evidence of the purchase must be on file in the Individual's records to support all goods and services purchased. Authorization for these services requires Support Coordinator documentation that specifies how the Individual Directed Goods and Services meet the above-specified criteria for these services. Individuals receiving flexible support coordination are required to follow these same procedures.

Revised August 12, 2011

ADDITIONAL SERVICE INFORMATION:

1. Individual Directed Goods and Services are provided by vendors with the applicable Georgia business license as required by the local, city or county government in which the services are provided.

Supported Employment NOW & COMP Waiver					
HIPAA Transaction Code	Code	Mod1	Mod2 Self D	Mod3 CoEmp	Mod4
Supported Employment Individual	T2019	UB	UC	UA	
Supported Employment Group	T2019	HQ	UC	UA	

Definition of Service: Individuals can choose the self-direction or co-employer options with Supported Employment Services.

Supported Employment services are ongoing supports that enable individuals, for whom competitive employment at or above the minimum wage is unlikely absent the provision of supports, and who, because of their disabilities, need supports, to perform in a regular work setting. The scope and intensity of Supported Employment supports may change over time, based on the needs of the individual. Supported Employment services are conducted in a variety of settings, particularly work sites where individuals without disabilities are employed.

Individuals who receive Supported Employment services must require long-term, direct, or indirect job-related support in job supervision, adapting equipment, adapting behaviors, transportation assistance, peer support, and/or personal care assistance during the work day. Supported Employment services consist of activities needed to obtain and sustain paid work by individuals, including job location, job development, supervision, training, and services and supports that assist individuals in achieving self-employment through the operation of a business, including helping the individual identify potential business opportunities, assisting in the development of a business plan, identifying the supports that are necessary for the individual to operate a business, and ongoing assistance, counseling and guidance once the business has been launched. These services do not include the supervisory activities rendered as a normal part of the business setting.

The planned outcomes of these services are to increase the hours worked by each individual toward the goal of forty hours per week and to increase the wages of each individual toward the goal of increased financial independence. Supported Employment services are based on the individual individual's needs, preferences, and informed choice. These services allow for flexibility in the amount of support an individual receives over time and as needed in various work sites.

Supported Employment Group services are provided to groups of individuals, with a staff to individual ratio of one to two or more. The staff to individual ratio for Supported Employment Group services cannot exceed one (1) to ten (10). Supported Employment Individual services are provided to an individual, with a one-to-one staff to individual ratio.

ADDITIONAL SERVICE INFORMATION:

1. Supported Employment may be provided in individual or group settings. When contracts or Memorandums of Agreement require providers to report the types of settings in which Supported Employment has occurred, providers will report those settings using the following categories:

Community Based Employment Services – Individual
Community Based Employment Services – Group

2. Service design is based on self-determination principles and evidenced based practices, which support individuals to express their choices and direct their services.
3. Provider supports individuals receiving services to experience meaningful days by assuring that activities are directly related to the individual's interests and preferences as documented in the ISP.
4. Service design and implementation encourage and build on existing social networks and natural sources of support and result in increased interdependence, contribution and inclusion in community life.
5. Provider shall assure that individuals (and/or their families, as appropriate) have accurate and individualized information regarding the impact and value of employment and wages on benefits.
6. Service shall be aimed at increased opportunities for meaningful adult career development with focus towards paid employment.
7. Services and planning meetings shall be scheduled to accommodate individual and family needs.
8. Provider shall collaborate with the Regional Office Intake and Evaluation and Planning List Administrators, and Support Coordination agencies in the development of the Individual Support Plan and implementation of the Support Intensity Scale for each individual in service. Contractor's direct support staff will directly participate in both the ISP and the SIS.
9. The SIS will contribute to, but not determine exclusively, the nature of the employment goals identified in the ISP as they shall always be primarily identified through person-centered planning and discovery.
10. Provider shall have the capacity (by staff expertise or through contract) to support individuals with complex behavioral and or medical needs.
11. Service design shall be outcome based with focus on self-determination principles and evidence based practices that continually support individuals towards responsible citizenship.
12. Group Supported Employment Services: a staff to individual ratio of one to two or more, not to exceed one (1) to ten (10).
13. Individual Supported Employment Services: a one-to-one staff to individual ratio.

Prevocational NOW & COMP Waiver					
HIPAA Transaction Code	Code	Mod1	Mod2 Self D	Mod3 Co Emp	Mod4
Prevocational Services	T2015				

Definition of Service:

Prevocational Services prepare an individual for paid or unpaid employment. These services are for the individual not expected to be able to join the general work force within one year as documented in the Individual Service Plan. If compensated, individuals are paid in accordance with the requirements of Part 525 of the Fair Labor Standards Act.

Prevocational Services occur in facility-based settings or at community sites outside the facility for small groups of individuals, called mobile crews, who travel from the facility to these community sites. Mobile crews receive Prevocational Services by performing tasks, such as cleaning or landscaping, at community sites other than the individual's home or family home or any residential setting.

The emphasis of Prevocational Services is directed to habilitative rather than explicit employment objectives. These services include teaching individuals concepts necessary to perform effectively in a job in the community. Activities included in these services are directed at teaching concepts such as rule compliance, attendance, task completion, problem solving, endurance, work speed, work accuracy, increased attention span, motor skills, safety, and appropriate social skills.

The intended outcome of these services is to prepare the individual for paid or unpaid employment through increased skills. Prevocational Services are individually planned to meet the Individual's needs for preparation for paid or unpaid employment. These services are provided either facility-based or at community sites other than the individual's home or family home or any other residential setting.

Prevocational Services are provided to groups of individuals at a facility or to small groups of individuals who travel to sites outside the facility, referred to as mobile crews. The staff to individual ratio for facility-based Prevocational Services cannot exceed one (1) to ten (10). The staff to individual ratio for Mobile Crew Prevocational Services cannot exceed one (1) to six (6).

ADDITIONAL SERVICE INFORMATION:

1. Service design is based on self-determination principles and evidenced based practices, which support individuals to express their choices and direct their services.
2. Service design and implementation encourage and build on existing social networks and natural sources of support and result in increased interdependence, contribution and inclusion in community life.
3. Provider shall assure that individuals (and/or their families, as appropriate) have accurate and individualized information regarding the impact and value of wages on benefits.
4. Service shall be aimed at increased opportunities for meaningful adult career development with focus towards paid employment.

5. Services and planning meetings shall be scheduled to accommodate individual and family needs.
6. Provider shall collaborate with the Regional Office Intake and Evaluation and Planning List Administrators, and Support Coordination agencies in the development of the Individual Support Plan and implementation of the Support Intensity Scale for each individual in service. Contractor's direct support staff will directly participate in both the ISP and the SIS.
7. Provider shall have the capacity (by staff expertise or through contract) to support individuals with complex behavioral and or medical needs.
8. Service design shall be outcome based with focus on self-determination principles and evidence based practices that continually support individuals towards responsible citizenship.
9. Providers rendering facility-based Prevocational Services and other services (e.g., Community Access Services and adult therapy services) can provide these services in the same facility; however, the services must be documented and billed separately, and any waiver individual receiving multiple services may not receive these services at the same time of the same day.

Respite Services					
NOW & COMP Waiver					
HIPAA Transaction Code	Code	Mod1	Mod2	Mod3	Mod4
Respite Care Services 15 Minutes	S5150				
Respite Care Services Overnight	S5151				

Definition of Service:

Respite Services provide brief periods of support or relief for caregivers of individuals with disabilities. Respite is provided in the following situations:

When families or the usual caretakers are in need of additional support or relief;

When the individual needs relief or a break from the caretaker;

When a individual is experiencing a crisis and needs structured, short-term support;

When relief from care giving is necessitated by unavoidable circumstances, such as a family emergency.

Planned or scheduled respite, or Maintenance Respite, provides brief periods of support or relief for caregivers or Individuals. Respite Services might also be needed to respond to emergency situations. Emergency/Crises Respite is intended to be a short term service for an individual experiencing a crisis (usually behavioral) and requires a period of structured support, or when respite services are necessitated by unavoidable circumstances, such as a family emergency. Maintenance Respite and Emergency/Crises Respite may be provided In-Home (provider delivers service in the individual's home) or Out-Of-Home (The individual receives service outside of their home).

Respite Services may be provided in the individual's own or family home, or outside the individual's home in a private residence of a Respite Services provider (i.e., a home that is owned or rented by the provider or an employee of the provider) or in a licensed Personal Care Home. Respite Services include short-term services during a day or overnight services.

ADDITIONAL SERVICE INFORMATION:

1. Provider agencies that render in-home Respite Services must hold a Private Home Care license if providing services as required by DCH/HFR.
2. Provider agencies that render out-of-home Respite Services in a Personal Care Home must have a Personal Care Home license.
3. Respite Services in personal care homes can only be rendered in personal care homes in which *all* residents are adults with developmental disabilities.
4. Respite Services provided in Personal Care Homes serve no more than a total of four (4) individuals at a time.

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5. Respite Services provided in the private residence of a provider serve no more than one (1) individual in the home at a time.
6. DBHDD may grant an exception of the private residence capacity limit up to two (2) individuals when serving *only* individuals under the age of 18.

Specialized Services					
NOW & COMP Waiver					
HIPAA Transaction Code	Code	Mod1 Self D	Mod2	Mod3	Mod4
Specialized Medical Supplies	T2028	UC			
Specialized Medical Equipment	T2029	UC			
Vehicle Adaptation	T2039	UC			
Environmental Accessibility Adaptation	S5165	UC			

Definition of Service: Specialized Medical Supplies (SMS) Services include various supplies which enable individuals to interact more independently with their environment thus enhancing their quality of life and reducing their dependence on physical support from others. SMS consist of food supplements, special clothing, diapers, bed wetting protective chucks, and other supplies that are specified in the Individual Service Plan and are not available under the Medicaid State Plan. Ancillary supplies necessary for the proper functioning of approved devices are also included in this service.

Specialized Medical Equipment (SME) Services include various devices, controls or appliances which are designed to enable individuals to interact more independently with their environment thus enhancing their quality of life and reducing their dependence on physical support from others. SME services also include assessment or training needed to assist individuals with mobility, seating, bathing transferring, security, or other skills such as operating a wheelchair, locks, door openers, or side lyers. These services additionally consist of customizing a device to meet an individual's needs.

Vehicle Adaptation Services include various adaptations and technical assistance to individually or family owned vehicles which are designed to enable individuals to interact more independently with their environment thus enhancing their quality of life and reducing their dependence on physical support from others. Vehicle Adaptations are limited to a individual's or his or her family's privately owned vehicle and include such things as a hydraulic lift, ramps, special seats and other interior modifications to allow for access into and out of the vehicle as well as safety while moving. The adapted or to be adapted vehicle must be the individual's primary means of transportation.

Environmental Accessibility Adaptation Services include adaptations and technical assistance to individually or family owned private residences which are designed to enable individuals to interact more independently with their environment thus enhancing their quality of life and reducing their dependence on physical support from others. These services include physical adaptations to the individual's or family's home which are necessary to ensure the health, welfare and safety of the individual, or enable the individual to function with greater independence in the home and without which, the individual would require institutionalization. Environmental Accessibility Adaptations consist of the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems, which are necessary to accommodate the medical equipment and supplies necessary for the welfare of the individual, and are of direct medical or remedial benefit to the individual.

ADDITIONAL SERVICE INFORMATION:

1. Specialized Medical Supplies services must be documented to be the payer of last resource. The DME program prior approval process is used to determine medical necessity for medical supplies. The NOW and COMP do not cover items that have been denied through the DME and other programs for lack of medical necessity. Providers for Specialized Medical Supplies should refer to the Department of Community Health, Division of Medical Assistance, Part II, Policies and Procedures for Durable Medical Equipment, Part II, Policies and Procedures for Orthotics and Prosthetics and Part III, Hearing Services for additional information about coverage of these services.
2. Specialized Medical Equipment services must be documented to be the payer of last resource. The DME program prior approval process is used to determine medical necessity for medical equipment. The NOW and COMP do not cover items that have been denied through the DME and other programs for lack of medical necessity.
3. Individuals may choose the self-direction option with Specialized Medical Equipment Services. Providers for Specialized Medical Equipment should refer to the Department of Community Health, Division of Medical Assistance, Part II, Policies and Procedures for Durable Medical Equipment, Part II, Policies and Procedures for Orthotics and Prosthetics and Part III, Hearing Services for additional information about coverage of these services.
4. Any item billed under Vehicle Adaptation Services must not be available under the State Medicaid plan. These services must also be documented to be the payer of last resource. The NOW and COMP do not cover items that have been denied through the DME and other programs for lack of medical necessity.
5. Any item billed under Environmental Accessibility Adaptation Services must not be available under the State Medicaid Plan. These services must also be documented to be the payer of last resource. The NOW and COMP do not cover items that have been denied through the DME and other programs for lack of medical necessity.

Natural Support Training Service

NOW & COMP Waiver

HIPAA Transaction Code	Code	Mod1	Mod2 Self D	Mod3	Mod4
Natural Support Training Service	T2025	UD	UC		

Definition of Service: Individuals can choose the self-direction option with Natural Support Training Services.

Natural Support Training (NST) Services provide training and education to individuals who provide *unpaid* support, training, companionship, or supervision to individuals. For purposes of this service, individual is defined as any individual, family member, neighbor, friend, companion, or co-worker who provides uncompensated care, training, guidance, companionship, or support to an individual served on the waiver. These services must relate to the individual individual's needs due to his or her disability and tie to a specific goal in the Individual Service Plan. All training for individuals who provide unpaid support to the individual provided through NST Services must be included in the Individual's ISP.

NST Services include individualized training of families and members of the individuals' natural support networks for the acquisition or enhancement of their ability to support the waiver individual. This training consists of instruction about treatment regimens and other services included in the ISP. NST Services comprise training on the use of equipment as specified in the ISP. There services may include updates in training required to maintain the individual safely at home. NST Services encompass the costs of registration and training fees associated with formal instruction in areas relevant to the individual's disability needs identified in the ISP. These services do not include the costs of travel, meals, and overnight lodging to attend a training event or conference.

NST Services are provided by Developmental Disability Professionals (see Provider Manual for definition). These services may be provided in an individual's own or family home, the Developmental Disability Professional's office, outpatient clinics, Supported Employment work sites, or other community settings specific to community-based Natural Support Training goals specified in the Individual Service Plan.

ADDITIONAL SERVICE INFORMATION:

1. NST Services must not duplicate any family education or training provided through Adult Physical Therapy Services, Adult Occupational Therapy Services, Adult Speech and Language Therapy Services, or Behavioral Supports Consultation Services.
2. NST Services may not occur simultaneously or on the same day as Adult Physical Therapy Services, Adult Occupational Therapy Services, Adult Speech and Language Therapy Services, or Behavioral Supports Consultation Services.

Therapy Services					
NOW & COMP Waiver					
HIPAA Transaction Code	Code	Mod1	Mod2 Self D	Mod3	Mod4
Adult Occupational Therapy	97003		UC		
	97530	GO	UC		
	97533	GO	UC		
Adult Physical Therapy	97001		UC		
	97110		UC		
Adult Speech and Language Therapy	92506		UC		
	92507	GN	UC		
	92609		UC		

Definition of Service: Individual can choose self-direction option with these therapies.

Adult Occupational Therapy Services are evaluation and therapeutic services that are not otherwise covered by Medicaid State Plan services. These services address the occupational therapy needs of the adult individual that result from his or her developmental disability. Adult Occupational Therapy Services include occupational therapy evaluation, individual/family education, occupational therapy activities to improve functional performance, and sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands. Adult Occupational Therapy Services are provided by a Georgia licensed occupational therapist and by order of a physician. These services may be provided in an individual's own or family home, the Occupational Therapist's office, outpatient clinics, facilities in which Community Access or Prevocational Services are provided, Supported Employment work sites, or other community settings specific to community-based therapy goals specified in the Individual Service Plan. Adult Occupational Therapy Services may not be provided to individuals receiving Community Residential Alternative Services in the Comprehensive Supports Waiver.

Adult Physical Therapy Services are evaluation and therapeutic services that are not otherwise covered by Medicaid State Plan services. These services address the physical therapy needs of the adult individual that result from his or her developmental disability. Adult Physical Therapy Services include physical therapy evaluation, individual/family education, and therapeutic exercises to develop sitting and standing balance, strength and endurance, and range of motion and flexibility. Adult Physical Therapy Services also consist of muscle strengthening and endurance to facilitate transfers from wheelchairs and the use of other equipment. Adult Physical Therapy Services are provided by a Georgia licensed physical therapist and by order of a physician. These services may be provided in an individual's own or family home, the Physical Therapist's office, outpatient clinics, facilities in which Community Access or Prevocational Services are provided, Supported Employment work sites, or other community settings specific to community-based therapy goals specified in the Individual Service Plan. Adult Physical Therapy Services may not be provided to individuals receiving Community Residential Alternative Services in the Comprehensive Supports Waiver.

Adult Speech and Language Therapy Services cover evaluation and therapeutic services that are not

otherwise covered by Medicaid State Plan services. These services address the speech and language therapy needs of the adult individual that result from his or her developmental disability. Adult Speech and Language Therapy Services include the evaluation of speech language, voice, and language communication, auditory processing, and/or aural rehabilitation status. Adult Speech and Language Therapy Services also consist of individual/family education, speech language therapy, and therapeutic services for the use of speech-generating devices, including programming and modification. Adult Speech and Language Therapy Services are provided by a Georgia licensed speech and language pathologist and by order of a physician. These services may be provided in an individual's own or family home, the Speech and Language Pathologist's office, outpatient clinics, facilities in which Community Access or Prevocational Services are provided, Supported Employment work sites, or other community settings specific to community-based therapy goals specified in the Individual Service Plan. Adult Speech and Language Therapy Services may not be provided to individuals receiving Community Residential Alternative Services in the Comprehensive Supports Waiver.

ADDITIONAL SERVICE INFORMATION:

1. Services must be provided by a Georgia licensed individual in the specific therapy discipline.
2. Provider agencies must have available a sufficient number of employees or professionals under contract that are Georgia licensed individuals in the specific therapy discipline.

Support Coordination NOW & COMP Waiver					
HIPAA Transaction Code	Code	Mod1	Mod2	Mod3	Mod4
Support Coordination	T2022				

Definition of Service:

Support Coordination services are a set of interrelated activities for identifying, coordinating, and reviewing the delivery of appropriate services for individuals. Support Coordination services include the following:

- Assessment and Periodic Reassessment
- Development and Periodic Revision of the Individual Service Plan
- Referral and Related Activities
- Monitoring and Follow-up Activities

Support Coordination services assist individuals in coordinating all services, whether Medicaid reimbursed services or services provided by other funding sources. These services include completing the Individual Service Plan (ISP) document and any revisions, and monitoring the implementation of the ISP and the health and welfare of individuals. The frequency of Support Coordination services is based on the individual needs of the individual and as required to address any identified health and safety risks or service provider issues.

Support Coordination services are provided by agencies that employ a sufficient number of Support Coordinators to meet the Support Coordination services needs of individuals served by the agency. Support Coordinators assure the completion of the written ISP document and any revisions. Support Coordinators are also responsible for monitoring the implementation of the ISP, the health and welfare of individuals, and the quality and outcome of services. Monitoring includes direct observation, review of documents, and follow up to ensure that services plans have the intended effect and that approaches to address challenging behaviors, medical and health needs, and skill acquisition are coordinated in their approach and anticipated outcome. Support Coordinators are also responsible for the ongoing evaluation of the satisfaction of individuals and their families with the ISP and its implementation. Support Coordinators assist individuals and their families or representatives in making informed decisions about the participant-direction option and assist those who opt for participant-direction with enrollment in this option.

ADDITIONAL SERVICE INFORMATION:

1. Support Coordination is provided by Support Coordination Agencies only.
2. Provider agencies rendering Support Coordination services must:

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- Have at minimum five (5) years experience in providing case management services for individuals with MR/DD, and demonstrate success in supporting individuals in community inclusion and person centered planning;
- Have established working relationships with local advocacy groups, experience advocating for individuals in the community, and preparing individuals for self advocacy;
- Have experience and demonstrated success with person centered outcome based planning, and developing plans based on the individual's choices and support needs identified in the Supports Intensity Scale;
- Have experience with measuring quality of services and satisfaction with services, ensuring that the services that are provided are consistent with quality measures and expectations of the individual;
- Demonstrate experience in serving diverse cultural and socioeconomic populations.

Transportation Services					
NOW & COMP Waiver					
HIPAA Transaction Code	Code	Mod1	Mod2	Mod3	Mod4
Transportation – Trip	T2003				
Transportation – Trip – Self Directed	T 2003	UC			
Transportation – Trip – Co-Employer	T 2003	UA			
Transportation Commercial Carrier, Multi Pass	T 2004				
Transportation Commercial Carrier, Multi Pass Self Directed	T 2004	UC			

Definition of Service: Individuals may choose the participant-direction or co-employer options with Transportation Services.

Transportation Services enable waiver individuals to access non-medical services, activities, resources, and organizations typically utilized by the general population. These services are only provided as independent, stand-alone waiver services when transportation is not otherwise included as an element of another waiver service. Transportation services are not intended to replace available formal or informal transit options for individuals. Whenever possible, family, neighbors, friends or community agencies, which can provide this service, without charge, are to be utilized. The need for Transportation Services and the unavailability of other resources for transportation must be documented in the Individual Service Plan (ISP).

Transportation Services provide transportation for the individual to waiver services and other community services, activities, resources, and organizations typically utilized by the general population. These services include:

One-way or round trips provided by Georgia licensed drivers and/or DD Service Agencies; and

Transit by commercial carrier available to the community at large.

Transportation Services must not be available under the Medicaid Non-Emergency Transportation Program, State Plan, Individual with Disabilities Education Act (IDEA), or the Rehabilitation Act. These services do not include transit provided through Medicaid non-emergency transportation. Transportation Services are not available to transport an individual to school (through 12th grade). These services do not include transportation that is included as an element of another waiver service as follows:

- Community Living Support Services
- Prevocational Services
- Supported Employment Group Services
- Community Access Group or Individual Services, which entail activities and settings primarily utilized by people with disabilities, such as transportation to and from a Mental Retardation Service

Center or other day center.

Transportation Services are only for individuals who do not have formal or informal transit options available. The type and amount of Transportation Services provided are specific to the individual and detailed in his or her Individual Service Plan.

ADDITIONAL SERVICE INFORMATION:

1. Individual Providers rendering Transportation Services must hold a valid Class C license as defined by the Georgia Department of Driver Services (or any allowable other state license per Department of Community Health, Division of Medical Assistance policy).
2. DD Service Provider Agency driver staff providing Transportation Services must hold the class of license appropriate to the vehicle operated as defined by the Georgia Department of Driver Services (or any allowable other state license per Department of Community Health, Division of Medical Assistance policy).

PART III OF THE PROVIDER MANUAL CONTAINS OPERATIONAL STANDARDS FOR:

Georgia Crisis Response System (GCRS-DD)
Host Home/Life-Sharing
Family Support Services

Part I

Eligibility, Service Definitions and Requirements

SECTION III

***Developmental Disabilities
Intake Screening and Annual
Health Forms***

Fiscal Year 2012



**Georgia Department of Behavioral Health &
Developmental Disabilities**

April 2012

DBHDD

Georgia Department of Behavioral Health and Developmental Disabilities
Intake Screening Summary

- Initial Family Supports Screening: Date:
- Initial Intake and Evaluation Screening: Date:

I. Personal and Demographic Information

Name:						
	* First	* Middle		* Last		
Address:						
	* Street/Apartment number (if applicable)			* City		
				() -		
	* County		* State	* Zip code	* Telephone:	
* Marital Status:		* Gender:		* Race:	* Ethnicity (Hispanic/Latino Origin)	
<input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> Sep		<input type="checkbox"/> M <input type="checkbox"/> F		Select One...	Select One...	
* Birth date:		* SSN#:		* MHID		
Medicaid#:		Medicare#:		* Primary Diagnosis:	Select One...	
Legal Status:	<input type="checkbox"/> Minor	<input type="checkbox"/> Competent			<input type="checkbox"/> Legally Incompetent (Documentation Required)	
Legal Guardian: (if applicable)				Relationship to Applicant:		
Address:				Telephone #:		
* Primary Contact for Correspondence:				* Relationship to Applicant:		
* Address:				* Telephone:		
Next of Kin:				Relationship to Applicant:		
Address:				Telephone #:		
*Date of Contacts	*Contact Successful (Person Spoke With)	*No Answer	*Left Message	*Date of Appointment:	*Location of Appointment	
		Select One...	Select One...			
		Select One...	Select One...			
		Select One...	Select One...			
Appointment	Select One...		Individuals Present	<input type="checkbox"/> Applicant <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Family <input type="checkbox"/> Other:		

Georgia Department of Behavioral Health and Developmental Disabilities
Intake Screening Summary

<i>* Sensory Impairments:</i>	<i>* English Proficiency</i>
Select One...	Select One...

II. Services currently receiving:

<i>Generic</i>	<input type="checkbox"/> Early Intervention	<input type="checkbox"/> Source	<input type="checkbox"/> CCSP	<input type="checkbox"/> School	<input type="checkbox"/> Other (specify)
<i>GIA</i>	<input type="checkbox"/> Family Support (specify)	<input type="checkbox"/> Day Services (specify)	<input type="checkbox"/> Residential (specify)	<input type="checkbox"/> Other (specify)	
<i>Waiver</i>	<input type="checkbox"/> NOW (specify)				
	<input type="checkbox"/> COMP (specify)				
Comments:					

III. Programs & Placements

<i>* Prior Placement (Check all that apply)</i>			
<input type="checkbox"/> Own Home	<input type="checkbox"/> Homeless	<input type="checkbox"/> Other Service/Program Option	<input type="checkbox"/> SWSH
<input type="checkbox"/> Gracewood	<input type="checkbox"/> Group Home	<input type="checkbox"/> Surrogate Home	<input type="checkbox"/> GRH-Atlanta
<input type="checkbox"/> Bainbridge (historical)	<input type="checkbox"/> Out of State	<input type="checkbox"/> DFCS Custody	<input type="checkbox"/> West Central Regional
<input type="checkbox"/> Rome Regional	<input type="checkbox"/> Brook Run (historical)	<input type="checkbox"/> Nursing Home	<input type="checkbox"/> Incarcerated
<input type="checkbox"/> Central State	<input type="checkbox"/> GRH-Savannah	<input type="checkbox"/> Rivers Crossing (historical)	<input type="checkbox"/> Other

IV. * Provided Information on (Check all that were provided):

<i>State Resources</i>	<i>Advocacy Groups / Other Resources</i>	
<input type="checkbox"/> Voc Rehab	<input type="checkbox"/> Unlock the Waiting List	<input type="checkbox"/> Local Community contacts
<input type="checkbox"/> Division of Aging	<input type="checkbox"/> Family Connections	<input type="checkbox"/> Respite Provider
<input type="checkbox"/> DFCS	<input type="checkbox"/> Parent to Parent	<input type="checkbox"/> Division of Aging
<input type="checkbox"/> Family Support Provider	<input type="checkbox"/> Emory Autism Center	<input type="checkbox"/> Support Coordination
<input type="checkbox"/> CMS	<input type="checkbox"/> SOURCE	<input type="checkbox"/> United Way
<input type="checkbox"/> Who to contact for PL changes (Regional Office)	<input type="checkbox"/> Marcus Institute	
	<input type="checkbox"/> Other	
Comments:		

Georgia Department of Behavioral Health and Developmental Disabilities
Intake Screening Summary

DOCUMENTATION OF NEED FOR SERVICES

Immediate Need (person needs service immediately):

- Death of the caregiver with no other supports (i.e., other family) available.
- Caregiver incapacitated with no other supports (i.e., other family) available (due to physical or psychological reasons).
- Caregiver unable or unwilling to continue providing care (Person dropped off; caregiver not found).
- Current placement poses an immediate danger to health and/or safety of the individual or others.
- Other family crisis with no caregiver support available.
Specify: _____

Short Term Need (person needs services within 6 months): Y/N

Level 1 Short Term Need (1 - 5)

- 1. There has been a death or other family crisis in the family, significantly jeopardizing the capacity of the caregiver to provide care.
- 2. Caregiver is ill and will soon be unable to continue providing care .
- 3. Person has behavioral issues posing potential serious bodily harm to self or others or behavior is likely to come to the attention of law enforcement.
- 4. Individual's health or behavioral needs have increased and needs cannot be met by current caregivers. Without additional support health and/or safety are jeopardized.

Level 2 Short Term Need (6 - 11)

- 5. Caregiver is ill and will soon be unable to continue to provide care.
- 6. Person has a caregiver(s) who would be unable to work if services are not provided. Person is losing eligibility for DFCS support within the next 6 month
- 7. Person is scheduled to leave jail, prison, DJJ or MHDDAD Forensic services in the next 6 months and does not have an adequate natural support system.
- 8. Caregiver has diminished capacity to meet needs.
- 9. Behavioral issues are moderate to severe but do not currently pose a danger to self or others.
- 10. Person is "aging out" of DFCS residential placement within 6 months and does not have an adequate support system.

Level 3 Short Term Need (12 - 15)

- 11. Inappropriate placement, awaiting proper placement (can manage for a short term).
- 12. Person has an aging caregiver (age 60+) who will soon not be able to continue providing care.
- 13. Person has exited special education or will exit within next 6 months and needs day/employment services
- 14. Circumstances or person or caregiver demonstrate clear need for alternative living arrangements within 6 months. Specify:

Georgia Department of Behavioral Health and Developmental Disabilities
Intake Screening Summary

Planning for Long Term need (person needs services 6 months or more in the future)

- Person is eligible, is not currently in need of services, but will need service if something happens to the caregiver
- Known need for service more than a year away.
Specify: _____
Enter date (/ /)
- Person is "aging out" of DFCS residential placement 6 months to 3 years in the future
Enter date (/ /)
- Person is leaving jail, prison, or other criminal justice setting 6 months or more in the future and will need services when he/she returns to the community.
Enter date (/ /)

Georgia Department of Behavioral Health and Developmental Disabilities
Intake Screening Summary

V. * Screening Recommendations for Services

<i>Services Needed</i>		
<i>NOW/COMP Service</i>	<i>Long Term Planning List</i>	<i>Short Term Planning List</i>
<input type="checkbox"/> Adult Physical Therapy Services	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Adult Occupational Therapy Services	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Adult Speech and Language Services	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Behavioral Support Services	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Community Access Group Services	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Community Access Individual Services	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Community Living Services	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Community Residential Alternative Services	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Environmental Accessibility Adaptation	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Financial Support Services	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Individualized Goods and Services	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Natural Support Training	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Prevocational Services	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Respite	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Specialized Medical Equipment	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Specialized Medical Supplies	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Supported Employment Group Services	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Supported Employment Individual Services	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Transportation	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Vehicle Adaptations	<input type="checkbox"/>	<input type="checkbox"/>
<i>* Eligibility:</i>	<i>* Services:</i>	<i>* More information Needed to determine eligibility:</i>
Select One...	Select One...	Select One...
<i>* Screener Recommendation/Comments:</i>		

Georgia Department of Behavioral Health and Developmental Disabilities
Intake Screening Summary

<i>NOW/COMP Service</i>	<i>Long Term Planning List</i>	<i>Short Term Planning List</i>
<input type="checkbox"/> Adult Physical Therapy Services	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Adult Occupational Therapy Services	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Adult Speech and Language Services	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Behavioral Support Services	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Community Access Group Services	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Community Access Individual Services	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Community Living Services	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Community Residential Alternative Services	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Environmental Accessibility Adaptation	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Financial Support Services	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Individualized Goods and Services	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Natural Support Training	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Prevocational Services	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Respite Services	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Specialized Medical Equipment	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Specialized Medical Supplies	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Supported Employment Group Services	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Supported Employment Individual Services	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Transportation	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Vehicle Adaptations	<input type="checkbox"/>	<input type="checkbox"/>

VI. * Regional Psychologist Findings of Eligibility:

* Psychologist Review/Recommendations:

VII. I&E Office Preliminary Determination:

<input type="checkbox"/> LTPL <input type="checkbox"/> STPL: <input type="checkbox"/> Immediate Need <input type="checkbox"/> Level 1 <input type="checkbox"/> Level 2 <input type="checkbox"/> Level 3		
* Eligibility:	* Services:	* More information Needed to determine eligibility:

Georgia Department of Behavioral Health and Developmental Disabilities
Intake Screening Summary

Select One...	Select One...	Select One...
<i>*Regional Office Recommendations/Comments:</i>		

Georgia Department of Behavioral Health and Developmental Disabilities
Intake Screening Summary

VIII. Clinical Information

* Reason for Referral:	
<p><i>Document changes in support needs/living situation/health/etc. that contributed to the request for services at this time (include current daily activities), as well as services to be considered:</i></p>	

* Communication:				
<input type="checkbox"/> No Impairment noted	<input type="checkbox"/> Single Words or Gestures	<input type="checkbox"/> Unable to communicate verbally	<input type="checkbox"/> American Sign Language	<input type="checkbox"/> Utilizes Language Technology
* Referral Source (Check all that apply):				
<input type="checkbox"/> Self	<input type="checkbox"/> DFCS	<input type="checkbox"/> Clergy	<input type="checkbox"/> Physician	<input type="checkbox"/> General Hospital
<input type="checkbox"/> Family	<input type="checkbox"/> State Hospital	<input type="checkbox"/> Criminal Court	<input type="checkbox"/> School	<input type="checkbox"/> Law Enforcement
<input type="checkbox"/> Juvenile Justice	<input type="checkbox"/> Access/Crisis Line	<input type="checkbox"/> Support Coordinator	<input type="checkbox"/> Service Provider	<input type="checkbox"/> Regional Office
Contact Person:		Telephone #:		

* Special Population (Check all that apply):				
<input type="checkbox"/> Vision Impairment	<input type="checkbox"/> Veteran	<input type="checkbox"/> HIV +	<input type="checkbox"/> Hearing Impairment	<input type="checkbox"/> SSI/Disabled
<input type="checkbox"/> Pregnant	<input type="checkbox"/> IV Drug User	<input type="checkbox"/> None/Not Reported		
* Has the individual previously received MH/AD Brief/Stabilization Services?		<input type="checkbox"/> Yes		<input type="checkbox"/> No
		Date of Last Contact: / /		
		Month/Year		

* Payor/Funding Source (Check all that apply)			
<input type="checkbox"/> Medicaid	<input type="checkbox"/> Medicare	<input type="checkbox"/> Peachcare	<input type="checkbox"/> Champus
<input type="checkbox"/> DJJ	<input type="checkbox"/> DFCS	<input type="checkbox"/> State Contracted Svcs	<input type="checkbox"/> Medicaid Waiver
<input type="checkbox"/> Self Pay	<input type="checkbox"/> Private Insurance If Private, please specify:		

Sources of Information:		
<input type="checkbox"/> Applicant	<input type="checkbox"/> Residential Staff	<input type="checkbox"/> Chart/Records
<input type="checkbox"/> Day Support Staff	<input type="checkbox"/> Support Coordinator	<input type="checkbox"/> Family/Legal Guardian

Georgia Department of Behavioral Health and Developmental Disabilities
Intake Screening Summary

IX. Financial Status

<i>Current Expenses:</i>	<i>May require help with:</i>	<i>Assisted by</i>
Select One...	<input type="checkbox"/> Purchases	Select One...
	<input type="checkbox"/> Budgeting	
	<input type="checkbox"/> Bills	
<i>House Hold Income (Monthly Gross)</i>		<i>Number of Individuals in Household</i>

X. Educational History

<i>Education Status:</i>							
Select One...							
<i>Check Current Level of School Attending:</i>							
<input type="checkbox"/> Elementary	School System:	<input type="checkbox"/> Middle/ Jr. High	School System:	<input type="checkbox"/> High School	School System:	<input type="checkbox"/> Pursuing GED	<input type="checkbox"/> College
<input type="checkbox"/> Attended Early Intervention Program (Babies Can't Wait, Speech/PT/OT etc)							
<input type="checkbox"/> Began Special Education (Year/Age):							
<input type="checkbox"/> Special Education Classification (MR/DD/OHI/EBD)							
<input type="checkbox"/> * Number of years of Education Completed:							
<input type="checkbox"/> * Number of days of School missed in last 30 days							
<input type="checkbox"/> Other (specify):							

XI. Family/Residential/Social/Recreational Supports

<i>Significant life events (within past 2 years) which impact current physical and mental status:</i>		
<i>Current Natural Support System/Community Involvement:</i>		
<i>Check all that apply</i>		<i>Frequency of Contact/Describe</i>
<input type="checkbox"/> Not applicable	<input type="checkbox"/> Mother	
	<input type="checkbox"/> Father	
	<input type="checkbox"/> Grandparents	
	<input type="checkbox"/> Siblings	
	<input type="checkbox"/> Other	
<i>Community Involvement:</i>	<input type="checkbox"/> Church	

Georgia Department of Behavioral Health and Developmental Disabilities
Intake Screening Summary

<input type="checkbox"/> Not applicable	<input type="checkbox"/> Social Clubs	
	<input type="checkbox"/> Sports	
	<input type="checkbox"/> Other:	

Describe individual's current living situation (include family makeup/involvement/home environment):

- Private Residence
- Homeless Shelter
- Homeless (Not in a shelter)
- Residential Care
- Jail/Correctional Facility
- Foster Home
- Psychiatric Residential Treatment Facility (PTRF)
- Institutional Setting/Nursing Home
- Other

Individual's Primary Caregiver (Provide details of relationship):

- Self
- Parent
- Spouse
- Grandparent
- Other Relative
- Foster Parent
- Other (Specify relationship)

Individual's Primary Caregiver is: over 60 over 70 over 80

Georgia Department of Behavioral Health and Developmental Disabilities
Intake Screening Summary

XII. Functional Abilities/Activities of Daily Living

<i>Rate (using this number system) current functional ability to accomplish the following daily living activities/skills and provide details below:</i>									
<i>1: Total Assistance Needed</i>			<i>2: Assistance by more than one person</i>			<i>3: Assistance with one person</i>			
<i>4: Needs Assistive/Adaptive Equipment</i>			<i>5: Performs with Verbal Prompts</i>			<i>6: Independent</i>			
Rate	Task	Rate	Task	Rate	Task	Rate	Task	Rate	Task
	<i>Eating</i>		<i>Dressing</i>		<i>Bathing</i>		<i>Toileting</i>		<i>Grooming</i>
	<i>Walking</i>		<i>Transfer</i>		<i>Meal Prep</i>		<i>Housekeeping</i>		<i>Money Management</i>
	<i>Nutritional Habits</i>		<i>Shopping</i>		<i>Health Monitoring</i>		<i>Medication Administration & Management</i>		<i>Laundry</i>
	<i>Mobility</i>		<i>Travel</i>						
<i>Description of Skills</i>									

XIII. Developmental History & Milestones

<i>Prenatal History and noted Developmental Delays: (include at what age, loss/improvement of skills etc.)</i>						
<i>Milestones</i>						
<i>Approximate Age Individual when:</i>	<i>Sat unassisted</i>		<i>Crawled</i>		<i>Walked</i>	
	<i>Talked</i>		<i>Toilet Trained</i>			

XIV. Behavioral Assessment

<i>Check all that apply</i>	<i>Frequency/Describe</i>
<i>Self Injurious Behaviors</i> <input type="checkbox"/> Not applicable	<input type="checkbox"/> Biting
	<input type="checkbox"/> Scratching
	<input type="checkbox"/> Head banging
	<input type="checkbox"/> Other:
<i>Aggressive Behaviors</i> <input type="checkbox"/> Not applicable	<input type="checkbox"/> Physical towards others
	<input type="checkbox"/> Verbal

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Intake Screening Summary

	<input type="checkbox"/> Sexual			
<i>Touching Behaviors</i> <input type="checkbox"/> Not applicable	<input type="checkbox"/> Inappropriate Greetings			
	<input type="checkbox"/> Hugging			
	<input type="checkbox"/> Kissing			
<i>Inappropriate Behaviors</i> <input type="checkbox"/> Not applicable	<input type="checkbox"/> Self-stimulation	<input type="checkbox"/> Towards Others	<input type="checkbox"/> Displays in Public	<input type="checkbox"/> Other
<i>Other Behaviors & Symptoms</i> <input type="checkbox"/> Not applicable	<input type="checkbox"/> Hypersomnia	<input type="checkbox"/> Insomnia	<input type="checkbox"/> Weight Loss	<input type="checkbox"/> Reclusive
	<input type="checkbox"/> Destructive	<input type="checkbox"/> Hoarding	<input type="checkbox"/> Excessive Complaints	<input type="checkbox"/> Anxious
	<input type="checkbox"/> Angry	<input type="checkbox"/> Bladder Incontinence	<input type="checkbox"/> Uncooperative	<input type="checkbox"/> Refuses Medications
	<input type="checkbox"/> Irritable	<input type="checkbox"/> Bowel Incontinence	<input type="checkbox"/> Stealing	<input type="checkbox"/> Requires Restraints
	<input type="checkbox"/> Confused	<input type="checkbox"/> Suspicious	<input type="checkbox"/> Restless	<input type="checkbox"/> Wandering
	Ideations: <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicidal	Plan: Means:	Attempts <input type="checkbox"/> Suicide <input type="checkbox"/> Homicidal	# of Times: Method:
* Type of Substances Used	* Employment Status	<i>Reason not in work force</i>	<i>Non-Competitive Work</i>	
Select One...	Select One...	Select One...	Select One...	
<i>Additional Information: (include any psychiatric symptoms/history noted)</i>				

XV. Legal Status

* Legal Status <i>(Check one)</i>	<input type="checkbox"/> Voluntary		<input type="checkbox"/> Involuntary	
<i>Legal Custody</i> <i>(Check all that apply)</i>	<input type="checkbox"/> DFCS Custody		<input type="checkbox"/> Other Court-Appointed Guardian	
<i>Legal Involvement</i> <i>(Check all that apply)</i>	<input type="checkbox"/> DFCS	<input type="checkbox"/> Juvenile Justice	<input type="checkbox"/> Treatment Court (MH/AD)	<input type="checkbox"/> Probate Court
	<input type="checkbox"/> Jail/Law Enforcement	<input type="checkbox"/> Adult Criminal Court	<input type="checkbox"/> Adult Probation	<input type="checkbox"/> Parole

Georgia Department of Behavioral Health and Developmental Disabilities
Intake Screening Summary

<i>Agency Requiring Consumer to Obtain Services (Check all that apply)</i>	<input type="checkbox"/> DFCS	<input type="checkbox"/> Juvenile Justice	<input type="checkbox"/> Treatment Court (MH/AD)	<input type="checkbox"/> Probate Court
	<input type="checkbox"/> Jail/Law Enforcement	<input type="checkbox"/> Adult Criminal Court	<input type="checkbox"/> Adult Probation	<input type="checkbox"/> Parole
* Justice System Involvement	Has consumer been involved with criminal/juvenile justice system in the past year? (Includes arrests, probation, parole, commitments, adjudications, diversions, or awaiting sentencing) <input type="checkbox"/> Yes <input type="checkbox"/> No			
* Arrests	Number of arrests, regardless of nature of offense or outcome, in the past 30 days.			

<i>Staff Completing the Screening (Include Name, Credentials, Position, Title)</i>	<i>Date of Screening</i>

<i>Psychologist Signature</i>	<i>Date of Determination</i>

<i>Regional I&E Signature</i>	<i>Date of Determination</i>

XVI. Psychologist Additional Review:

* Psychologist Review of Findings and Recommendations:	
<i>Psychologist Signature</i>	<i>Date of Determination</i>

ANNUAL HEALTH EXAMINATION

PART I: To be completed by the provider agency prior to the physician visit

Full Name		Preferred Name		Gender
Address		City	County	Zip
Telephones	Home	Work/Day	Other	
Age	DOB	Race/Ethnicity	Marital Status	
Religious Preference		Legal Status: Guardian		

Contacts/Next of Kin (if minor or adjudicated, parent or legal guardian)

Name	Relationship	Legal Guardian	Y	N
Address				
Telephones	Home	Work	Cell	

Allergies (if none specify NKA)

Type of Allergy	Specific Allergy
Medication	
Food	
Insect Bites/Stings	
Other Allergies	

Current Medication Summary: List all medications currently ordered for the person.

Medication Name	Dosage/Route/Frequency	Purpose of Medication	Ordered By	Original Date Ordered	Specific Concerns

Illness/ Surgery/Hospitalization Date Illness/surgery/Hospitalization Date

Chronic and ongoing medical issues, including how it affects the person's life.

Description of the issue or concern causing the physician visit including how it is affecting the person. Bring tracking documents if applicable, such as vital signs, frequent use of PRN medications, etc.

Additional information that might be pertinent to the issue, concern or that would be helpful to know about the person

Part I completed by _____ Date _____

+++++

Part II: To be completed by Physician, Physician's Assistant, MD completing annual health exam

SUMMARY OF FINDINGS

TREATMENTS ORDERED

MEDICATIONS ORDERED

INSTRUCTIONS/PRECAUTIONS/LIMITATIONS

FOLLOW-UP REQUIRED INCLUDING RETURN VISIT

ADDITIONAL COMMENTS.

Date _____
Health Care Staff Signature _____
(MD, Physician's Assistant, Nurse Practitioner)

PART III: Agency Review of Annual Health Exam. Describe follow-up within provider agency.

Date _____
Staff Signature/Title _____

Part I

Eligibility, Service Definitions and Requirements

SECTION IV

***Consumer Eligibility, Service
Definition and Service
Guidelines***

For

Other Specialty Services

Fiscal Year 2012



**Georgia Department of Behavioral Health
& Developmental Disabilities**

April 2012

Treatment Court Services

Definition of Service: Treatment Courts are specialized judicial forums designed to facilitate treatment for first-time, non-violent offenders with addictive diseases and/or mental illness. Treatment Courts combine intense judicial supervision, comprehensive substance abuse and/or mental health treatment, random and frequent drug testing, incentives and sanctions, clinical case management and ancillary services. A variety of different services are available through treatment courts:

- Treatment Courts – Screening, Outreach & Crisis Services
- Treatment Courts – Outpatient Services
- Treatment Courts – Day & Employment Services
- Treatment Courts – Residential Services

Please refer to the service definitions following for details.

Treatment Courts: Screening, Crisis & Outreach Services (Mental Health & Addictive Diseases)

Definition of Service: The intent of these services is to assess the needs of individuals served, development service plan, refer to appropriate services, and address crisis situations as needed. These services may include: initial screening, diagnostic evaluation, outreach referral and/or crisis intervention.

Target Population:	Adults with mental health and/or substance abuse issues who are directed to services through treatment courts.
Expected Benefit:	Reduction of symptoms and improvement in quality of life resulting in decreased or no involvement with the criminal justice system.
UAS: Budget and Expense Categories	115 – Adult Mental Health 715 – Adult Addictive Diseases

Additional Service Information:

1. Providers who deliver screening, crisis and outreach services under Treatment Court contracts should report expenses for those services using the appropriate UAS budget codes listed above, not the 100 or 700 budget codes.
2. Screening, crisis and outreach services provided under Treatment Court contracts should be reported to MHMRIS using only the subunits listed above and no other subunits.
3. A provider may report screening, crisis and outreach expenses and services using budget codes and subunits other than those listed above only for services that are not provided under Treatment Court contracts.

Treatment Courts: Outpatient Services (Mental Health & Addictive Diseases)

Definition of Service: These services shall be provided as needed to individuals receiving services through treatment courts and may include: individual, group and family counseling, ambulatory detoxification, community support services, physician and nursing assessment to address the issues that led to involvement in the criminal justice system.

Target Population:	Adults with mental health and/or substance abuse issues who are directed to services through treatment courts.
Expected Benefit:	Reduction of symptoms and improvement in quality of life resulting in decreased or no involvement with the criminal justice system.
UAS: Budget and Expense Categories	115 – Adult Mental Health 715 – Adult Addictive Diseases

Additional Service Information:

1. Providers who deliver outpatient services under Treatment Court contracts should report expenses for those services using the appropriate UAS budget codes listed above, not the 100 or 700 budget codes.
2. Outpatient services provided under Treatment Court contracts should be reported to MHMRIS using only the subunits listed above and no other subunits.
3. A provider may report outpatient expenses and services using budget codes and subunits other than those listed above only for services that are not provided under Treatment Court contracts.

Treatment Courts: Day & Employment Services (Mental Health & Addictive Diseases)

Definition of Service: These services are intended for individuals with more severe issues and may include the following services: substance abuse day treatment, peer support, psychosocial rehabilitation services and community-based employment services.

Target Population:	Adults with mental health and/or substance abuse issues who are directed to services through treatment courts.
Expected Benefit:	Reduction of symptoms and improvement in quality of life resulting in decreased or no involvement with the criminal justice system.
UAS: Budget and Expense Categories	115 – Adult Mental Health 715 – Adult Addictive Diseases

Additional Service Information:

1. Providers who deliver day and employment services under Treatment Court contracts should report expenses for those services using the appropriate UAS budget codes listed above, not the 100 or 700 budget codes.
2. Day and employment services provided under Treatment Court contracts should be reported to UAS using only the categories above.

3. A provider may report day and employment expenses and services using budget codes and subunits other than those listed above only for services that are not provided under Treatment Court contracts.

**Treatment Courts:
Residential Services (Mental Health & Addictive Diseases)**

Definition of Service: These services shall be provided to individuals served by treatment courts and may include a wide variety of residential treatment options based on the needs of the individual served.

Target Population:	Adults with mental health and/or substance abuse issues who are directed to services through treatment courts.
Expected Benefit:	Reduction of symptoms and improvement in quality of life resulting in decreased or no involvement with the criminal justice system.
UAS: Budget and Expense Categories	115 – Adult Mental Health 715 – Adult Addictive Diseases

Additional Service Information:

1. Providers who deliver residential services under Treatment Court contracts should report expenses for those services using the appropriate UAS budget codes listed above, not the 100 or 700 budget codes.
2. Residential services provided under Treatment Court contracts should be reported to MHMRIS using only the subunits listed above and no other subunits.
3. A provider may report residential expenses and services using budget codes and subunits other than those listed above only for services that are not provided under Treatment Court contracts.

Ready For Work: Outpatient Services							
HIPAA Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
See Item E.2. Below							

Definition of Service: Ready for Work Intensive Outpatient Services will provide comprehensive gender specific treatment for addiction, beginning with ASAM level II.5 (at least 20 hours/week) that includes: substance abuse treatment, group and individual therapy, outreach, parenting, family involvement, recovery group attendance, psycho education, pharmacotherapy, relapse prevention, trauma groups, and ongoing treatment and aftercare. All components of gender specific treatment should be included. This program is designed for those who meet the TANF needy family definition in order to promote employment, parenting and other life skills. Limited slots are available for Non-TANF individual's who meet the most in need criteria or core customer definition and would benefit from gender specific services.

The services that the Ready for Work Intensive Outpatient Package will include are as follows:

1. Behavioral Health Assessment
2. Nursing Assessment
3. Psychiatric Treatment
4. Diagnostic Assessment
5. Consumer Support Services
6. Individual Counseling
7. Group Counseling (including psycho-educational groups focusing, relapse prevention and recovery)
8. Family Counseling/Psycho-Educational Groups for Family Members

RFW Providers that are eligible to bill Medicaid for services provided in an outpatient program may bill for the unbundled services listed in the package, up to the daily maximum amount for each service. Although not all services provided in outpatient services are Medicaid billable, the program expectations for services are clearly defined in the Ready For Work Manual.

A consumer may have variable length of stay. The level of care should be determined as a result of consumers' multiple assessments. It is recommended that individuals attend at a frequency appropriate to their level of need. Ongoing clinical assessment should be conducted to determine step down in level of care and/or addition of other ancillary services.

In addition to the MHDDAD Provider Manual guidelines, all RFW Providers must adhere to the Ready for Work Program Manual.

Target Population	Adult women who are diagnosed with substance abuse disorders who may or may not be receiving TANF cash assistance, a child welfare case, or have children in their custody
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Benefit Information	Available to all ongoing core customers, requires a MICP New Episode Request or Update request (to add as a single service to an existing authorization)
Utilization Criteria	<u>Available to those with LOCUS Scores:</u> 2: Low Intensity Community Based Services 3: High Intensity Community-Based Services 4: Medically Monitored Non-Residential (transition)
Ordering Practitioner	Physician, Physician's Assistant, Advanced Practice Registered Nurse (Clinical Nurse Specialist or Nurse Practitioner).
Unit Value	See Item E.2.
Initial Authorization	180 days
Re-Authorization	180 days
Maximum Daily Units	See Item E.2.
Authorization Period	180 days
UAS: Budget and Expense Categories	Adult Addictive Diseases: SAPT BG: 620 TANF: 621 State Funds: 622
Admission Criteria	<ol style="list-style-type: none"> 1. A DSM IV diagnosis of Substance Abuse or Dependence or substance-related disorder with a co-occurring DSM IV diagnosis of mental illness 2. Substance abuse is a barrier to employability 3. The individual would benefit from participating in a women's program to process gender specific issues associated with addiction and recovery <p>TANF Criteria:</p> <ol style="list-style-type: none"> 1. Consumer must meet the DFCS definition for "Needy Family". To meet this definition the individuals must meet one of three non-financial criteria and one financial requirement <ol style="list-style-type: none"> a. Current TANF Recipients- Individuals with active TANF cash assistance cases b. Former TANF Recipients- Individuals whose TANF assistance with terminated within the previous twelve months due to employment c. Families at Risk- Individuals with active DFCS child protective cases 2. Financial Criteria. The limit for the RFW program is set at 235% of the Federal Poverty Level for individuals who are not eligible for TANF cash assistance. <p>Non-TANF Criteria: Consumers determined to be Non-TANF and not eligible for services in the above criteria but do meet the core customer definition may be served with limited service slots funded with SAPTBG Federal funds. A consumer is determined Non-TANF if:</p> <ol style="list-style-type: none"> 1. A woman pregnant for the first time 2. A woman who has lost parental custody of her children, i.e. is not

	<p>working on reunification</p> <p>3. A woman who is not associated with DFCS (TANF or CPS), meets core customer definition and would benefit from gender specific treatment</p> <p>Prioritization Criteria for Eligible Recipients</p> <ol style="list-style-type: none"> 1. Pregnant women will be given priority status for admission to this program. If no slots are available for this program, preference must be given to admitting her to another appropriate program, even if out of catchment area. If a provider is unable to admit a pregnant consumer, provider must place her on a waiting list and within 48 hours pregnant consumer must be in a program. 2. High priority is given to women who meet the Needy Family Definition. <p>Preference is to be given to those women who are in a condition to benefit most from the services and opportunities provided by this program.</p>
<p>Continuing Stay Criteria</p>	<ol style="list-style-type: none"> 1. The individual's condition continues to meet the admission criteria. 2. Progress notes document progress in reducing use and abuse of substances; developing social networks and lifestyle changes; increasing educational, vocational, social and interpersonal skills; understanding addictive disease; and/or establishing a commitment to a recovery and maintenance program, but the overall goals of the treatment plan have not been met. 3. There is a reasonable expectation that the individual can achieve the goals in the necessary time frame.
<p>Discharge Criteria</p>	<p>An adequate continuing care or discharge plan is established and linkages are in place; and one or more of the following:</p> <ol style="list-style-type: none"> 1. Goals of the treatment plan have been substantially met; or 2. Consumer recognizes the severity of her drug/alcohol usage and is beginning to apply the skills necessary to maintain recovery by accessing appropriate community supports 3. If a consumer is involved with DFCS or another referring agency a discharge staffing should be completed in collaboration both RFW and other referring organization. 4. Receiving recommended prenatal care if pregnant 5. Deliver a drug free baby if pregnant 6. If consumer is staffed to be discharged before clinically appropriate, a clinical staffing must be completed and provide the following information: documented reason for early discharge, and an aftercare plan. <p>Transfer to a higher level of service is warranted if:</p> <ol style="list-style-type: none"> 1. Individual's condition or nonparticipation; or 2. The individual refuses to submit or has positive random drug screens; or 3. Consumer exhibits symptoms of acute intoxication and/or

	<p>withdrawal or</p> <ol style="list-style-type: none"> 4. The individual requires services not available at this level or 5. Consumer has consistently failed to achieve essential treatment objectives despite revisions to the treatment plan and advice concerning the consequences of continues alcohol/drug use to such an extent that no further process is likely to occur
Service Exclusions	Services cannot be offered with Mental Health Intensive Outpatient Package, Psychosocial Rehabilitation, or other Residential treatment service.
Clinical Exclusions	<ol style="list-style-type: none"> 1. If an individual is actively suicidal or homicidal 2. Women should have no cognitive and/or intellectual impairments which will prevent them from participating in and benefiting from the recommended level of care 3. Detoxification and inpatient needs must be met prior to admission to the program (alternative provider and/or community resources should be used to serve women with acute treatment needs) 4. Women must be medically stable to treat on an outpatient basis

A. Required Components

1. This service must be licensed by DCH/HFR under the Rules and Regulations for Drug Abuse Treatment Programs, 290-4-2.
2. Ready For Work Intensive Outpatient Services must have at least 3 levels of care. II.5 (20 hrs/week), II.1 (10 or more hrs), and Level I (9 or less hours). Hours of operation should be accommodating for consumers who work (i.e. evening/weekend hours)
3. Evidence based practices are to be utilized. These may include Motivational Interviewing/Enhancement, stage-based interventions, refusal skill development, Cognitive Behavioral Therapy, Matrix model, TREM. Relapse prevention planning and techniques, and others as appropriate to the individual and issues to be addressed. Practitioners providing this service are expected to maintain knowledge and skills regarding current research trends in best/evidence based practices.
4. The program provides structured treatment or therapeutic services, utilizing activity schedules as part of its operational method, i.e., plans or schedules of days or times of day for certain activities. The program should also utilize group and/or individual counseling and/or therapy.
5. The program utilizes methods, materials, settings, and outside resources appropriate to the developmental and cognitive levels, capabilities, age, and gender of participants.
6. The program utilizes methods, materials, approaches, activities, settings, and outside resources appropriate for and targeted to individuals with co-occurring disorders of mental illness and substance abuse and targeted to individuals with co-occurring developmental disabilities and substance abuse when such individuals are referred to the program.
7. The program conducts random drug screening and uses the results of these tests for marking consumers' progress toward goals and for service planning.
8. This service must operate at an established site approved to bill Medicaid for services. However, limited individual or group activities may take place off-site in natural community settings as is appropriate to each individual's treatment plan.

- a. Narcotics Anonymous (NA) and/or Alcoholics Anonymous (AA) meetings offsite may be considered part of these limited individual or group activities for billing purposes only when time limited and only when the purpose of the activity is introduction of the participating individual to available NA and/or AA services, groups or sponsors. NA and AA meetings occurring during the SA Intensive Outpatient package may not be counted toward the billable hours for any individual outpatient services, nor may billing related to these meetings be counted beyond the basic introduction of an individual to the NA/AA experience.
9. RFW services may operate in the same building as other services; however, there must be a distinct separation between services in staffing, program description, and physical space during the hours the RFW Intensive Outpatient Services is in operation.
10. Adequate space, equipment, furnishings, supplies, and other resources must be provided in order to effectively provide services and so that the program environment is clean and in good repair. Space, equipment, furnishings, supplies, transportation, and other resources for participating individuals' use within the Substance Abuse Intensive Outpatient package must not be substantially different from that provided for other uses for similar numbers of individuals.

B. Staffing Requirements

1. The program must be under the clinical supervision of a **Level 4 or above** who is onsite a minimum of 50% of the hours the service is in operation.
2. Services must be provided by staff who are:
 - a. Level 4 (LAPC, LMSW, CACII, CADC, CCADC and Addiction Counselor Trainee with supervision)
 - b. Level 5 (Paraprofessionals, high school graduates) under the supervision of an Level 4 or above
3. Programs must have documentation that there is one Level 4 staff that is "co-occurring capable." This person's knowledge must go beyond basic understanding and must demonstrate actual staff capabilities in using that knowledge for individuals with co-occurring disorders. Personnel documentation should demonstrate that this staff person has received a minimum of 5 hours/year of training in co-occurring treatment. Effective January 1, 2010, programs must have documentation that there is at least 1 level 4 staff (excluding an Addiction Counselor Trainee) that is "co-occurring capable."
4. There must be at least a Level 4 on-site at all times the service is in operation, regardless of the number of individuals participating.
5. The maximum face-to-face ratio cannot be more than 12 individuals to 1 direct program staff based on average daily attendance of individuals in the program.
6. A physician and/or a Registered Nurse or a Licensed Practical Nurse with appropriate supervision must be available to the program either by a physician and/or nurse employed by the agency, through a contract with a licensed practitioner, or by written referral or affiliation agreement with another agency or agencies that offer such services.
 - a. The physician is responsible for addiction and psychiatric consultation, assessment, and care (including but not limited to ordering medications and/or laboratory testing) as needed. The nurse is responsible for nursing assessments, health screening, medication administration, health education, and other nursing duties as needed.

7. Level 4 staff may be shared with other programs as long as they are available as required for supervision and clinical operations and as long as their time is appropriately allocated to staffing ratios for each program.

C. Clinical Operations

1. It is expected that the transition planning for less intensive service will begin at the onset of RFW services. Documentation must demonstrate this planning.
2. Consumers receiving RFW Outpatient services must have a qualifying diagnosis present in the medical record prior to the initiation of services. The diagnosis must be given by persons identified in O.C.G.A Practice Acts as qualified to provide a diagnosis.
3. Each consumer should participate in setting individualized goals for themselves and in assessing their own skills and resources related to sobriety, use/abuse, and maintaining recovery. Goals are set by exploring strengths and needs in the consumer's living, learning, social, and working environments. Implementation of services may take place individually or in groups.
4. As mentioned above RFW Outpatient Services must have different phases of treatment for consumers. These levels are to be assessed regularly and highly individualized. In the beginning phase of treatment, the consumers are to receive intensive substance abuse treatment and when clinically appropriate receive less substance abuse services and more wrap around services. Primary work or work related activities should be implemented in to treatment no later than 90 days from admission. Services to include documentation of an assessment of work skills, abilities, and all work activities taking place, and if clinically appropriate the initiation of work activities. If not clinically appropriate for a consumer to engage in work related activities, it must be documented.

The following services must be included in the Ready For Work Outpatient Program, many of these activities are reimbursable through Medicaid. RFW Services are required to have a multitude of wrap around services, see RFW Provider manual for a description.

The activities include but are not limited to:

- a. **Group Outpatient Services:**
 - i. Psycho-educational activities focusing on the disease of addiction prevention, the health consequences of addiction, and recovery
 - ii. Therapeutic group treatment and counseling
 - iii. Parenting groups
 - iv. Trauma group
 - v. Linkage to natural supports and self-help opportunities
- b. **Individual Outpatient Services**
 - i. Individual counseling
 - ii. Individualized treatment, service, and recovery planning
- c. **Family Outpatient Services**
 - i. Family education and engagement
 - ii. Nurturing parenting
- d. **Community Support Individual**
 - i. Vocational readiness and support
 - ii. Service coordination unless provided through another service provider
 - iii. Life skills training (i.e. education on healthy eating habits, hygiene)

- iv. Continuing Care: Providers need to have at least 7 contacts per month one of which must be a face-to-face interaction with a consumer (If CSI is billed as a discrete service it must meet that guideline's additional requirements)
 - v. Linkage to health care
 - e. **Behavioral Health Assessment & Service Plan Development and Diagnostic Assessment**
 - i. Assessment and reassessment
 - ii. Service Plan Development
 - f. **Services not covered by Medicaid**
 - i. Drug screening/toxicology examinations
 - ii. Transportation
 - iii. Work Activities
5. In addition to the above required activities within the program, the following must be offered as needed either within the program or through referral to/or affiliation with another agency or practitioner, and may be billed in addition to the billing for Substance Abuse Intensive Outpatient Package:
- a. Individual counseling in exceptional circumstances for traumatic stress and other mental illnesses for which special skills or licenses are required
 - b. Physician assessment and care
 - c. Psychological testing
 - d. Health screening
6. The program must have a Ready for Work Outpatient Services Organizational Plan addressing the following:
- a. The philosophical model of the program and the expected outcomes for program participants (i.e., harm reduction, abstinence, beginning of or maintaining individually defined recovery, employment readiness, relapse prevention, stabilization and treatment of those with co-occurring disorders).
 - b. The schedule of activities and hours of operations.
 - c. Staffing patterns for the program.
 - d. How assessments will be conducted.
 - e. How staff will be trained in the administration of addiction services and technologies.
 - f. How staff will be trained in the recognition and treatment of co-occurring disorders of mental illness and substance abuse pursuant to the Georgia Best Practices
 - g. How services for individuals with co-occurring disorders will be flexible and will include services and activities addressing both mental health and substance abuse issues of varying intensities and dosages based on the symptoms, presenting problems, functioning, and capabilities of such individuals.
 - h. How individuals with co-occurring disorders who cannot be served in the regular program activities will be provided and/or referred for time-limited special integrated services that are co-occurring enhanced as described in the Georgia Suggested Best Practices
 - i. How services will be coordinated with the substance abuse array of services including assuring or arranging for appropriate referrals and transitions.
 - j. How the requirements in these service guidelines will be met.

D. Service Access

The package is offered at least 5 hours per day at least 4 days per week with no more than 2 consecutive days between offered services, and distinguishes between those individuals needing between 9 and 20 hours per week of structured services per week (ASAM Level II.1) and those needing 20 hours or more of structured services per week (ASAM Level II.5 or III.1) in order to begin recovery and learn skills for recovery maintenance.

E. Additional Medicaid Requirements

1. Work activities referenced in Item C.4. may not be billed to the Medicaid authority via services identified in E.2. below.
2. RFW Outpatient providers that are Medicaid approved and serving Medicaid consumers shall utilize the RFW Intensive Outpatient Package. This allows providers to select all services that will be offered in a substance abuse outpatient setting. Billable services and daily limits within RFW Intensive Outpatient Package are as follows:

Package	Service Group	Maximum Authorization Units	Maximum Daily Units
RFW Intensive Outpatient	Behavioral Health Assessment & Service Plan Development	32	24
P0008	Diagnostic Assessment	4	2
	Psychiatric Treatment	12	1
	Nursing Assessment & Care	48	16
	Community Support Individual	600	48
	Individual Outpatient Services	36	1
	Group Outpatient Services	1170	20
	Family Outpatient Services	100	8

F. Billing/Reporting Requirements

1. All applicable Medicaid, MICP, and other DBHDD reporting requirements must be met.
2. Under the "Package," each service must meet the requirements of the Service Group in order for the service to be billed (refer to Part I, Section I of this manual)

G. Documentation Requirements

1. Provider must document services in accordance with the specifications for documentation requirements specified in Part II, Section V of the Provider Manual.
2. Every admission and assessment must be documented.
3. Progress notes must include written daily documentation of important occurrences; level of functioning; acquisition of skills necessary for recovery; progress on goals identified in the IRP including acknowledgement of addiction, progress toward recovery and use/abuse reduction and/or abstinence; use of drug screening results by staff; and evaluation of service effectiveness. Clinicians are to sign and date each note.
4. Daily attendance of each individual participating in the program must be documented showing the number of units in attendance for billing purposes.

5. This service may be offered in conjunction with ACT or Crisis Residential Services for a limited time to transition consumers from one service to the more appropriate one. When this service is used in conjunction with ACT or Crisis Residential services, documentation must demonstrate careful planning to maximize the effectiveness of this service as well as an appropriate reduction in service amounts of the service to be discontinued. Utilization of Ready for Work Outpatient Services with these services is subject to review by the External Review Organization.

Ready For Work Independent Living Supports (SafePort, TANF A/P)							
HIPAA Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
See Item E.2. Below							
<p>Definition of Service: Ready for Work Independent Living Support Services will provide comprehensive gender specific treatment for addiction, beginning with ASAM level II.5 (at least 20 hours/week) that includes: substance abuse treatment, group and individual therapy, outreach, parenting, family involvement, recovery group attendance, psycho education, pharmacotherapy, relapse prevention, trauma groups, and ongoing treatment and aftercare. All components of gender specific treatment should be included. This program is designed for those who meet the TANF needy family definition in order to promote employment, parenting and other life skills. Limited slots are available for Non-TANF individual's who meet the most in need criteria or core customer definition and would benefit from gender specific services. Independent Living Support Services must have safe and secure housing for consumers. This housing can be funded through another organization or state agency. Independent living services can utilize the Substance Abuse Intensive Outpatient Package.</p> <p>The services that the RFW Intensive Outpatient Package will include are as follows:</p> <ol style="list-style-type: none"> 1. Behavioral Health Assessment 2. Nursing Assessment 3. Psychiatric Treatment 4. Diagnostic Assessment 5. Consumer Support Individual Services 6. Individual Counseling 7. Group Counseling (including psycho-educational groups focusing, relapse prevention and recovery) 8. Family Counseling/Psycho-Educational Groups for Family Members <p>RFW Providers that are eligible to bill Medicaid for services provided in an outpatient program may bill for the unbundled services listed in the package, up to the daily maximum amount for each service. Although not all services provided in outpatient services are Medicaid billable, the program expectations for services are clearly defined in the Ready For Work Manual.</p> <p>A consumer may have variable length of stay. The level of care should be determined as a result of consumers' multiple assessments. It is recommended that individuals attend at a frequency appropriate to their level of need. Ongoing clinical assessment should be conducted to determine step down in level of care and/or addition of other ancillary services.</p> <p>In addition to the MHDDAD Provider Manual guidelines, all RFW Providers must adhere to the Ready for Work Program Manual.</p>							

Target Population	Adult women who are diagnosed with substance abuse disorders who may or may not be receiving TANF cash assistance, a child welfare case, or have children in their custody
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Benefit Information	Available to all ongoing core customers, requires a MICP New Episode Request or Update request (to add as a single service to an existing authorization)
Utilization Criteria	<u>Available to those with LOCUS Scores:</u> 3: High Intensity Community-Based Services 4: Medically Monitored Non-Residential (transition) 5: Medically Monitored Residential Services
Ordering Practitioner	Physician, Physician's Assistant, Advanced Practice Registered Nurse (Clinical Nurse Specialist or Nurse Practitioner).
Unit Value	See Item E.2.
Initial Authorization	180 days
Re-Authorization	180 days
Maximum Daily Units	See Item E.2.
Authorization Period	180 days
UAS: Budget and Expense Categories	See Item E.2. and <u>Adult Addictive Diseases: 627, 626</u>
Admission Criteria	<ol style="list-style-type: none"> 1. A DSM IV diagnosis of Substance Abuse or Dependence or substance-related disorder with a co-occurring DSM IV diagnosis of mental illness 2. Substance abuse is a barrier to employability 3. The individual would benefit from participating in a women's program to process gender specific issues associated with addiction and recovery <p>TANF Criteria:</p> <ol style="list-style-type: none"> 1. Consumer must meet the DFCS definition for "Needy Family". To meet this definition the individuals must meet one of three non-financial criteria and one financial requirement <ol style="list-style-type: none"> a. Current TANF Recipients- Individuals with active TANF cash assistance cases b. Former TANF Recipients- Individuals whose TANF assistance with terminated within the previous twelve months due to employment c. Families at Risk- Individuals with active DFCS child protective cases 2. Financial Criteria. The limit for the RFW program is set at 235% of the Federal Poverty Level for individuals who are not eligible for TANF cash assistance. <p>Non-TANF Criteria: Consumers determined to be Non-TANF and not eligible for services in the above criteria but do meet the core customer definition may be served with limited service slots funded with SAPTBG Federal funds. A consumer is determined Non-TANF if:</p> <ol style="list-style-type: none"> 1. A woman pregnant for the first time 2. A woman who has lost parental custody of her children, i.e. is not

	<p>working on reunification</p> <p>3. A woman who is not associated with DFCS (TANF or CPS), meets core customer definition and would benefit from gender specific treatment</p> <p>Prioritization Criteria for Eligible Recipients</p> <ol style="list-style-type: none"> 1. Pregnant women will be given priority status for admission to this program. If no slots are available for this program, preference must be given to admitting her to another appropriate program, even if out of catchment area. If a provider is unable to admit a pregnant consumer, provider must place her on a waiting list and within 48 hours pregnant consumer must be in a program. 2. High priority is given to women who meet the Needy Family Definition. <p>Preference is to be given to those women who are in a condition to benefit most from the services and opportunities provided by this program.</p>
<p>Continuing Stay Criteria</p>	<ol style="list-style-type: none"> 1. The individual's condition continues to meet the admission criteria. 2. Progress notes document progress in reducing use and abuse of substances; developing social networks and lifestyle changes; increasing educational, vocational, social and interpersonal skills; understanding addictive disease; and/or establishing a commitment to a recovery and maintenance program, but the overall goals of the treatment plan have not been met. 3. There is a reasonable expectation that the individual can achieve the goals in the necessary time frame.
<p>Discharge Criteria</p>	<p>An adequate continuing care or discharge plan is established and linkages are in place; and one or more of the following:</p> <ol style="list-style-type: none"> 1. Goals of the treatment plan have been substantially met; or 2. Consumer recognizes the severity of her drug/alcohol usage and is beginning to apply the skills necessary to maintain recovery by accessing appropriate community supports 3. If a consumer is involved with DFCS or another referring agency a discharge staffing should be completed in collaboration both RFW and other referring organization. 4. Receiving recommended prenatal care if pregnant 5. Deliver a drug free baby if pregnant 6. If consumer is staffed to be discharged before clinically appropriate, a clinical staffing must be completed and provide the following information: documented reason for early discharge, and an aftercare plan. <p>Transfer to a higher level of service is warranted if:</p> <ol style="list-style-type: none"> 1. Individual's condition or nonparticipation; or 2. The individual refuses to submit or has positive random drug screens; or 3. Consumer exhibits symptoms of acute intoxication and/or

	<p>withdrawal or</p> <ol style="list-style-type: none"> 4. The individual requires services not available at this level or 5. Consumer has consistently failed to achieve essential treatment objectives despite revisions to the treatment plan and advice concerning the consequences of continues alcohol/drug use to such an extent that no further process is likely to occur
Service Exclusions	Services cannot be offered with Mental Health Intensive Outpatient Package, Psychosocial Rehabilitation or any Residential treatment service.
Clinical Exclusions	<ol style="list-style-type: none"> 1. If an individual is actively suicidal or homicidal 2. Women should have no cognitive and/or intellectual impairments which will prevent them from participating in and benefiting from the recommended level of care 3. Detoxification and inpatient needs must be met prior to admission to the program (alternative provider and/or community resources should be used to serve women with acute treatment needs) 4. Women must be medically stable.

A. Required Components

1. This service must be licensed by DCH/HFR under the Rules and Regulations for Drug Abuse Treatment Programs, 290-4-2.
2. RFW Independent Living Services are mandated to have safe and secure housing for consumers. This housing may be funded through other state agencies or organizations.
3. Ready For Work Independent Living Services must have at least 3 levels of care. II.5 (20 hrs/week), II.1 (10 or more hrs), and Level I (9 or more hours). Hours of operation should be accommodating for consumers who work (i.e. evening/weekend hours)
4. Evidence based practices are to be utilized. These may include Motivational Interviewing/Enhancement, stage-based interventions, refusal skill development, Cognitive Behavioral Therapy, Matrix model, TREM. Relapse prevention planning and techniques, and others as appropriate to the individual and issues to be addressed. Practitioners providing this service are expected to maintain knowledge and skills regarding current research trends in best/evidence based practices.
5. The program provides structured treatment or therapeutic services, utilizing activity schedules as part of its operational method, i.e., plans or schedules of days or times of day for certain activities. The program should also utilize group and/or individual counseling and/or therapy.
6. The program utilizes methods, materials, settings, and outside resources appropriate to the developmental and cognitive levels, capabilities, age, and gender of participants.
7. The program utilizes methods, materials, approaches, activities, settings, and outside resources appropriate for and targeted to individuals with co-occurring disorders of mental illness and substance abuse and targeted to individuals with co-occurring developmental disabilities and substance abuse when such individuals are referred to the program.
8. The program conducts random drug screening and uses the results of these tests for marking consumers' progress toward goals and for service planning.

9. This service must operate at an established site approved to bill Medicaid for services. However, limited individual or group activities may take place off-site in natural community settings as is appropriate to each individual's treatment plan.
 - a. Narcotics Anonymous (NA) and/or Alcoholics Anonymous (AA) meetings offsite may be considered part of these limited individual or group activities for billing purposes only when time limited and only when the purpose of the activity is introduction of the participating individual to available NA and/or AA services, groups or sponsors. NA and AA meetings occurring during the SA Intensive Outpatient package may not be counted toward the billable hours for any individual outpatient services, nor may billing related to these meetings be counted beyond the basic introduction of an individual to the NA/AA experience.
10. RFW services may operate in the same building as other services; however, there must be a distinct separation between services in staffing, program description, and physical space during the hours the RFW Independent Living Services is in operation.
11. Adequate space, equipment, furnishings, supplies, and other resources must be provided in order to effectively provide services and so that the program environment is clean and in good repair. Space, equipment, furnishings, supplies, transportation, and other resources for participating individuals' use within the Substance Abuse Intensive Outpatient package must not be substantially different from that provided for other uses for similar numbers of individuals.

B. Staffing Requirements

1. The program must be under the clinical supervision of a **Level 4 or above** who is onsite a minimum of 50% of the hours the service is in operation.
2. Services must be provided by staff who are:
3. Level 4 (LAPC, LMSW, CACII, CADC, CCADC and Addiction Counselor Trainee with supervision)
4. Level 5 (Paraprofessionals, high school graduates) under the supervision of an Level 4 or above
5. Programs must have documentation that there is one Level 4 staff that is "co-occurring capable." This person's knowledge must go beyond basic understanding and must demonstrate actual staff capabilities in using that knowledge for individuals with co-occurring disorders. Personnel documentation should demonstrate that this staff person has received a minimum of 4 hours of training in co-occurring treatment within the past 2 years. Effective January 1, 2010, programs must have documentation that there is at least 1 level 4 staff (excluding an Addiction Counselor Trainee) that is "co-occurring capable.
6. There must be at least a Level 4 on-site at all times the service is in operation, regardless of the number of individuals participating.
7. The maximum face-to-face ratio cannot be more than 12 individuals to 1 direct program staff based on average daily attendance of individuals in the program.
8. A physician and/or a Registered Nurse or a Licensed Practical Nurse with appropriate supervision must be available to the program either by a physician and/or nurse employed by the agency, through a contract with a licensed practitioner, or by written referral or affiliation agreement with another agency or agencies that offer such services.
9. The physician is responsible for addiction and psychiatric consultation, assessment, and care (including but not limited to ordering medications and/or laboratory testing) as

needed. The nurse is responsible for nursing assessments, health screening, medication administration, health education, and other nursing duties as needed.

10. Level 4 staff may be shared with other programs as long as they are available as required for supervision and clinical operations and as long as their time is appropriately allocated to staffing ratios for each program.

C. Clinical Operations

1. It is expected that the transition planning for less intensive service will begin at the onset of RFW services. Documentation must demonstrate this planning.
2. Consumers receiving RFW Independent Living Services (SA Intensive Outpatient Package) must have a qualifying diagnosis present in the medical record prior to the initiation of services. The diagnosis must be given by persons identified in O.C.G.A Practice Acts as qualified to provide a diagnosis.
3. Each consumer should participate in setting individualized goals for themselves and in assessing their own skills and resources related to sobriety, use/abuse, and maintaining recovery. Goals are set by exploring strengths and needs in the consumer's living, learning, social, and working environments. Implementation of services may take place individually or in groups.
4. As mentioned above, RFW Independent Living Services must have different phases of treatment for consumers. These levels are to be assessed regularly and highly individualized. In the beginning phase of treatment, the consumers are to receive intensive substance abuse treatment and when clinically appropriate receive less substance abuse services and more wrap around services. Primary work or work related activities should be implemented in to treatment no later than 90 days from admission. Services to include documentation of an assessment of work skills, abilities, and all work activities taking place, and if clinically appropriate the initiation of work activities. If not clinically appropriate for a consumer to engage in work related activities, it must be documented.

The following services must be included in the Ready For Work Independent Living Support Program., Many of these activities are reimbursable through Medicaid. RFW Services are required to have a multitude of wrap around services, see RFW Provider manual for a description.

The activities include but are not limited to:

a. Group Outpatient Services:

- i. Psycho-educational activities focusing on the disease of addiction prevention, the health consequences of addiction, and recovery
- ii. Therapeutic group treatment and counseling
- iii. Parenting groups
- iv. Trauma group
- v. Linkage to natural supports and self-help opportunities

b. Individual Outpatient Services

- i. Individual counseling
- ii. Individualized treatment, service, and recovery planning

c. Family Outpatient Services

- i. Family education and engagement

- ii. Nurturing parenting
 - d. **Community Support Individual**
 - i. Vocational readiness and support
 - ii. Service coordination unless provided through another service provider
 - iii. Life skills training (i.e. education on healthy eating habits, hygiene)
 - iv. Continuing Care: Providers need to have at least 7 contacts per month one of which must be a face-to-face interaction with a consumer (If CSI is billed as a discrete service it must meet that guideline's additional requirements)
 - v. Linkage to health care
 - e. **Behavioral Health Assessment & Service Plan Development and Diagnostic Assessment**
 - i. Assessment and reassessment
 - ii. Service Plan Development
 - f. **Services not covered by Medicaid**
 - i. Drug screening/toxicology examinations
 - ii. Transportation
 - iii. Work Activities
5. In addition to the above required activities within the program, the following must be offered as needed either within the program or through referral to/or affiliation with another agency or practitioner, and may be billed in addition to the billing for Substance Abuse Intensive Outpatient Package:
- a. Individual counseling in exceptional circumstances for traumatic stress and other mental illnesses for which special skills or licenses are required
 - b. Physician assessment and care
 - c. Psychological testing
 - d. Health screening
6. The program must have a Ready for Work Independent Living Supports Organizational Plan addressing the following:
- a. The philosophical model of the program and the expected outcomes for program participants (i.e., harm reduction, abstinence, beginning of or maintaining individually defined recovery, employment readiness, relapse prevention, stabilization and treatment of those with co-occurring disorders).
 - b. The schedule of activities and hours of operations.
 - c. Staffing patterns for the program.
 - d. How assessments will be conducted.
 - e. How staff will be trained in the administration of addiction services and technologies.
 - f. How staff will be trained in the recognition and treatment of co-occurring disorders of mental illness and substance abuse pursuant to the Georgia Best Practices
 - g. How services for individuals with co-occurring disorders will be flexible and will include services and activities addressing both mental health and substance abuse issues of varying intensities and dosages based on the symptoms, presenting problems, functioning, and capabilities of such individuals.
 - h. How individuals with co-occurring disorders who cannot be served in the regular program activities will be provided and/or referred for time-limited special

integrated services that are co-occurring enhanced as described in the Georgia Suggested Best Practices

- i. How services will be coordinated with the substance abuse array of services including assuring or arranging for appropriate referrals and transitions.
- j. How the requirements in these service guidelines will be met.

D. Service Access

The SA Intensive Outpatient package is offered at least 5 hours per day at least 4 days per week with no more than 2 consecutive days between offered services, and distinguishes between those individuals needing between 9 and 20 hours per week of structured services per week (ASAM Level II.1) and those needing 20 hours or more of structured services per week (ASAM Level II.5 or II.1) in order to begin recovery and learn skills for recovery maintenance.

E. Additional Medicaid Requirements

- 1. Work activities referenced in Item C.4. may not be billed to the Medicaid authority via services identified in E.2. below.
- 2. RFW Independent Living supports provided by an approved Medicaid provider for a Medicaid consumer shall utilize RFW Intensive Outpatient Package. This allows providers to select all services that will be offered in a substance abuse outpatient setting. Billable services and daily limits within RFW Intensive Outpatient Package are as follows:

Package	Service Group	Maximum Authorization Units	Maximum Daily Units
RFW Intensive Outpatient	Behavioral Health Assessment & Service Plan Development	32	24
P0008	Diagnostic Assessment	4	2
	Psychiatric Treatment	12	1
	Nursing Assessment & Care	48	16
	Community Support Individual	600	48
	Individual Outpatient Services	36	1
	Group Outpatient Services	1170	20
	Family Outpatient Services	100	8

F. Billing/Reporting Requirements

- 1. All applicable Medicaid, MICP, and other DBHDD reporting requirements must be met.
- 2. Under the "Package," each service must meet the requirements of the Service Group in order for the service to be billed (refer to Part I, Section I of this manual)

G. Documentation Requirements

- 1. Provider must document services in accordance with the specifications for documentation requirements specified in Part II, Section V of the Provider Manual.
- 2. Every admission and assessment must be documented.
- 3. Progress notes must include written daily documentation of important occurrences; level of functioning; acquisition of skills necessary for recovery; progress on goals identified in the IRP including acknowledgement of addiction, progress toward recovery and use/abuse

- reduction and/or abstinence; use of drug screening results by staff; and evaluation of service effectiveness. Clinicians are to sign and date each note.
4. Daily attendance of each individual participating in the program must be documented showing the number of units in attendance for billing purposes.
 5. This service may be offered in conjunction with ACT or Crisis Residential Services for a limited time to transition consumers from one service to the more appropriate one. When this service is used in conjunction with ACT or Crisis Residential services, documentation must demonstrate careful planning to maximize the effectiveness of this service as well as an appropriate reduction in service amounts of the service to be discontinued. Utilization of Ready for Work Independent Services with these services is subject to review by the External Review Organization.

Ready For Work Residential Services

HIPAA Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
See Package Detail in Section F. below.							

Definition of Service: Ready for Work Residential Services will provide comprehensive gender specific treatment for addiction, beginning with ASAM level III.5 (at least 25 hours/week) through level I. Services include: substance abuse treatment, group and individual therapy, outreach, parenting, family involvement, recovery group attendance, psycho education, pharmacotherapy, relapse prevention, trauma groups, and ongoing treatment and aftercare. All components of gender specific treatment should be included. This program is designed for those who meet the TANF needy family definition in order to promote employment, parenting and other life skills. Therapeutic child care services are required for Residential programs. Limited slots are available for Non-TANF individual's who meet the most in need criteria or core customer definition and would benefit from gender specific services.

The services that the RFW Residential Package will include are as follows:

1. Structured Residential RFW/TANF
2. Beh Health Assmt & Serv Plan Dev
3. Diagnostic Assessment
4. Psychiatric Treatment
5. Nursing Assessment and Care
6. Medication Administration

A consumer may have variable length of stay. The level of care should be determined as a result of consumers' multiple assessments. It is recommended that individuals attend at a frequency appropriate to their level of need. Ongoing clinical assessment should be conducted to determine step down in level of care and/or addition of other ancillary services.

In addition to the MHDDAD Provider Manual guidelines, all RFW Providers must adhere to the Ready for Work Program Manual.

Target Population	Adult women who are diagnosed with substance abuse disorders who may or may not be receiving TANF cash assistance, a child welfare case, or have children in their custody
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Benefit Information	Available to all ongoing core customers, requires a MICP New Episode Request or Update request (to add as a single service to an existing authorization)
Utilization Criteria	<u>Available to those with LOCUS Scores:</u> 4: Medically Monitored Non-Residential 5: Medically Monitored Residential Services
Ordering Practitioner	Physician, Physician's Assistant, Advanced Practice Registered Nurse (Clinical Nurse Specialist or Nurse Practitioner).
Unit Value	1 day
Initial Authorization	180 days
Re-Authorization	180 days
Maximum Daily Units	1 unit
Authorization Period	180 days
UAS: Budget and Expense Categories	<u>Adult Addictive Diseases:</u> SAPT Block Grant: 624 TANF: 625 State-funded: 626
Admission Criteria	<ol style="list-style-type: none"> 1. A DSM IV diagnosis of Substance Abuse or Dependence or substance-related disorder with a co-occurring DSM IV-TR diagnosis of mental illness 2. Substance abuse is a barrier to employability 3. The individual would benefit from participating in a women's program to process gender specific issues associated with addiction and recovery <p>TANF Criteria:</p> <ol style="list-style-type: none"> 1. Consumer must meet the DFCS definition for "Needy Family". To meet this definition the individuals must meet one of three non-financial criteria and one financial requirement 2. Current TANF Recipients- Individuals with active TANF cash assistance cases 3. Former TANF Recipients- Individuals whose TANF assistance with terminated within the previous twelve months due to employment 4. Families at Risk- Individuals with active DFCS child protective cases 5. Financial Criteria. The limit for the RFW program is set at 235% of the Federal Poverty Level for individuals who are not eligible for TANF cash assistance. <p>Non-TANF Criteria:</p> <p>Consumers determined to be Non-TANF and not eligible for services in the above criteria but do meet the core customer definition may be served with limited service slots funded with SAPTBG Federal funds. A consumer is determined Non-TANF if:</p> <ol style="list-style-type: none"> 1. A woman pregnant for the first time 2. A woman who has lost parental custody of her children, (i.e. is not working on reunification)

	<p>3. A woman who is not associated with DFCS (TANF or CPS), meets core customer definition and would benefit from gender specific treatment</p> <p>Prioritization Criteria for Eligible Recipients</p> <ol style="list-style-type: none"> 1. Pregnant women will be given priority status for admission to this program. If no slots are available for this program, preference must be given to admitting her to another appropriate program, even if out of catchment area. If a provider is unable to admit a pregnant consumer, provider must place her on a waiting list and within 48 hours pregnant consumer must be in a program. 2. High priority is given to women who meet the Needy Family Definition. 3. Preference is to be given to those women who are in a condition to benefit most from the services and opportunities provided by this program.
<p>Continuing Stay Criteria</p>	<ol style="list-style-type: none"> 1. The individual's condition continues to meet the admission criteria. 2. Progress notes document progress in reducing use and abuse of substances; developing social networks and lifestyle changes; increasing educational, vocational, social and interpersonal skills; understanding addictive disease; and/or establishing a commitment to a recovery and maintenance program, but the overall goals of the treatment plan have not been met. 3. There is a reasonable expectation that the individual can achieve the goals in the necessary time frame.
<p>Discharge Criteria</p>	<p>An adequate continuing care or discharge plan is established and linkages are in place; and one or more of the following:</p> <ol style="list-style-type: none"> 1. Goals of the treatment plan have been substantially met; or 2. Consumer recognizes the severity of her drug/alcohol usage and is beginning to apply the skills necessary to maintain recovery by accessing appropriate community supports 3. If a consumer is involved with DFCS or another referring agency a discharge staffing should be completed in collaboration both RFW and other referring organization. 4. Receiving recommended prenatal care if pregnant 5. Deliver a drug free baby if pregnant 6. If consumer is staffed to be discharged before clinically appropriate, a clinical staffing must be completed and provide the following information: documented reason for early discharge, and an aftercare plan. <p>Transfer to a higher level of service is warranted if:</p> <ol style="list-style-type: none"> 1. The individual refuses to submit or has positive random drug screens; or 2. Consumer exhibits symptoms of acute intoxication and/or withdrawal or

	<ol style="list-style-type: none"> 3. The individual requires services not available at this level or 4. Consumer has consistently failed to achieve essential treatment objectives despite revisions to the treatment plan and advice concerning the consequences of continues alcohol/drug use to such an extent that no further process is likely to occur
Service Exclusions	Services cannot be offered with Mental Health Intensive Outpatient Package, SA Intensive Outpatient Package, RFW Outpatient Package, Psychosocial Rehabilitation, or other residential treatment service .
Clinical Exclusions	<ol style="list-style-type: none"> 1. If an individual is actively suicidal or homicidal with a plan and intent 2. Women should have no cognitive and/or intellectual impairments which will prevent them from participating in and benefiting from the recommended level of care 3. Detoxification and inpatient needs must be met prior to admission to the program (alternative provider and/or community resources should be used to serve women with acute treatment needs) 4. Women must be medically stable in order to reside in a group living conditions and participate in treatment

Additional Service Criteria:

A. Required Components

1. This service must be licensed by DCH/HFR under the Rules and Regulations for Drug Abuse Treatment Programs, 290-4-2.
2. Ready For Work Residential Services must have at least 3 levels of care. III.5 (25 hrs/week), III.3 (10 to 20), and Level III.1 (5 or less hours). Hours of operation should be accommodating for consumers who work (i.e. evening/weekend hours)
3. Evidence based practices are to be utilized. These may include Motivational Interviewing/Enhancement, stage-based interventions, refusal skill development, Cognitive Behavioral Therapy, Matrix model, TREM. Relapse prevention planning and techniques, and others as appropriate to the individual and issues to be addressed. Practitioners providing this service are expected to maintain knowledge and skills regarding current research trends in best/evidence based practices.
4. The program provides structured treatment or therapeutic services, utilizing activity schedules as part of its operational method, i.e., plans or schedules of days or times of day for certain activities. The program should also utilize group and/or individual counseling and/or therapy.
5. Therapeutic Childcare Services are required for Ready For Work Residential Services. See the Ready For Work Manual for specific details of these services
6. The program utilizes methods, materials, settings, and outside resources appropriate to the developmental and cognitive levels, capabilities, age, and gender of participants.
7. The program utilizes methods, materials, approaches, activities, settings, and outside resources appropriate for and targeted to individuals with co-occurring disorders of mental illness and substance abuse and targeted to individuals with co-occurring developmental disabilities and substance abuse when such individuals are referred to the program.

8. The program conducts random drug screening and uses the results of these tests for marking consumers' progress toward goals and for service planning.
9. An adequate and safe living environment must be provided for dependent children age 13 and younger that includes therapeutic child care services. After school and weekend programming should be available.
10. This service must operate at an established site approved to bill for services. However, limited individual or group activities may take place off-site in natural community settings as is appropriate to each individual's treatment plan.
11. RFW services may operate in the same building as other services; however, there must be a distinct separation between services in staffing, program description, and physical space during the hours the RFW Residential Services are in operation.
12. Adequate space, equipment, furnishings, supplies, and other resources must be provided in order to effectively provide services and so that the program environment is clean and in good repair. Space, equipment, furnishings, supplies, transportation, and other resources for participating individuals' use within the Ready For Work Residential Services must not be substantially different from that provided for other uses for similar numbers of individuals.

B. Staffing Requirements

1. The program must be under the clinical supervision of a **Level 4 or above** who is onsite a minimum of 50% of the hours the service is in operation.
2. Services must be provided by staff who are:
 - a. Level 4 (LAPC, LMSW, CACII, CADC, CCADC and Addiction Counselor Trainee with supervision) or practitioners with a higher credential
 - b. Level 5 (Paraprofessionals, high school graduates) under the supervision of an Level 4 or above
3. Programs must have documentation that there is one Level 4 staff that is "co-occurring capable." This person's knowledge must go beyond basic understanding and must demonstrate actual staff capabilities in using that knowledge for individuals with co-occurring disorders. Personnel documentation should demonstrate that this staff person has received a minimum of 5 hours/year of training in co-occurring treatment.
4. There must be at least a Level 4 on-site at all times the service is in operation, regardless of the number of individuals participating.
5. The maximum face-to-face ratio cannot be more than 12 individuals to 1 direct program staff based on average daily attendance of individuals in the program.
6. A physician and/or a Registered Nurse or a Licensed Practical Nurse with appropriate supervision must be available to the program either by a physician and/or nurse employed by the agency, through a contract with a licensed practitioner, or by written referral or affiliation agreement with another agency or agencies that offer such services.
7. The physician is responsible for addiction and psychiatric consultation, assessment, and care (including but not limited to ordering medications and/or laboratory testing) as needed. The nurse is responsible for nursing assessments, health screening, medication administration, health education, and other nursing duties as needed.
8. Level 4 staff may be shared with other programs as long as they are available as required for supervision and clinical operations and as long as their time is appropriately allocated to staffing ratios for each program.

C. Clinical Operations

1. It is expected that the transition planning for less intensive service will begin at the onset of RFW Residential Services. Documentation must demonstrate this planning.
2. Consumers receiving RFW Residential Services must have a qualifying diagnosis present in the medical record prior to the initiation of services. The diagnosis must be given by persons identified in O.C.G.A Practice Acts as qualified to provide a diagnosis (Level 1).
3. Each consumer should participate in setting individualized goals for themselves and in assessing their own skills and resources related to sobriety, use/abuse, and maintaining recovery. Goals are set by exploring strengths and needs in the consumer's living, learning, social, and working environments. Implementation of services may take place individually or in groups.
4. As mentioned above RFW Residential Services must have different phases of treatment for consumers. These levels are to be assessed regularly and highly individualized. In the beginning phase of treatment, the consumers are to receive intensive substance abuse treatment and when clinically appropriate receive less substance abuse services and more wrap around services. An appropriate step-down service shall include recommending/referring outpatient services. Continuing Care: Providers need to have at least 7 contacts per month one of which must be a face to face interaction with a consumer.
5. Primary work or work related activities should be implemented in to treatment no later than 90 days from admission. Services to include documentation of an assessment of work skills, abilities, and all work activities taking place, and if clinically appropriate the initiation of work activities. If not clinically appropriate for a consumer to engage in work related activities, it must be documented.
6. The following the services must be included in the Ready For Work Residential Package.. RFW Services are required to have a multitude of wrap around services, see RFW Provider manual for a description.

The activities include but not limited to:

- Psycho-educational activities focusing on the disease of addiction prevention, the health consequences of addiction, and recovery
- Therapeutic group treatment and counseling
- Parenting groups
- Trauma group
- Linkage to natural supports and self-help opportunities
- Individual counseling
- Individualized treatment, service, and recovery planning
- Linkage to health care
- Family education and engagement
- Nurturing parenting
- Vocational readiness and support
- Service coordination unless provided through another service provider
- Life skills training (i.e. education on healthy eating habits, hygiene)
- Assessment and reassessment
- Drug screening/toxicology examinations

- Transportation
 - Individual counseling in exceptional circumstances for traumatic stress and other mental illnesses for which special skills or licenses are required
 - Physician assessment and care
 - Psychological testing
 - Health screening
7. The program must have a Ready for Work Residential Services Organizational Plan addressing the following:
- a. The philosophical model of the program and the expected outcomes for program participants (i.e., harm reduction, abstinence, beginning of or maintaining individually defined recovery, employment readiness, relapse prevention, stabilization and treatment of those with co-occurring disorders).
 - b. The schedule of activities and hours of operations.
 - c. Staffing patterns for the program.
 - d. How assessments will be conducted.
 - e. How staff will be trained in the administration of addiction services and technologies.
 - f. How staff will be trained in the recognition and treatment of co-occurring disorders of mental illness and substance abuse pursuant to the Georgia Best Practices
 - g. How services for individuals with co-occurring disorders will be flexible and will include services and activities addressing both mental health and substance abuse issues of varying intensities and dosages based on the symptoms, presenting problems, functioning, and capabilities of such individuals.
 - h. How individuals with co-occurring disorders who cannot be served in the regular program activities will be provided and/or referred for time-limited special integrated services that are co-occurring enhanced as described in the Georgia Suggested Best Practices
 - i. How services will be coordinated with the substance abuse array of services including assuring or arranging for appropriate referrals and transitions.
 - j. How the requirements in these service guidelines will be met.

D. Service Access

Services are to be offered at least 5 hours per day at least 5 days per week with no more than 2 consecutive days between offered services, and distinguishes between those individuals needing between levels.

E. Additional Medicaid Requirements

The provider, via its DBHDD RFW contract, is paid for the complete set of services defined here. If the provider agency is a Medicaid-approved provider and is serving a Medicaid consumer, then it may bill Medicaid for the services provided only up to the "admission" to the RFW Residential program.

F. Reporting Requirements

All applicable Medicaid, MICP, and other DBHDD reporting requirements must be met.

Service Group Code	Package Name	Service Groups Included	Service Name	Auth Period in Days	Max Auth Units	Max Daily Units	Medicaid/ State
P0009	RFW Intensive Residential	20510	Structured Residential- RFW/TANF	180	180	1	State ¹
		10101	Beh Health Assmt & Serv Plan Development	180	32	24	Both
		10103	Diagnostic Assessment	180	4	2	Both
		10120	Psychiatric Treatment	180	24	1	Both
		10130	Nursing Assessment & Care	180	48	16	Both
		10140	Medication Administration	180	40	1	Both

G. Documentation Requirements

1. Provider must document services in accordance with the specifications for documentation requirements specified in Part II, Section V of the Provider Manual.
2. Every admission and assessment must be documented.
3. Progress notes must include daily logs of attendance. Daily attendance of each individual participating in the program must be documented showing.
4. Written weekly summaries of important occurrences; level of functioning; acquisition of skills necessary for recovery; progress on goals identified in the treatment plan including acknowledgement of addiction, progress toward recovery and use/abuse reduction and/or abstinence; use of drug screening results by staff; and evaluation of service effectiveness. Clinicians are to sign and date.
5. This documentation must confirm that the consumer was a resident of the Ready For Work Residential Program on that day.

Ready For Work Transitional Housing Service							
HIPAA Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
TBD							

Definition of Service: Ready for Work Transitional Housing Service provides a safe, stable, drug free residence for no more than 6 months to a TANF eligible woman or a woman who is involved with a Child Protective Service case and her dependent children. The environment should be gender specific and can include dependent children between birth and 18 years old. This service also includes aftercare programming that consists of no more than 9 hours per week. Aftercare Programming must include: continuing care groups (relapse prevention, gradual transitioning back into the community), linkage within the community (i.e. 12 step groups, health care) with intensive case management, life skills (i.e. parenting, budgeting, healthy eating habits, etc.), job skills/ job readiness groups, transportation, consumer oversight in residences and random drug screens (at least 2 per month). Transitional housing is to be a step down in service from Ready for Work residential or outpatient programs; thus, a successful completion of Ready for Work residential, outpatient, or at least an ASAM level II program is necessary.

Length of stay can be 1-6 months if clinically appropriate.

Target Population	Adult Women (and their dependent children) who are diagnosed with substance abuse disorder(s) AND who are TANF Eligible OR have an active Child Protective Service (CPS) case with Dept of Family and Children Services (DFCS)
Benefit Information	Available for DFCS involved women and their dependent children, requires a MICP Update Request (to add as a single service to an existing authorization)
Utilization Criteria	<u>Available to those with LOCUS Scores:</u> 1: Recovery Maintenance and Health Maintenance 2: Low Intensity Community Based Services
Ordering Practitioner	Licensed Professionals (LPC, LCSW, LAPC, LMSW), Certified Professionals (MAC, CACII, CCADC, CADC)
Unit Value	1 Day
Initial Authorization	180 Days
Re-Authorization	n/a
Maximum Daily Units	1 Unit
Authorization Period	180 Days
UAS: Budget and Expense Categories	<u>Adult Addictive Diseases</u> TANF: 630

Admission Criteria	<ol style="list-style-type: none"> 1. DSM IV diagnosis of Substance Dependence or Abuse 2. DFCS Involvement (Meets TANF Needy Family Definition or has an open CPS case) 3. Successfully completed a Ready For Work Residential, Outpatient, or an ASAM Level II Program 4. Alcohol and drug free and stable on medications (if applicable) 5. Substance Abuse has been a barrier in self-sufficiency (parenting and employment) in the past 6. The individual would benefit from participating in a women's transitional housing program to receive supportive services while transitioning back into the community
Continuing Stay Criteria	<ol style="list-style-type: none"> 1. Individual's condition continues to meet the admission criteria 2. Found and/or maintaining employment, but continues to need supportive services and stable living environment 3. Participation in aftercare programming and remaining alcohol and drug free
Discharge Criteria	<p>A discharge plan must be established with the following:</p> <ol style="list-style-type: none"> 1. Linkage of consumer with community (i.e. self help groups, mental physical health needs) 2. Stable living environment 3. Plans and arrangements for children (i.e. school enrollment, childcare) 4. Employment <p>Transfer to a higher level of service is warranted if:</p> <ol style="list-style-type: none"> 1. Individual's condition or nonparticipation; or 2. The individual refuses to submit or has positive random drug screens; or 3. Consumer exhibits symptoms of acute intoxication and/or withdrawal or 4. The individual requires services not available at this level or 5. Consumer has consistently failed to achieve essential objectives despite revisions to the treatment plan and advice concerning the consequences of continues alcohol/drug use to such an extent that no further process is likely to occur
Service Exclusions	<p>Transitional Housing Services cannot be offered with Ready For Work Residential or Outpatient Packages or any other substance abuse services.</p>
Clinical Exclusions	<ol style="list-style-type: none"> 1. If an individual is actively suicidal or homicidal 2. Women should have no cognitive and/or intellectual impairments which will prevent them from participating in and benefiting from the recommended level of care 3. Detoxification and inpatient needs must be met prior to admission to the program (alternative provider and/or community resources should be used to serve women with acute treatment needs) 4. Women must be medically stable

Additional Service Criteria:

A. Required Components

1. The Contractor shall provide a safe, stable, drug free residence and utilities (power and water) for no more than 6 months to a TANF eligible woman or a woman who is involved with a Child Protective Service case and her dependent children.
 - a) If children are residing with their mother, provider must childproof the home and provide a safe play area.
 - b) The transitional home must provide a bathroom for every four residents and a tub/shower for every eight residents.
 - c) The home must provide a living room, a dining area, a kitchen and a bedroom for all residents
 - d) Staff persons are checked for previous criminal history, must have basic training in first aid, cardiopulmonary resuscitation
 - e) Providers must be mindful of the placement of a family that has older children (ages 12-18) taking into consideration trauma, privacy, and gender issues. Clinical teams must evaluate age appropriateness of housing situation taking in consideration ages of children 12 years and older.
2. ASAM Level I services must be provided to all participants in transitional housing for no more than 9 hours per week. Consumers in this level of care shall not count for a providers' outpatient or residential TANF consumers. The aftercare for transitional housing service can be Provider's Ready For Work Aftercare program; however, this programming must provide the services listed below.
 - a) These topics must be a part of Transitional Housing Services:
 - i. Relapse prevention,
 - ii. Linkage within the community (i.e. 12 step groups, health care)
 - iii. intensive case management (transitioning out of treatment),
 - iv. Life skills (i.e. parenting, budgeting, healthy eating habits, etc.),
 - v. Job skills/ job readiness groups
 - vi. Randomized drug screens (at least 2 per month)
 - b) This is a step down level in the continuum of care. Women in this phase of treatment should have more independence with support.
 - i. Consumer should have a comprehensive case management in the first 2 months and then a gradual tapering of services
 - ii. Staff should be available for empowerment and supervision and to complete randomized (or as clinically appropriate). Room/apartment checks should be completed as a clinical tool to hold consumers accountable.
 - c) Transportation must be provided for the consumers, this may include public transportation fare, staff transporting consumers using agency vehicles, and/or providing gas for consumer's automobile.
3. Providers should continue to work with the consumers' DFCS case workers to ensure consistency of care

B. Staffing Requirements

1. The program must be under the clinical supervision of a level 4(LAPC, LMSW, CACII, CADC, CCADC and Addiction Counselor Trainees) or above

2. Aftercare Services must be provided by staff who are at least a level 5 (RADT, CACI, paraprofessionals)
3. Staff who are providing case management should be a professional, paraprofessional, and/or sober and in recovery for at least 1 year.

C. Clinical Operations

1. Transitional Housing Services should provide a schedule for aftercare programming and to ensure stability and consistency for consumers
2. Transitional Housing Services may be in the same apartment complex or building as the residential services; however, the living space designated to transitional housing must be distinctly different. Consumers who are in the Residential or Outpatient treatment must not be living in the same apartment as a consumer in transitional housing services
3. Food and shopping must be completed by consumers, providers should not provide food, charge, or collect money/EBT cards
4. Medications and medical needs should be the responsibility of the consumer. The provider should not hold or dispense medications to consumers in Transitional Housing Services
5. Each Consumer should participate in setting individualized goals for themselves and in assessing their own skills and resources related to sobriety, use/abuse, and maintaining recovery. Goals are set by exploring strength and needs in the consumer's living, learning social and working environments.
6. Transitional Housing Services must have a written organizational plan addressing the following:
 7. Schedule of Activities and hours
 8. Staffing Patterns of the Program
 9. Policies and Procedures
 10. House Rules for Consumers
11. A consumer must be in a slot for at least 16 consecutive days of the month for the full reimbursement. If a consumer is in a slot for 7-15 days, providers shall be reimbursed for half of the reimbursement.

D. Service Access

Aftercare services are to be offered at during the evenings and/or weekends to accommodate consumers' work schedules

E. Additional Medicaid Requirements

Medicaid does not reimburse for this service

F. Reporting Requirements

1. Department requires providers to provide information regarding the consumer information. The reporting form has been supplied to the providers by the Division. This report must be submitted by the 10th of the following month. The consumers that providers count for the transitional housing service program must not be counted in the provider's regular TANF reporting.
2. All applicable DBHDD reporting requirements must be met

G. Documentation Requirements

1. Providers must document weekly summaries of consumers' progress
2. Results of Drug screens must be documented
3. Admissions and discharges must be captured.

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PART II

Community Service Standards for All Providers

Provider Manual for Community Mental Health, Developmental Disabilities and Addictive Diseases Providers

Fiscal Year 2012
(Updated for April 1, 2012 Implementation)



**Georgia Department of Behavioral Health &
Developmental Disabilities**

April 2012

DBHDD

THE DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL DISABILITIES STANDARDS FOR ALL PROVIDERS FY 2012

VISION: A SATISFYING, INDEPENDENT LIFE WITH DIGNITY AND RESPECT

It is the vision of the Department of Behavioral Health and Developmental Disabilities (DBHDD) that every person who participates in our services leads a satisfying, independent life with dignity and respect.

BEHAVIORAL HEALTH SERVICES

DBHDD is working to implement the vision found in President George W. Bush's *New Freedom Initiative on Mental Health*, which says:

"We are committed to a future where recovery is the expected outcome and when mental illness can be prevented or cured. We envision a nation where everyone with a mental illness will have access to early detection and the effective treatment and supports essential to live, work, learn and participate fully in their community."

For children and adolescents, DBHDD is working to provide services, support, care and treatment that are family-driven and youth-guided that supports the resiliency of the individual child or youth within their natural environment.

DEVELOPMENTAL DISABILITY SERVICES

DBHDD believes it is critical that services, supports, treatment and care respect the vision of the individual. Each agency or organization must incorporate this belief and practice into its service delivery to support individuals with intellectual and developmental disabilities in living a meaningful life in the community. Specifically, the provider must ensure:

- Person-centered service planning and delivery that address what is important to and for individuals
- Capacity and capabilities, including qualified and competent providers and staff
- Participant safeguards
- Satisfactory participant outcomes
- Systems of care that have the infrastructure necessary to provide coordinated services, supports, treatment and care
- Participants rights and responsibilities
- Participant access

The Standards that follow are applicable to DBHDD or organizations that provide services to individuals that are financially supported in whole or in part by funds authorized through DBHDD, regardless of the age or disability of the individual served.

Participant self-determination includes freedom, authority and responsibility and is considered key to achieving the vision of *a satisfying, independent life with dignity and respect for everyone*.

ORGANIZATIONAL PRACTICES

A. The Organization Clearly Describes Available Services, Supports, Care and Treatment

1. The organization has a description of its services, supports, care and treatment that includes a description of:
 - a. The population served;
 - b. How the organization plans to strategically address the needs of those served; and
 - c. Services available to potential and current individuals.
2. The organization details the desired expectation of the services, supports, care and treatment offered and the outcomes for each of these services.
3. The level and intensity of services, supports, care and treatment offered is:
 - a. Within the scope of the organization;
 - b. According to benchmarked practices; and
 - c. Timely as required by individual need.
4. The program description identifies staff to individual served ratios for each service offered:
 - a. Ratios reflect the needs of consumers served, implementation of behavioral procedures, best practice guidelines and safety considerations.
 - b. Ratios reflect considerations such as licensure waivers, special (exceptional) rates reflecting unique individual care needs, etc.
5. Children seventeen and younger may not be served with adults unless the children are residing with their parents or legal guardians in residential programs such as the Ready for Work program.
 1. Emancipated minors and juveniles who are age 17 years may be served with adults when their life circumstances demonstrate they are more appropriately served in an adult environment.
 2. Situations representing exceptions to this standard must have written documentation from the DBHDD Regional office.
 - i. Exceptions must demonstrate that it would be disruptive to the living configuration and relationships to disturb the 'family' make-up of those living together

B. Strong Operational Procedures Support the Organization, Its Staff and Individuals Served

1. Applicable statutory requirements, rules, regulations, licensing, accreditation, and contractual/agreement requirements are evident in organizational policies, procedures and practices.
2. The organization has internal structures that support good business practices.
 - a. There are clearly stated current policies and procedures for all aspects of the operation of the organization;
 - b. Policies and corresponding procedures direct the practice of the organization; and
 - c. Staff is trained in organization policies and procedures.
3. The organization has administrative and clinical structures that are clear and that support individual care.
 - a. Administrative and clinical structures promote unambiguous relationships and responsibilities.
4. Organizations that provide developmental disabilities services must participate in the Georgia Developmental Disabilities Provider Information websites. The addresses are (1) www.dbhdd.ga.gov and (2) www.georgiaddproviders.org/
5. There is a written budget which includes expenses and revenue that serves as a plan for managing resources.

- a. Utilization of fiscal resources is assessed in Quality Improvement processes and/or by the Board of Directors.
- 6. The organization policy must state explicitly in writing whether research is conducted or not on individuals served by the organization.
 - a. If the organization wishes to conduct research involving individuals, a research design shall be developed and must be approved by:
 - i. The agency's governing authority; and
 - ii. The Regional Coordinator for the DBHDD; and
 - iii. The Institutional Review Board operated by the Department of Community Health (DCH) and its policies regarding the Protection of Human Subjects found in DBHDD directive herein.
 - b. The Research design shall include:
 - i. A statement of rationale;
 - ii. A plan to disclose benefits and risks of research to the participating person;
 - iii. A commitment to obtain written consent of the persons participating; and
 - iv. A plan to acquire documentation that the person is informed that they can withdraw from the research process at any time.
 - c. The organization using unusual medication and investigational experimental drugs shall be considered to be doing research.
 - i. Policies and procedures governing the use of unusual medications and unusual investigational and experimental drugs shall be in place;
 - ii. Policies, procedures, and guidelines for research promulgated by the DCH Institutional Review Board shall be followed;
 - iii. The research design shall be approved and supervised by a physician; and
 - iv. Information on the drugs used shall be maintained including:
 - 1. Drug dosage forms;
 - 2. Dosage range;
 - 3. Storage requirements;
 - 4. Adverse reactions; and
 - 5. Usage and contraindications.
 - v. Pharmacological training about the drug(s) shall be provided to nurses who administer the medications; and
 - vi. Drugs utilized shall be properly labeled.
 - d. If research is conducted, there is evidence that involved individuals are:
 - i. Fully aware of the risks and benefits of the research;
 - ii. Have documented their willingness to participate through full informed consent; and
 - iii. Can verbalize their wish to participate in the research. If the individual is unable to verbalize or otherwise communicate this information, there is evidence that a legal representative, guardian or guardian ad litem has received this information and consented accordingly.

OUTCOME OF SERVICES

C. Individuals receive Services, Supports, Care or Treatment that result in a Satisfying Independent Life with Dignity and Respect

- 1. Services, supports, care or treatment approaches support the individual in:
 - a. Living in the most integrated community setting appropriate to the individual's requirement, preferences and level of independence;

- b. Exercising meaningful choices about living environments, providers of services received, the types of supports, and the manner by which services are provided;
- c. Obtaining quality services in a manner as consistent as possible with community living preferences and priorities; and
- d. Inclusion and community integration is supported and evident in documentation.

D. Respect for the Dignity of the Individual is demonstrated

1. Access to appropriate services, supports, care and treatment is available regardless of:
 - a. Age;
 - b. Race, National Origin, Ethnicity;
 - c. Gender;
 - d. Religion;
 - e. Social status;
 - f. Physical disability;
 - g. Mental disability;
 - h. Gender identity;
 - i. Sexual orientation.
2. There are no barriers in accessing the services, supports, care and treatment offered by the organization, including but not limited to:
 - a. Geographic;
 - b. Architectural;
 - c. Communication:
 - i. Language access is provided to individuals with limited English proficiency or who are sensory impaired;
 - ii. All applicable DBHDD policies regarding Limited English Proficiency and Sensory Impairment are followed.
 - d. Attitudinal;
 - e. Procedural; and
 - f. Organizational scheduling or availability.
3. There is evidence of organizational person-centered planning and service delivery.
4. Sensitivity to individual's differences and preferences is evident.
5. Practices and activities that reduce stigma are implemented.
6. Interactions with individuals demonstrate:
 - a. Respect;
 - b. Careful listening; and
 - c. Are positive and supportive.

E. Human and Civil Rights are maintained

1. The organization has policies and promotes practices that:
 - a. Do not discriminate;
 - b. Promote receiving equitable supports from the organization;
 - c. Provide services, supports, care and treatment in the least restrictive environment;
 - d. Emphasize the use of teaching functional communication and using least restrictive interventions; and
 - e. Incorporate Clients Rights or Patients Rights Rules found at, www.dbhdd.ga.gov as applicable to the organization; and
 - f. Delineates the rights and responsibilities of persons served.
2. In policy and practice, the organization makes it clear that under no circumstances will the following occur:
 - a. Threats (overt or implied);

- b. Corporal punishment;
 - c. Fear-eliciting procedures;
 - d. Abuse or neglect of any kind;
 - e. Withholding nutrition or nutritional care; or
 - f. Withholding of any basic necessity such as clothing, shelter, rest or sleep.
3. Grievance, complaint and appeals of internal and external policies and processes are clearly written in language accessible to individuals served and are promulgated and consistent with all applicable DBHDD policies regarding *Complaints and Grievances* regarding community services. Notice of procedures is provided to individuals, staff and other interested parties, and providers maintain records of all complaints and grievances and the resolutions of same.
4. Federal and state laws and rules are evident in policy and practice including, but not limited to:
- a. **For all community based programs**, practices promulgated by DBHDD or the Rules and Regulations for Clients Rights, Chapter 290-4-9 are incorporated into the care of individuals served. Issues addressed include but are not limited to the right to:
 - i. Care in the least restrictive environment;
 - ii. Humane treatment or habilitation that affords protection from harm, exploitation or coercion.
 - iii. Unless adjudicated incompetent by a court of law, be considered legally competent for any purpose without due process of law, including to maintain:
 - 1. Civil;
 - 2. Political
 - 3. Personal; and
 - 4. Property rights.
 - b. **For all crisis stabilization units serving adults, children or youth**, practices promulgated by DBHDD or the Rules and Regulations for Patients Rights, Chapter 290-4-6 are incorporated into the care of adults, children and youth served in crisis stabilization units. Issues addressed include but are not limited to the right to:
 - i. Care in the least restrictive environment;
 - ii. Humane treatment or habilitation that affords protection from harm, exploitation or coercion;
 - iii. Unless adjudicated incompetent by a court of law, be considered legally competent for any purpose without due process of law, including:
 - 1. Civil;
 - 2. Political
 - 3. Personal; or
 - 4. Property rights.
 - c. **For all programs serving individuals with substance use and abuse issues**, in addition to practices promulgated by DBHDD or the Rules and Regulations for Clients Rights, Chapter 290-4-9, confidentiality procedures for substance abuse individual records comply with 42 CFR, Part 2, Confidentiality of Alcohol and Drug Abuse Patient Records, Final Rule (June 9, 1987), or subsequent revisions thereof.
 - i. All substance abuse individuals are provided written notice about the confidentiality of substance abuse records at the time of admission or soon thereafter when the individual is capable of rational communication;
 - ii. This notification is documented in the individual's record; and
 - iii. The individual's signature on the notification form serves as

documentation of notification.

5. All individuals are informed about their rights and responsibilities:
 - a. At the onset of services, supports, care and treatment;
 - b. At least annually during care;
 - c. Through information that is readily available, well prepared and written using language accessible and understandable to the individual; and
 - d. Evidenced by the individual's or legal guardian signature on notification.
6. All individuals determine how their right to confidentiality will be addressed, including but not limited to who they wish to be informed about their services, supports, care and treatment.
7. Effective July 1, 2012, the organization must have written policies and procedures regarding the visitation rights of individuals, including a requirement that any reasonable restrictions must be based on the seriousness of the individual's mental or physical condition as ordered in writing by the attending physician. Such orders shall state the type and extent of the restriction, and shall expire in 24 hours after written, unless terminated sooner. Additional orders shall follow the same procedure. The organization must meet the following requirements:
 - i. Inform each individual (or guardian, or parent or custodian of a minor, as applicable) of his or her visitation rights, including any clinical restriction of such rights, when he or she is informed of his or her other rights under this section;
 - ii. Inform each individual (or guardian, or parent or custodian of a minor, as applicable) of the right, subject to his or her consent, to receive the visitors whom he or she designates, including, but not limited to, a spouse, a domestic partner (including a same sex domestic partner), another family member, or a friend, and his or her right to withdraw or deny such consent at any time. Provided, however, that the parent, guardian or custodian of a minor may restrict his or her visitation rights;
 - iii. Not restrict, limit, or otherwise deny visitation privileges on the basis of race, color, national origin, religion, sex, gender identity, sexual orientation or disability;
 - iv. Ensure that all visitors enjoy full and equal visitation privileges consistent with the preferences of the individual;
 - v. Not restrict visitation by an individual's attorney or personal physician on the basis of the individual's physical or mental condition.

F. Behavioral Support Services are addressed consistent with Best Practices

1. In policy, procedures and practice, the organization makes it clear whether and under what circumstances the following restrictive interventions can be implemented based on the service(s) provided by the organization and licensure requirements. In all cases, federal and state laws and rules are followed and include but are not limited to the following:
 - a. Use of adaptive supportive devices or medical protective devices;
 - i. May be used in any service, support, care and treatment environment; and
 - ii. Use is defined by a physician's order (order not to exceed six calendar months).
 - iii. Written order to include rationale and instructions for the use of the device.
 - iv. Authorized in the individual service plan (ISP).
 - v. Are used for medical and/or protective reason (s) and not for behavior control.

- b. Time out (used only in DD or C&A services):
 - i. Under no circumstance is egress restricted;
 - ii. Time out periods must be brief, not to exceed 15 minutes;
 - iii. Procedure for time-out utilization incorporated in behavior plan;
 - iv. Reason justification and implementation for time out utilization documented.
- c. Personal restraint (also known as manual hold or manual restraint): The application of physical force, without the use of any device, for the purpose of restricting the free movement of a person's body;
 - i.. May be used in all community settings except residential settings licensed as Personal Care Homes;
 - ii. Circumstances of use must represent an emergency safety intervention of last resort affecting the safety of the individual or of others;
 - iii. Brief handholding (less than 10 seconds) support for the purpose of providing safe crossing, safety or stabilization does not constitute a personal hold;
 - iv. If permitted, Personal Restraint (ten seconds or more), shall not exceed five (5) minutes and this intervention is documented.
- d. Physical restraint (also known as mechanical restraint): A device attached or adjacent to the individual's body that one cannot easily remove and that restricts freedom of movement or normal access to one's body or body parts.
 - i. Prohibited in community settings **except** in community programs designated as crisis stabilization units for adults, children or youth;
 - ii. Circumstances of use in behavioral health, crisis stabilization units must represent an emergency safety intervention of last resort affecting the safety of the individual or of others.
- e. Seclusion: The involuntary confinement of an individual alone in a room or in any area of a room where the individual is prevented from leaving, regardless of the purpose of the confinement. The practice of "restrictive time-out" (RTO) is seclusion and may not be utilized except in compliance with the requirement related to seclusion. The phrase "prevented from leaving" includes not only the use of a locked door, but also the use of physical or verbal control to prevent the individual from leaving.
 - i. Seclusion may be used in the community **only** in programs designated as crisis stabilization programs for adults, children or adolescents;
 - ii. Circumstances of use in behavioral health crisis stabilization programs must represent an emergency safety intervention of last resort affecting the safety of the individual or of others;
 - iii. Is not permitted in developmental disabilities services.
- f. **Chemical restraint may never be used under any circumstance.** Chemical restraint is defined as a medication or drug that is:
 - i. Not a standard treatment for the individual's medical or psychiatric condition;
 - ii. Used to control behavior;
 - iii. Used to restrict the individual's freedom of movement.
- g. Examples of chemical restraint are the following:
 - i. The use of over the counter medications such as Benadryl for the purpose of decreasing an individual's activity level during regular waking hours;
 - ii. The use of an antipsychotic medication for a person who is not psychotic but simply 'pacing' or mildly agitated.
- h. PRN antipsychotic and mood stabilizer medications for behavior control are not permitted. See Part II, Section 1; Appendix 1 for list of medications.

2. When individuals demonstrate challenging behaviors the approach to developing a behavior support plan and treatment should be consistent with the *Guidelines for Supporting Adults with Challenging Behaviors in Community Settings and/or Best Practice Standards for Behavioral Support Services* (www.dbhdd.ga.gov). Care is taken to determine what the function of each challenging behavior serves for that individual in his/her environment while also considering:

- a. Physiological issues such as possible medical and psychiatric issues; including physical disabilities such as difficulty seeing, hearing, or ambulating;
- b. Social issues such as lack of available, inclusive social networks;
- c. Psychological issues;
- d. Environmental issues such as staffing concerns;
- e. The need for a crisis/safety plan.

3. All organizations must have the capacity to address individuals' behavioral needs. If the cause of the challenging behavior cannot be determined or satisfactorily addressed by the provider, there should be evidence of consultation with an outside professional who is licensed or qualified through education, supervised training and experience to address the behavior needs of the individual.
4. A behavior support plan must be developed for individuals with developmental disabilities who receive psychotropic medications for symptoms other than a Mental Illness or Epilepsy and is intended to reduce the need for those medications over time.
5. The provider insures authors of BSP are properly qualified to develop interventions. Those authoring such plans should minimally meet DDP and/or professional criteria as a Psychologist, Behavioral Specialist or a Board Certified Behavior Analyst.

G. Integration into the Larger Natural Community is Evident

1. Inclusion and community integration is supported and evident.
2. Individuals have responsibilities in the community such as employment, volunteer activities, church and civic membership and participation, school attendance, and other age-appropriate activities
3. The organization has community partnerships that demonstrate input and involvement by:
 - a. Advocates;
 - b. The person served;
 - c. Families; and
 - d. Business and community representatives.
4. The organization makes known its role, functions and capacities to the community including other organizations as appropriate to its array of services, supports, care and treatment as a basis for:
 - a. Joint planning efforts;
 - b. Continuity in cooperative service delivery, including the educational system;
 - c. Provider networking;
 - d. Referrals; and
 - e. Sub-contracts.

H. Quality Improvement Processes and Management of Risk to Individuals, Staff and Others is a Priority

1. There is a well-defined quality improvement plan for assessing and improving organizational quality. The organization is able to demonstrate how:
 - a. Issues are identified;
 - b. Solutions are implemented;
 - c. New or additional issues are identified and managed on an ongoing basis;
 - d. Internal structures minimize risks for individuals and staff;

- e. Processes used for assessing and improving organizational quality are identified ; and
 - f. Effective July 1, 2012, the quality improvement plan is reviewed/updated at a minimum annually and this review is documented.
2. Areas of risk to persons served and to the organization are identified based on services, supports, treatment or care offered including, but not limited to:
- a. Incidents;
 - i. There is evidence that incidents are reported to the DBHDD Office of Incident Management and Investigation as required by DBHDD Policy, *Reporting and Investigating Deaths and Critical Incidents in Community Services*;
 - b. Accidents;
 - c. Complaints;
 - d. Grievances;
 - e. Individual Rights Violations;
 - i. There is documented evidence that any restrictive interventions utilized must be reviewed by the organization’s Rights Committee;
 - f. Practices that limit freedom of choice or movement;
 - g. Medication Management;
 - h. Infection Control;
 - i. Behavior Support Plan tracking and monitoring;
 - j. Breaches of Confidentiality; and
 - k. Health and Human Rights of persons with Developmental disabilities.
3. Indicators of performance are in place for assessing and improving organizational quality. The organization is able to demonstrate:
- a. The indicators of performance established for each issue;
 - i. The method of routine data collection;
 - ii. The method of routine measurement;
 - iii. The method of routine evaluation;
 - iv. Target goals/expectations for each indicator;
 - b. Outcome Measurements determined and reviewed for each indicator on a quarterly basis;
 - c. Distribution of Quality Improvement findings on a quarterly basis to:
 - 1. Individuals served or their representatives as indicated;
 - 2. Organizational staff;
 - 3. The governing body; and
 - 4. Other stakeholders as determined by the governance authority.
4. The organization’s practice of cultural diversity competency is evident by:
- a. Staff articulating an understanding of the social, cultural, religious and other needs and differences unique to the individual;
 - b. Staff honoring these differences and preferences (such as worship or dietary preferences) in the daily care of the individual; and
 - c. The inclusion of cultural competency in Quality Improvement processes.
5. At least five per cent (5%) of records of persons served are reviewed each quarter. Records of individuals who are “at risk” are included. Reviews include these determinations:
- a. That the record is:
 - i. Organized;
 - ii. Complete;
 - iii. Accurate; and
 - iv. Timely
 - b. Whether services are based on assessment and need;
 - c. That individuals have choices;

- d. Documentation of service delivery including individuals' responses to services and progress toward ISP goals;
 - e. Documentation of health service delivery;
 - f. Medication management and delivery, including the use of PRN /OTC medications; and their effectiveness;
 - g. That approaches implemented for persons with challenging behaviors are addressed as specified in the *Guidelines for Supporting Adults with Challenging Behaviors in Community Settings*. When a behavioral support plan is necessary, providers of developmental disabilities services develop these plans in accordance with the *Best Practice Standards for Behavioral Support Service* (www.dbhdd.georgia.gov).
6. Record reviews should be kept for a period of at least two years.
 7. Appropriate utilization of human resources is assessed, including but not limited to:
 - a. Competency;
 - b. Qualifications;
 - c. Numbers and type of staff, for example, a behavior specialist, required based on the services, supports, treatment and care needs of persons served; and
 - d. Staff to individual ratios.
 8. The organization has an advisory board made up of citizens, local business providers, individuals and family members. The Board:
 - a. Meets at least semi-annually;
 - b. Reviews items such as but not limited to:
 - i. Policies;
 - ii. Risk management reports; and
 - iii. Budgetary issues.
 - c. Provides objective guidance to the organization.

I. A Holistic Approach to Services, Supports, Care and Treatment that Enhances the Individual's Capacity to Lead a Satisfying, Independent Life

1. Individualized services, supports, care and treatment determinations are made on the basis of an assessment of needs with the individual. The purpose of the assessment is to determine the individual's hopes, dreams or vision for their life and to determine how best to assist the individual in reaching those hopes, dreams or vision, including determining appropriate staff to deliver these services.
2. Assessments should include but are not limited to the following:
 - a. The individual's:
 - i. Hopes and dreams, or personal life goals;
 - ii. Perception of the issue(s) of concern;
 - iii. Strengths;
 - iv. Needs;
 - v. Abilities; and
 - vi. Preferences.
 - b. Medical history;
 - c. A current health status report or examination in cases where:
 - i. Medications or other ongoing health interventions are required;
 - ii. Chronic or confounding health factors are present;
 - iii. Medication prescribed as a part of DBHDD services has research indicating necessary surveillance of the emergence of diabetes, hypertension, and/or cardiovascular disease;
 - iv. Allergies or adverse reactions to medications have occurred; or
 - v. Withdrawal from a substance is an issue.
 - d. Appropriate diagnostic tools such as impairment indices, psychological testing, or laboratory tests;
 - e. Social history;

- f. Family history;
 - g. School records (for school age individuals);
 - h. Collateral history from family or persons significant to the individual, if available.
 - i. NOTE that when collateral history is taken, information about the individual **may not be shared** with the person giving the collateral history unless the individual has given specific written consent; and
 - i. Review of legal concerns including:
 - ii. Advance directives;
 - iii. Legal competence;
 - iv. Legal involvement of the courts;
 - v. Legal status as it relates to Title 37; and
 - vi. Legal status as adjudicated by a court.
3. Additional assessments should be performed or obtained by the provider if required to fully inform the services, supports, care and treatment provided. These may include but are not limited to:
 - a. Assessment of trauma or abuse;
 - b. Suicide risk assessment;
 - c. Functional assessment;
 - d. Cognitive assessment;
 - e. Behavioral assessments;
 - f. Spiritual assessment;
 - g. Assessment of independent living skills;
 - h. Cultural assessment;
 - i. Recreational assessment;
 - j. Educational assessment;
 - k. Vocational assessment; and
 - l. Nutritional assessment;
 4. The individual is informed of the findings of the assessments in a language he or she can understand.
 5. An individualized service plan or individualized recovery plan is developed with the guidance of an in-field professional (Refer to the *Standards for All Providers* for definitions related to in-field professionals).
 - a. Individuals direct decisions that impact their lives;
 - b. Others assisting in the development of the individualized plan are persons who:
 - i. Are significant in the life of the individual;
 - ii. Have a historical perspective of the wishes and preferences of the individual;
 - iii. The individual gives consent to have input from family and friends, if desired; and
 - iv. Will deliver the specific services, supports, care and treatment identified in the plan.
 1. For individuals with coexisting, complex and confounding needs, cross disciplinary approaches to planning should be used;
 2. Planning should be facilitated by professional(s) qualified to plan or provide supports to persons with this level of complexity;
 3. Representatives of other agencies outside of the DBHDD or providers affecting the daily life of the individual should be present and participating.
 6. Each individualized plan should be:
 - a. Driven by the individual;

- b. Focused on outcomes the individual wishes to achieve;
 - c. Fully explained to the individual using language he or she can understand; and
 - d. Agreed to by the individual.
7. Components of the plan are:
- a. Statement(s) of goals or desired outcomes;
 - b. Documented objectives that are:
 - i. Specific
 - ii. Measurable
 - iii. Achievable
 - iv. Relevant
 - v. Realistic
 - vi. Time-limited with specified target dates
 - c. Specific services, supports, care and treatment to be provided related to each goal or outcome;
 - d. The frequency or intensity that the specific service, support, care and treatment will be given or provided;
 - e. Identification of staff responsible to deliver or provide the specific service, support, care and treatment;
 - f. A page for signature, title and date by participants (including the individual) that is attached to the plan, indicating participant presence;
 - i. There is evidence of involvement in the plan of all professionals providing services, supports, care and treatment to the individual;
 - g. Clear authorization of the plan;
 - i. Refer to definitions of service included in this Provider Manual to determine who must authorize the plan:
 - 1. Part I, Section I: *MH and AD Consumer Eligibility, Service Definitions and Service Guidelines*;
 - 2. Part I, Section II: *DD Consumer Eligibility, Access and Planning List, Service Definitions and Service Guidelines*.
 - ii. A physician must authorize the plan when it includes medical care and treatment or as required by Georgia Department of Community Health Division of Medical Assistance, Part II Policies and Procedures for Comprehensive Support Waiver Program (COMP) and New Option Waiver Program (NOW): *Protocol for Physician Signature is in waiver manual*;
 - iii. When more than one physician is involved in individual care, there is evidence that a RN or MD has reviewed all in-field information to assure there are no contradictions or inadvertent contraindications within the care and treatment orders or plan.
 - iv. When a behavior support plan is used to reduce challenging behaviors, there must be evidence that the following issues have been addressed. The plan is:
 - 1. Individualized;
 - 2. Based on a functional assessment;
 - 3. One that has ruled out medical causes;
 - 4. Developed and overseen by a qualified professional (Refer to the *Standards for All Providers* for definitions related to in-field professionals);
 - 5. Inclusive of rationale for the following:
 - a. Use of identified approaches;
 - b. The timing of their use;
 - c. An assessment of the impact on personal choice of the individual;

- d. The targeted behavior; and
 - e. How the targeted behavior will be recognized for success.
 - 6. Implemented by trained and competent staff;
 - 7. Has monitoring plans and termination criteria;
 - 8. Consent provided by the individual and/or his or her legal guardian;
 - 9. Discussed with the individual and family/natural supports (as permitted by the individual);
 - 10. Developed in accordance with Best Practice Standards for Behavioral Supports Services for providers of developmental disabilities services (www.dbhdd.ga.gov).
 - v. Intrusive or restrictive procedures must be clearly justified through documentation of less restrictive procedures ineffectiveness and/or the need for more intrusive procedures due to the safety or health risks presented by the targeted behaviors. These procedures are authorized, incorporated into the safety BSP, approved by ISP interdisciplinary team, reviewed by organization's Rights Committee and supervised by qualified professional (s) and may not be in conflict with federal or state laws, rules, regulations or standards;
 - vi. Refer and adhere to all federal and state laws and rules, department standards to include but not limit to the document *Guidelines for Supporting Adults with Challenging Behaviors in Community Settings* and the Best Practice Standards for Behavioral Support Services when developing a behavior support plan (www.dbhdd.ga.gov).
8. Documents to be incorporated by reference into an individualized plan include but are not limited to:
 - a. Medical updates as indicated by physician orders or notes;
 - b. Addenda as required when a portion of the plan requires reassessment;
 - c. A personal crisis plan which directs in advance the individual's desires/wishes/plans/objectives in the event of a crisis;
 - d. A behavior support plan for individuals demonstrating:
 - i. challenging behaviors; and/or
 - ii. with a Developmental Disability who receive psychotropic medications for symptom management other than that of a mental illness or epilepsy.
 - e. Wellness Recovery Action Plan (WRAP);
 - f. Safety Plan.
9. The intent of the development of the ISP is a process that focuses on the individual's hopes, dreams and vision of a "life well-lived." Information included within this individualized plan should be presented as a single plan describing the individual's service/support needs within a daily life versus a daily service. Support networks should work closely together to identify issues of risk and needed supports to address those risks while never losing sight that the individual is at the center of the planning process and included in all discussions.
10. Individualized plans or portions of the plan must be reassessed as indicated by the following:
 - a. Changing needs, circumstances and responses of the individual, including but not limited to:
 - i. Any life change;
 - ii. Change in provider;

- iii. Change of address;
 - iv. Change in frequency of service; and
 - v. Change in medical, behavioral, cognitive or, physical status;
 - b. As requested by the individual;
 - c. As required for re-authorization;
 - d. At least annually;
 - e. When goals are not being met.
- 11. There is evidence that the person's data from tracking sheets and learning logs have been reviewed, analyzed for trends, and summarized to determine progress toward goals at least quarterly.
- 12. Wellness of individuals is facilitated through:
 - a. Advocacy;
 - b. Individual care practices;
 - c. Education;
 - d. Sensitivity to issues affecting wellness including but not limited to:
 - i. Gender;
 - ii. Culture; and
 - iii. Age.
 - e. Incorporation of wellness goals within the individual plan.
- 13. Policies, procedures and practice describe processes for referral of the individual based on ongoing assessment of individual need:
 - a. Internally to different programs or staff; or
 - b. Externally to services, supports, care and treatment not available within the organization including, but not limited to:
 - i. Health care for:
 - 1. Routine assessment such as annual physical examinations;
 - 2. Chronic medical issues;
 - 3. Ongoing psychiatric issues;
 - 4. Acute and emergent needs;
 - a. Medical
 - b. Psychiatric
 - ii. Diagnostic testing such as psychological testing or labs; and
 - iii. Dental services.
- 14. Specific to Behavioral Health services, providers must work with each enrolled individual to develop and implement, as needed, a crisis plan. Providers must have a process in place to provide after-hours accessibility and have the ability to respond, face-to-face as clinically indicated, to crisis situations that occur with enrolled individuals in a timely manner per the contact/agreement with DBHDD. The Georgia Crisis and Access Line (GCAL) are not to be used as the crisis or after hour's access for enrolled individuals. However, providers may utilize GCAL in order to gain access to higher levels of care (e.g. Crisis Stabilization Units, other inpatient services, etc.) or facilitate coordination with Georgia Emergency Management Agency services (i.e. 911).
- 15. Specific to Developmental Disabilities services, providers must have processes in place to implement crisis intervention as needed. The staff must be trained to respond to a crisis situation that occurs at the service site and, have a crisis plan at a minimum addresses:
 - a. Approved Interventions to be utilized by staff;
 - b. Availability of additional resources to assist in diffusing the crisis;
 - c. If the acute crisis presents a substantial risk of imminent harm to self and others, include community based crisis services as an alternative to emergency room care, institutional placement, and/or law enforcement involvement (including incarceration); and

- d. Protocols to access community-based crisis services to include the Georgia Crisis Response Systems.

J. Infection Control Practices are Evident in Service Settings

1. The organization, at a minimum, has a basic Infection Control Plan that includes the following:
 - a. Standard Precautions;
 - b. Hand washing protocols;
 - c. Proper disposal of biohazards, such as needles, lancets, scissors, tweezers, and other sharp instruments; and
 - d. Management of common illness likely to be emergent in the particular service setting;
2. The organization has effective cleaning and maintenance procedures sufficient to maintain a sanitary and comfortable environment that prevents the development and transmission of infection.
3. The organization adheres to policies and procedures for controlling and preventing infections in the service setting. Staff is trained and monitored to ensure infection control policies and procedures are followed.
4. All staff adheres to Standard Precautions and follows the organization's written policies and procedures in infection control techniques.
5. The organization's infection control plan is reviewed bi-annually for effectiveness and revision, if necessary.
6. The organization has available the quantity of bed linens and towels, etc. essential for the proper care of individuals at all times. These items are washed, stored, and transported in a manner that prevents the spread of infection.
7. Routine laundering of an individual's clothing and personal items is done separately from the belongings of other individuals.
8. Procedures for the prevention of infestation by insects, rodents or pests shall be maintained and conducted continually to protect the health of individuals served.
9. The organization ensures that an individual's personal hygiene items, such as toothbrushes, hairbrushes, razors, nail clippers, etc., are maintained separately and in a sanitary condition.
10. Any pets living in the service setting must meet the following requirements:
 - a. No vicious animals shall be kept;
 - b. All animals must be inoculated for rabies annually;
 - c. Exotic animals must be obtained from federally approved sources; and
 - d. Parrots and Psittacine family birds must be USDA inspected and banded.

K. Organizations having Oversight for Medication or that Administer Medication Follow Federal and State Laws, Rules, Regulations and Best Practice Guidelines

1. A copy of the physician (s) order or current prescription dated/signed within the past year is placed in the individual's record for every medication administered or self-administered with supervision. These include:
 - a. Regular, on-going medications;
 - b. Controlled substances;
 - c. Over-the-counter medications;
 - d. PRN (when needed) medications; or
 - e. Discontinuance order.
2. A valid physician's order must contain:
 - a. The individual's name;
 - b. The name of the medication;
 - c. The dose;

- d. The route;
 - e. The frequency;
 - f. Special instructions, if needed; and
 - g. The physician's signature.
 - h. A copy of the Medical Office Visit Record with the highlighted physician's medication order may also be kept as documentation.
3. Anti-psychotic medications must be prescribed by a psychiatrist or psychiatric nurse practitioner.
 4. The organization has written policies, procedures, and practices for all aspects of medication management including, but not limited to:
 - a. Prescribing: requires the comparison of the physician's medication prescription to the label on the drug container and to the Medication Administration Record (MAR) to ensure they are all the same before each medication is administered or supervised self-administration is done.
 - b. Ordering: describes the process by which medication orders are filled by a pharmacy.
 - c. Authenticating orders: describes the required time frame for actual or faxed physician's signature on telephone or verbal orders accepted by a licensed nurse;
 - d. Procuring medication and refills: procuring initial prescription medication and over-the-counter drugs within twenty-four hours of prescription receipt, and refills before twenty-four hours of the exhaustion of current drug supply.
 - e. Labeling: includes the Rights of Medication Administration
 - f. Storing: includes prescribed medications, floor stock drugs, refrigerated drugs, and controlled substances.
 - g. Security: signing out a dose for an individual, and at a minimum, a daily inventory for controlled medications and floor stock medications; and daily temperature logs for locked, refrigerated medications are required.
 - h. Storage, inventory, dispensing and labeling of sample medications: requires documented accountability of these substances at all stages of possession.
 - i. Dispensing: describes the process allowed for pharmacists and/or physicians only. Includes the verification of the individual's medications from other agencies and provides a documentation log with the pharmacist's or physician's signature and date when the drug was verified.
 - j. Supervision of individual self-administration: includes all steps in the process from verifying the physician's medication order to documentation and observation of the individual for the medication's effects. Makes clear that staff members may not administer medications unless licensed to do so, and the methods staff members may use to supervise or assist, such as via hand-over-hand technique, when an individual self-administers his/her medications.
 - k. Administration of medications includes all aspects of the process to be done from verifying the physician's medication order, to who can administer the medications, to documentation and observation of the individual for the medication's effects. Administration of medications may be done only by those who are licensed in this state to do so.
 - l. Recording: includes the guidelines for documentation of all aspects of medication management. This includes adding and discontinuing medication, charting scheduled and as needed medications, observations regarding the effects of drugs, refused and missing doses, making corrections, and a legend for recording. The legend includes initials, signature, and title of staff member.

- m. Disposal of discontinued or out-of-date medication: includes an environmentally friendly method or disposal by pharmacy.
 - n. Education to the individual and family (as desired by the individual) regarding all medications prescribed and documentation of the education provided in the clinical record;
 - o. All PRN or “as needed” medications will be accessible for each individual as per his/her prescriber(s) order(s) and as defined in the individuals’ ISP. Additionally, the organization must have written protocols and documented practice that ensures safe and timely accessibility that includes, at a minimum, how medication will be stored, secured or need refrigeration when transported to different programs and home visits.
5. Organizational policy, procedures and documented practices stipulate that:
- a. Only licensed medical personnel can directly administer medication;
 - i. In homes licensed as Community Living Arrangements (CLA)/Personal Care Homes (PCH), staff may administer medications in accordance with CLA Rules 290-9-37.01 through .25 and PCH Rules 111-8-62.01 through .25.
 - ii Licensed DD provider agencies, including co-employer agencies utilizing proxy caregivers to provide Health Maintenance activities, must meet the Rules and Regulations for Proxy Caregivers in Licensed Healthcare facilities to include but not limited to:
 - a. Have a written informed consent in the individual’s record that designate the selected proxy care giver to receive training to provide the health care activities outlined in the physician’s written order working under a nurse protocol agreement or job description;
 - b. Demonstrate knowledge and skills to perform the health maintenance activities in the written plan;
 - c. Health maintenance activities to be implemented by the proxy caregiver are clearly defined in the written care plan and a copy provided for the proxy care giver;
 - d. The organization’s policy, procedures, and documented practices clearly define what health maintenance activities can or cannot be provided and that delivery of such activities are specified for each individual
 - b. Only physicians or pharmacists may re-package or dispense medications.
 - 1. This includes the re-packaging of medications into containers such as “day minders” and medications that are sent with the individual when the individual is away from his residence.
 - 2. Note that an individual capable of independent self-administration of medication may be coached in setting up their personal “day minder.”
 - c. There are safeguards utilized for medications known to have substantial risk or undesirable effects, including but not limited to:
 - 1. Storage;
 - 2. Handling;
 - 3. Insuring appropriate lab testing or assessment tools accompany the use of the medication;
 - 4. Obtaining and maintaining copies of appropriate lab testing and assessment tools that accompany the use of the medications prescribed from the individual’s physician for the individual’s clinical record, or at a minimum, documenting in the clinical record the requests for the copies of these tests and assessments; and follow-up appointments with the individual’s physician’s for any further actions needed.

- d. Education regarding the risks and benefits of the medication is documented and explained in language the individual can understand. Medication education provided by the organization's staff should be documented in the clinical record. Informed consent for the medication is the responsibility of the physician; however, the organization obtains and maintains copies of these, or at a minimum, documents its request for copies of these in the clinical record
- e. Where medications are self-administered, protocols are defined for training to support individual self-administration of medication.
- f. Staff is educated regarding:
 - i. Medications taken by individuals, including the benefits and risks;
 - ii. Monitoring and supervision of individual self-administration of medications;
 - iii. The individual's right to refuse medication;
 - iv. Documentation of medication requirements.
- g. There are protocols for the handling of licit and illicit drugs brought into the service setting. This includes confiscating, reporting, documenting, educating, and appropriate discarding of the substances.
- h. Requirements for safe storage of medication are as required by law includes single and double locks, shift counting of the medications, individual dose sign-out recording, documented planned destruction, refrigeration and daily temperature logs.
- i. The organization defines requirements for timely notification to the prescribing professional regarding:
 - i. Drug reactions;
 - ii. Medication problems;
 - iii. Medication errors; and
 - iv. Refusal of medication by the individual.
- j. When the organization allows verbal orders from physicians, those orders will be authenticated:
 - i. Within 72 hours by fax with the physicians signature on the page (including electronic signature);
 - ii. The fax must be maintained in the individual's record;
- k. There are practices for regular and ongoing physician review of prescribed medications including, but not limited to:
 - i. Appropriateness of the medication;
 - ii. Documented need for continued use of the medication;
 - iii. Monitoring of the presence of side effects;(Individuals on medications likely to cause tardive dyskinesia are monitored at prescribed intervals using an Abnormal Involuntary Movement Scale (AIMS testing)
 - iv. Monitoring of therapeutic blood levels, if required by the medication such as Blood Glucose testing, Dilantin blood levels and Depakote blood levels; such as kidney or liver function tests;
 - v. Ordering specific monitoring and treatment protocols for Diabetic, hypertensive, seizure disorder, and cardiac individuals, especially related to medications prescribed and required vital sign parameters for administration;
 - vi. Writing medication protocols for specific individuals in:
 - 1. Homes licensed as Community Living Arrangements or Personal Care Homes for identified staff members to administer:
 - a) epinephrine for anaphylactic reaction;
 - b) insulin required for diabetes;

- c) suppositories for ameliorating serious seizure activity; and
 - d) medications through a nebulizer under conditions described in the Community Living Arrangement Rule 290-9-37-.20 (2).
- vii. Monitoring of other associated laboratory studies.
 - l. For organizations that secure their medications from retail pharmacy, there is a biennial assessment of agency practice of management of medications **at all sites housing medications**. An independent licensed pharmacist or licensed registered nurse conducts the assessment. The report shall include, but may not be limited to:
 - a) A written report of findings, including corrections required;
 - b) A photocopy of the pharmacist license or a photocopy of the license of the Registered Nurse;
 - c) A statement of attestation from the independent licensed pharmacist or licensed Registered Nurse that all issues have been corrected.
 - l. For organizations that employ a licensed pharmacist, there is a biennial assessment of agency practice of management of medications **at all sites housing medications**. A licensed pharmacist or licensed registered nurse conducts the assessment. The report shall include, but may not be limited to:
 - i A written report of findings, including corrections required;
 - ii A photocopy of the pharmacist license or a photocopy of the license of the Registered Nurse.
 - iii. A statement of attestation from the independent licensed pharmacist or licensed Registered Nurse that all issues have been corrected.
 - m. For organizations that conduct any of the appropriate laboratory test on-site, documented evidence is provided that the organization's Clinical Laboratory Improvement Amendment (CLIA) Waiver is current. Refer to the list of waived tests updated January 15, 2010 on the Centers for Medicaid and Medicare Services website.
- 6. There are policies and procedures governing documentation of self-administration or administration of medication.
- 7. The "Eight Rights" for medication administration are defined with detailed guidelines for staff to implement within the organization to verify that right:
 - a. Right person: includes the use of at least two identifiers and verification of the physician's medication order with the label on the prescription drug container and the MAR entry to ensure that all are the same every time before a medication is taken via self-administration or administered by a licensed staff member. The amount of the medication should make sense as to the volume of liquid or number of tablets to be taken.
 - b. Right medication: includes verification of the medication order with the label on the prescription drug container and the MAR entry to verify that all are the same every time before a medication is taken via self-administration or administered by a licensed staff member. The medication is inspected for expiration date. Insulin should be verified with another person prior to administering.
 - c. Right time: includes the times the agency schedules medications, or the specific physician's instructions related to the drug.
 - d. Right dose: includes verification of the physician's medication order of dosage amount of the medication; with the label on the prescription drug container and the Medication Administration Record entry to ensure that all are the same every time before a medication is taken via self-administration or administered by a

- licensed staff member. The amount of the medication should make sense as to the volume of liquid or number of tablets to be taken.
- e. Right route: includes the method of administration;
 - f. Right position: includes the correct anatomical position; individual should be assisted to assume the correct position for the medication method or route to ensure its proper effect, instillation, and retention.
 - g. Right documentation includes proper methods of the recording on the MAR; and
 - h. Right to refuse medications: includes staff responsibilities to encourage compliance, document the refusal, and report the refusal to the administration, nurse administrator, and physician.
8. A Medication Administration Record is in place for each calendar month that an individual takes or receives medication(s):
- a. Documentation of routine, ongoing medications occur in one discreet portion of the MAR and include but may not be limited to:
 - i. Documentation by calendar month that is sequential according to the days of the month;
 - ii. A listing of all medications taken or administered during that month including a full replication of information in the physician's order for each medication:
 1. Name of the medication;
 2. Dose as ordered;
 3. Route as ordered;
 4. Time of day as ordered; and
 5. Special instructions accompanying the order, if any, such as but not limited to:
 - a. Must be taken with meals;
 - b. Must be taken with fruit juice;
 - c. May not be taken with milk or milk products.
 - iii. If the individual is to take or receive the medication more than one time during one calendar day:
 1. Each time of day must have a corresponding line that permits as many entries as there are days in the month;
 - iv. All lines representing days and times preceding the beginning or ending of an order for medications shall be marked through with a single line;
 - v. When a physician discontinues (D/C) a medication order, that discontinuation is reflected by the entry of "D/C" at the date and time representing the discontinuation; followed by a mark through of all lines representing days and times that were discontinued.
 - b. Documentation of medications that are taken or received on a periodic basis, including over the counter medications, occur in a separate discreet portion of the MAR and include but may not be limited to:
 - i. A listing of each medication taken or received on a periodic basis during that month including a full replication of information in the physician's order for each medication:
 1. Name of the medication;
 1. Dose as ordered;
 2. Route as ordered;
 3. Purpose of the medication
 4. Frequency that the medication may be taken
 - ii. The date and time the medication is taken or received is documented for each use.

- iii. When 'prn' or 'as needed' medication is used, the PRN medications shall be documented on the same MAR after the routine medications and clearly marked as "PRN" and the effectiveness is documented.
- c. Each MAR shall include a legend that clarifies:
 - i. Identity of authorized staff initials using full signature and title;
 - ii. Reasons that a medication may be not given, is held or otherwise not received by the individual, such as but not limited to:
 - "H" = Hospital
 - "R" = Refused
 - "NPO" = Nothing by mouth
 - "HM" = Home Visit
 - "DS" = Day Service

L. Person Centered Focus is Evident in Documentation

- 1. The individual's record is a legal document that is current, comprehensive and includes those persons who are:
 - a. Assessed;
 - b. Served;
 - c. Supported;
 - d. Cared for; or
 - e. Treated.
- 2. Information in the record is:
 - a. Organized;
 - b. Complete;
 - c. Current;
 - d. Meaningful;
 - e. Succinct; and
 - f. Essential to:
 - i. Provide adequate and accurate services, supports, care and treatment;
 - ii. Tell an accurate story of services, supports, care and treatment rendered and the individual's response;
 - iii. Protect the individual; their rights; and
 - iv. Comply with legal regulation.
 - g. Dated, timed, and authenticated with the authors identified by name, credential and by title;
 - i. Notes entered retroactively into the record after an event or a shift must be identified as a "late entry";
 - ii. Documentation is to be done each shift or service contact by staff providing the service;
 - iii. If notes are voice recorded and typed or a computer is used to write notes that are printed, each entry must be dated and the physical documentation must be signed and dated by the staff writing the note. Notes should then be placed in the individual's record;
 - iv. If handwritten notes are transcribed electronically at a later date, the former should be kept to demonstrate that documentation occurred on the day billed.
 - h. Written in black or blue ink;
 - i. Red ink may be used to denote allergies or special precautions;
 - j. Corrected as legally prescribed by:
 - i. Drawing a single line through the error;
 - ii. Labeling the change with the word "error";
 - iii. Inserting the corrected information; and
 - iv. Initialing and dating the correction.

3. At a minimum, the individual's information shall include:
 - a. The name of the individual, precautions, allergies (or no known allergies - NKA) and "volume #x of #y" on the front of the record;
 - i. Note that the individual's name, allergies and precautions must also be flagged on the medication administration record;
 - b. Individual's identification and emergency contact information;
 - c. Financial information;
 - d. Rights, consent and legal information including but not limited to:
 - i. Consent for service;
 - ii. Release of information documentation;
 - iii. Any psychiatric or other advanced directive;
 - iv. Legal documentation establishing guardianship;
 - v. Evidence that individual rights are reviewed at least one time a year;
 - vi. Evidence that individual responsibilities are reviewed at least one time a year; and
 - vii. Legal status as it relates to Title 37.
 - e. Pertinent medical information;
 - f. Screening information and assessments, including but not limited to:
 - i. Functional, psychosocial and diagnostic assessments;
 - g. Individual service plan or individual recovery plan, including:
 - i. Identified outcomes or goals (in measurable terms);
 - ii. Interventions or activities occurring to achieve the goals;
 - iii. The individual's response to the interventions or activities (progress notes, tracking sheets, learning logs or data);
 - iv. A projected plan to modify or decrease the intensity of services, supports, care and treatment as goals are achieved; and
 - v. Discharge planning is begun at the time of admission that includes specific objectives to be met prior to decreasing the intensity of service or discharge.
 - h. Discharge summary information provided to the individual at the time of discharge that includes:
 - i. Strengths, needs, preferences and abilities of the individual;
 - ii. Services, supports, care and treatment provided;
 - iii. Achievements;
 - iv. Necessary plans for referral; and,
 - v. Service or organization to which the individual was discharged, if applicable.
 1. A dictated or hand-written summary of the course of services, supports, treatment or care incorporating the discharge summary information must be placed in the record within 30 days of discharge.
 - i. Progress notes or Learning Logs (for DD individuals) describing progress toward goals, including:
 - i. Implementation of interventions specified in the plan;
 - ii. The individual's response to the intervention or activity based on data.
 - j. Event notes documenting:
 - i. Issues, situations or events occurring in the life of the individual;
 - ii. The individual's response to the issues, situations or events;
 - iii. Relationships and interactions with family and friends, if applicable;
 - iv. Missed appointments including:
 1. Findings of follow-up; and,
 2. Strategies to avoid future missed appointments.
 - k. Records or reports from previous or other current providers;

1. Correspondence.
4. Documentation in the record reflects intensity of the services, supports, care and treatment.
 - a. Frequency and style of documentation are appropriate to the frequency and intensity of services, supports, care and treatment;
 - b. Documentation includes record of contacts with persons involved in other aspects of the individual's care, including but not limited to internal or external referrals.
5. The individual's response to the services, supports, care and treatment is a consistent theme in documentation.
6. There is a process for ongoing communication between staff members working with the same individuals in different programs, activities, schedules or shifts.
7. Assessments, ISPs, and documentation required by Medicaid are to be retained in the individuals' records for three years.

M. The Organization Maintains a System of Information Management that Protects Individual Information and that is Secure, Organized and Confidential

1. The organization has clear policies, procedures, and practices that support secure, organized and confidential management of information, to include electronic individual records if applicable.
2. Maintenance and transfer of both written and spoken information is addressed:
 - a. Personal individual information;
 - b. Billing information; and
 - c. All service related information.
3. The organization has a Confidentiality and HIPAA Privacy Policy that clearly addresses state and federal confidentiality laws and regulations. The organization has a Notice of Privacy Practices that gives the individual adequate notice of the organization's policies and practices regarding use and disclosure of their Protected Health Information. The notice should contain mandatory elements required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA, Title II). In addition, the organization should address:
 - a. HIPAA Privacy Rules, as outlined at 45 CFR Parts 160 and 164 are specifically reviewed with staff and individuals;
 - b. Appointment of the Privacy Officer;
 - c. Training to be provided to all staff;
 - d. Posting of the Notice of Privacy Practices in a prominent place;
 - e. Maintenance of the individual's signed acknowledgement of receipt of Privacy Notice in their record.
4. A record of all disclosures of Protected Health Information (PHI) should be kept in the medical record, so that the organization can provide an accounting of disclosures to the individual for 6 years from the current date. The record must include:
 - a. Date of disclosure
 - b. Name of entity or person who received the Protected Health Information;
 - c. A brief description of the Protected Health Information disclosed
 - d. A copy of any written request for disclosure
 - e. Written authorization from the individual or legal guardian to disclose PHI, where applicable.
5. Confidentiality policies if applicable, include procedures for substance abuse individual records comply with 42 CFR Part 2, Confidentiality of Alcohol and Drug Abuse Patient Records.
6. Authorization for release of information is obtained when Protected Health Information of an individual is to be released or shared between organizations or with others outside the organization. All applicable DBHDD policies and

procedures and HIPAA Privacy Rules (45 CFR parts 160 and 164) related to disclosure and authorization of Protected Health Information are followed.

Information contained in each release of information must include:

- a. Specific information to be released or obtained;
 - b. The purpose for the authorization for release of information;
 - c. To whom the information may be released or given;
 - d. The time period that the release authorization remains in effect (reasonable based on the topic of information, generally not to exceed a year); and,
 - e. A statement that authorization may be revoked at any time by the individual, to the extent that the organization has not already acted upon the authorization;
7. Exceptions to use of an authorization for release of information are clear in policy:
- a. disclosure may be made if required or permitted by law;
 - b. disclosure is authorized as a valid exception to the law;
 - c. A valid court order or subpoena are required for mental health or developmental disabilities records
 - d. A valid court order and subpoena are required for alcohol or drug abuse records ;
 - e. When required to share individual information with the DBHDD or any provider under contract or LOA with the DBHDD for the purpose of meeting your own obligations to the department; or
 - f. In the case of an emergency treatment situation as determined by the individual's physician, the chief clinical officer can release Protected Health Information to the treating physician or psychologist..
8. The organization has written operational procedures, consistent with legal requirements governing the retention, maintenance and purging of records.
- a. Records are safely secured, maintained, and retained for a minimum of six (6) years from the date of their creation or the date when last in effect (whichever is later);
 - b. Protocols for all records to be returned to or disposed of as directed by the contracting regions after specified retention period or termination of contract/agreement.
9. The organization has written policy, protocols and documented practice of how information in the record is transferred when an individual is relocated or discharged from service to include but not limited to:
- a. A complete certified copy of the record to the Department or the provider who will assume service provision, that includes individual's Protected Health Information, billing information, service related information such as current medical orders, medications, behavior plans as deemed necessary for the purposes of individual's continuity of care and treatment;
 - b. In addition unused Special Medical Supplies (SMS), funds, personal belongings, burial accounts
 - c. The time frames by which transfer of documents and personal belongings will be completed.

N. The Personal Funds of an Individual are managed by the individual and are protected

1. Policies and clear accountability practices regarding individual valuables and finances comply with all applicable DBHDD policies and Social Security Guide for Organizational and /or Representative Payees regarding management of personal needs spending accounts for individuals served.

2. Providers are encouraged to utilize persons outside the organization to serve as “representative payee” such as, but not limited to:
 - a. Family
 - b. Other person of significance to the individual
 - c. Other persons in the community not associated with the agency
3. The agency is able to demonstrate documented effort to secure a qualified, independent party to manage the individual’s valuables and finances when the person served is unable to manage funds and there is no other person in the life of the individual who is able to assist in the management of individual valuables or funds.
4. Individual funds cannot be co-mingled with the agency’s funds or other individuals’ funds.
5. Specific to Developmental Disabilities Services, if individual’s funds are not personally managed by the individual, a mechanism is in place for the review of funds by the individual or his or her representative:
 - a. At least once a quarter;
 - b. To include a review of the bank statement of funds received (including date of deposit, fund source), funds spent (date and source with receipt) and balance of funds available;
 - c. Documentation of individual review shall be maintained;
 - d. Review and update of other financial assets such as annuity accounts, personal belongings and burial funds.
6. The personal funds of all individuals served in Developmental Disabilities Community Residential Alternatives (CRA) shall adhere to all Federal and State rules and regulations and DBHDD Policy for Management/Supervision/Safeguarding of Possessions, Valuables, Personal Funds and Day to Day Living Expenses in Developmental Disabilities Residential Services.

O. Individuals are provided Services, Supports, Care and Treatment by Staff who are properly Licensed, Credentialed, Trained, and who are Competent.

1. Unless otherwise specified by DBHDD Policy or within the contract/agreement with the Department, one or more professionals in the field must be attached to the organization as employees of the organization or as consultants on contract.
 - a. The professional(s) attached to the organization have experience in the field of expertise best suited to address the needs of the individual(s) served.
 - i. Refer to of the *Standards for All Providers* for discussion of qualified professionals.
 - ii. Information regarding the professional(s) that must be attached to specific services may also be found at:
 1. Part I, Section I: *MH and AD Consumer Eligibility, Service Definitions and Service Guidelines*;
 2. Part I, Section II: *DD Consumer Eligibility, Access and Planning List, Service Definitions and Service Guidelines*.
 - b. When medical, psychiatric services involving medication or detoxification services are provided, the organization receives direction for that service from a professional with experience in the field, such as medical director, physician consultant, psychiatrist or addictionologist.
2. Organizational policy and practice demonstrates that appropriate professional staff shall conduct the following services, supports, care and treatment, including but not limited to:
 - a. Overseeing the services, supports, care and treatment provided to individuals;
 - b. Supervising the formulation of the individual service plan or individual recovery plan;
 - c. Conducting diagnostic, behavioral, functional and educational assessments;
 - d. Designing and writing behavior support plans;

- e. Implementing assessment, care and treatment activities as defined in professional practice acts; and
 - f. Supervising high intensity services such as screening or evaluation, assessment, partial hospitalization, and ambulatory or residential crisis services.
3. a. Specific to Behavioral Health Core and Specialty Services, providers must ensure an adequate staffing pattern to provide access to services. Providers should reference the Service Guideline for staffing requirements of Specialty Services. The below are minimum staffing requirements of Core Providers:
- 1. Medical Director/Psychiatrist that is on site a minimum of 10 hours weekly
 - 2. RN that is on site a minimum of 10 hours weekly
 - 3. Licensed Clinicians (LCSW, LPC, LAMFT)
 - 4. MAC, CACII, CADC, CCADC, or GCADC (II, III)
 - 5. Certified Peer Specialist (applicable for Adult Core Services only)
 - 6. Paraprofessionals
3. b. Specific to Developmental Disabilities Services, providers must ensure an adequate staffing pattern to provide access to services in accordance with service guidelines and professional designations. Refer to Service Guidelines in this Provider Manual for specific staffing requirements.
4. The type and number of professional staff attached to the organization are:
- a. Properly licensed or credentialed in the professional field as required;
 - b. Present in numbers to provide adequate supervision to staff;
 - c. Present in numbers to provide services, supports, care and treatment to individuals as required;
 - d. Experienced and competent in the profession they represent; and
 - e. In 24 hour or residential care settings, at least one staff trained in BCLS and first aid is scheduled at all times on each shift.
5. The type and number of all other staff attached to the organization are:
- a. Properly trained or credentialed in the professional field as required;
 - b. Paraprofessionals working in mental health and addictive diseases services must demonstrate mastery of each topic area within the Standard Training Requirements in Essential Learning. This includes paraprofessionals in all community programs, including those affiliated with the regional hospitals. Additional information regarding the Standard Training Requirement for Paraprofessionals can be found in Section U of this document;
 - c. DD providers using Proxy Caregivers must receive training that includes knowledge and skills to perform any identified specialized health maintenance activity. Additional information regarding Proxy Caregivers can be found in Section V of this document;
 - d. Present in numbers to provide services, supports, care and treatment to individuals as required; and
 - e. Experienced and competent in the services, supports, care and treatment they provide.
6. The organization has procedures and practices for verifying licenses, credentials, experience and competence of staff:
- a. There is documentation of implementation of these procedures for all staff attached to the organization; and
 - b. Licenses and credentials are current as required by the field.
7. Federal law, state law, professional practice acts and in-field certification requirements are followed regarding:
- a. Professional or non-professional licenses and qualifications required to provide the services offered. If it is determined that a service requiring

- licensure or certification by State law is being provided by an unlicensed staff, it is the responsibility of the organization to comply with DBHDD Policy regarding Licensing and Certification Requirements and the Reporting of Practice Act Violations.
- b. Laws governing hours of work such as but not limited to the Fair Labor Standards Act.
8. Job descriptions are in place for all personnel that include:
 - a. Qualifications for the job;
 - b. Duties and responsibilities;
 - c. Competencies required;
 - d. Expectations regarding quality and quantity of work; and
 - e. Documentation that the individual staff has reviewed, understands, and is working under a job description specific to the work performed within the organization.
 9. There is evidence that a national criminal records check (NCIC) is completed for all employees who provide services, supports, care and treatment to persons served within the organization. **The applicant should submit fingerprints prior to employment or if circumstances justify delay, within 10 business days of the employee's start date.** DBHDD Policy, *Criminal History Records Checks for Contractors* is followed and fingerprints are obtained by electronic fingerprint submission through Cogent Systems. See www.ga.cogentid.com.
 - a. There is mandatory disqualification from providing services for DBHDD for a minimum of five (5) years from the date of conviction, a plea of nolo contendere, or release from incarceration or probation, whichever is later. Refer to DBHDD Policy, *Criminal History Records Checks for Contractors* for list of crimes that restricts employment as a contractor or contractor employee.
 - b. DBHDD contractors or their employees are permanently ineligible to provide services for DBHDD if they have ever been convicted of abuse, neglect or maltreatment of a child, an individual receiving services, or a patient.
 - c. Contractors or their employees may be ineligible to provide services for DBHDD, if the criminal history record indicates any of the following that have direct relevancy to the responsibilities or duties of the position (Policy 04-104):
 1. Any other conviction or pattern of convictions
 2. A pattern of recent arrests
 3. A significant recent arrest (disqualification until charge is resolved).
 - d. Contractors or their employees that have been convicted of a criminal drug offense will be ineligible to provide services for DBHDD as follows
 1. Disqualification to provide services in any position for a period of two (2) years from the date of conviction for the first offense
 2. Disqualification to provide services in any position for a period of five (5) years from the most recent conviction for the second or subsequent offense. (Note: For purposes of this disqualification, "conviction" does not include treatment under Georgia First Offender Act or a plea of Nolo Contendere).
 10. The organization has policies, procedures and documentation practices detailing all human resources practices, including but not limited to:
 - a. Processes for determining staff qualifications including:
 - i. License or certification status;
 - ii. Training;
 - iii. Experience; and
 - iv. Competence.
 - b. Processes for managing personnel information and records including but not limited to:
 - i. Criminal records checks (including process for reporting CRC status

- change); and
 - ii. Drivers license checks
 - c. Provisions for and documentation of:
 - i. Timely orientation of personnel and development;
 - ii. Periodic assessment and development of training needs;
 - 1. Development of activities responding to those needs; and
 - iii. Annual work performance evaluations.
 - d. Provisions for sanctioning and removal of staff when:
 - i. Staff are determined to have deficits in required competencies;
 - ii. Staff is accused of abuse, neglect or exploitation.
11. All staff, direct support volunteers, and direct support consultants shall be trained and show evidence of competence in the following:
- a. Orientation requirements are specified for all staff and are provided **prior to direct contact with individuals** and are as follows:
 - i. The purpose, scope of services, supports, care and treatment offered including related policies and procedures;
 - ii. HIPAA and Confidentiality of individual information, both written and spoken;
 - iii. Rights and Responsibilities of individuals;
 - v. Requirements for recognizing and reporting suspected abuse, neglect or exploitation of any individual:
 - 1. To the DBHDD;
 - 2. Within the organization;
 - 3. To appropriate regulatory or licensing agencies; and,
 - 4. To law enforcement agencies.
 - b. Within the first sixty (60) days from date of hire, all staff having direct contact with individuals shall receive the following training including, but not limited to:
 - i. Person centered values, principles and approaches;
 - ii. A Holistic approach to care of the individual
 - iii. Medical, physical, behavioral and social needs and characteristics of the persons served;
 - iv. Human Rights and responsibilities (*);
 - v. Promoting positive, appropriate and responsive relationships with persons served, their families and stakeholders;
 - vi. The utilization of:
 - 1. Communication Skills (*);
 - 2. Applied Behavior Analysis (*) and
 - 3. Crisis intervention techniques to de-escalate challenging and unsafe behaviors (*)
 - i. Nationally benchmarked techniques for safe utilization of emergency interventions of last resort (if such techniques are permitted in the purview of the organization);
 - vii. Ethics, cultural preferences and awareness;
 - viii. Fire safety (*)
 - ix. Emergency and disaster plans and procedures (*)
 - x. Techniques of Standard Precautions, including:
 - 1. Preventative measures to minimize risk of HIV;
 - 2. Current information as published by the Centers for Disease Control (CDC); and
 - 3. Approaches to individual education.
 - xi. CPR/AED through the American Heart Association or the American Red Cross.

1. All medically licensed staff (nurses, physicians, psychiatrists, dentists, and CNAs) are required to have the Professional Rescuers level of training (Basic Life Support for Healthcare Providers and AED or CPR/AED for the Professional Rescuer).
 2. All other staff should have the Lay Rescuers level of training (Heartsaver CPR and AED or CPR/AED).
- Xii First aid and safety;
- xiii. Basic cardiac life support (BCLS) includes both written and hands on competency training required.
- xiv. Specific individual medications and their side effects (*)
- xv. Services, support, care and treatment specific topics appropriate to the care of persons served, such as but not limited to:
1. Symptom management;
 2. Principles of recovery relative to individuals with mental illness;
 3. Principles of recovery relative to individuals with addictive disease;
 4. Principles of recovery and resiliency relative to children and youth; and
 5. Relapse prevention.
- c. A minimum of 16 hours of training must be completed annually to include the trainings noted by an asterisk (*) in 11.b. (iv); 11.b (iv, vi, ix, x, xii).
12. The organization details in policy by job classification:
- a. Training that must be refreshed annually;
 - b. Additional training required for professional level staff;
 - c. Additional training/recertification (if applicable) required for all other staff.
13. Regular review and evaluation of the performance of all staff is evident at least annually.
- a. The evaluation should occur annually;
 - b. Managers who are clinically, administratively and experientially qualified conduct evaluations.
14. It is evident that the organization demonstrates administration of personnel policies without discrimination.

P. The Service Environment Demonstrates Respect for the Persons Served and is Appropriate to the Services Provided

1. Services are provided in an appropriate environment that is respectful of persons supported or served. The environment is:
 - a. Clean;
 - b. Age appropriate;
 - c. Accessible (individuals who need assistance with ambulation shall be provided bedrooms that have access to a ground level exit to the outside or have access to exits with easily negotiable ramps or accessible lifts. The home shall provide at least two (2) exits, remote from each other that are accessible to the individuals served).
 - d. Individual's rooms are personalized
 - e. Adequately lighted, ventilated, and temperature controlled.
2. There is sufficient space, equipment and privacy to accommodate:
 - a. Accessibility;
 - b. Safety of persons served and their families or others;
 - c. Waiting;
 - d. Telephone use for incoming and outgoing calls that is accessible and maintained in working order for persons served or supported; and

- e. To provide identified services and supports.
- 3. The environment is safe:
 - a. All local and state ordinances are addressed;
 - i. Copies of inspection reports are available;
 - ii. Licenses or certificates are current and available as required by the site or the service.
- 4. There is evidence of compliance with state and county of residence fire and life safety codes for the following:
 - i. Installation of Fire alarm system meets safety code;
 - ii. Fire drills are conducted for individuals and staff;
 - 1. Once a month at alternating times; including
 - 2. Twice a year during sleeping hours if residential services.
 - 3. All fire drills shall be documented with staffing involved
 - 4. DBHDD maintains the right to require an immediate demonstration of a fire drill during any on-site visit
- 5. Policies, plans and procedures are in place that addresses emergency evacuation, relocation preparedness and Disaster Response. Supplies needed for emergency evacuation are maintained in a readily accessible manner, including individuals' information, family contact information and current copies of physician's orders for all individual's medications.
 - a. Plans include detailed information regarding evacuating, transporting, and relocating individuals that coordinate with the local Emergency Management Agency and at a minimum address:
 - i. Medical emergencies;
 - ii. Missing persons;
 - 1. Georgia's Mattie's Call Act provides for an alert system when an individual with developmental disabilities, dementia, or other cognitive impairment is missing. Law requires residences licensed as Personal Care Homes to notify law enforcement within 30 minutes of discovering a missing individual.
 - iii. Natural disasters known to occur, such as tornadoes, snow storms or floods;
 - iv. Power failures;
 - v. Continuity of medical care as required;
 - vi. Notifications to families or designees; and
 - vii. Effective 7/1/2012, Continuity of Operation Planning to include identifying locations and providing a signed agreement where individuals will be relocated temporarily in case of damage to the site where services are provided (for more information: www.georgiadisaster.info, <http://www.fema.gov/about/org/ncp/coop/templates.shtm>)
 - b. Emergency preparedness notice and plans are:
 - i. Reviewed annually;
 - ii. Tested at least quarterly for emergencies that occur locally on a less frequent basis such as, but not limited to flood, tornado or hurricane;
 - iii. Drilled with more frequency if there is a greater potential for the emergency.
- 6. Residential living support service options;
 - a. Are integrated and established within residential neighborhoods;
 - b. Are single family units;
 - c. Have space for informal gatherings;
 - d. Have personal space and privacy for persons supported; and
 - e. **Are understood to be the "home" of the person supported or served.**

7. Video cameras may be used in common areas of programs that are not personal residences such as Crisis Stabilization Units where visualization of blind areas is necessary for an individual's safety. Cameras **may not be used** in the following instances:
 - a. In an individual's personal residence;
 - b. In lieu of staff presence; or
 - c. In the bedroom of individuals, as it is an invasion of privacy and is strictly prohibited.
8. There are policies, procedures, and practices for transportation of persons supported or served in residential services and in programs that require movement of persons served from place to place.
 - a. Policies and procedures apply to all vehicles used, including:
 - i. Those owned or leased by the organization;
 - ii. Those owned or leased by subcontractors; and
 - iii. Use of personal vehicles of staff.
 - b. Policies and procedures include, but are not limited to:
 - i. Authenticating licenses of drivers;
 - ii. Proof of insurance;
 - iii. Routine maintenance;
 - iv. Requirements for evidence of driver training;
 - v. Safe transport of persons served;
 - vi. Requirements for maintaining attendance of person served while in vehicles;
 - vii. Safe use of lift;
 - viii. Availability of first aid kits;
 - ix. Fire suppression equipment; and
 - x. Emergency preparedness.
9. Access is promoted at service sites deemed as intake, assessment or crisis programs through:
 - a. Clearly labeled exterior signs; and
 - b. Other means of direction to service and support locations as appropriate.

Q. The Organization that Contracts with Other Organizations Ensures the Affiliate's Compliance and Capacity to Provide Care (Including Host Homes)

1. The organization remains responsible for the affiliate's compliance with:
 - a. Contract/Agreement requirements;
 - b. Standards of practice and specified requirements in the Provider Manual for the Department of BHDD, including *Standards for All Providers*;
 - c. Licensure requirements;
 - d. Accreditation or standard compliance requirements; and
 - e. Quality improvement and risk reduction activities.
2. The affiliate's capacity to provide quality care is monitored, including:
 - a. Financial oversight and management of individual funds;
 - b. Staff competency and training;
 - c. Mechanisms that assure care is provided according to the plan of care for each individual served; and
 - d. The requirement for a Host Home Study when contracting with a Host Home provider.
3. There is evidence of active oversight of the affiliate's capacity and compliance.
4. A report shall be made quarterly to the agency's Board of Directors regarding:
 - a. Services provided by affiliate;
 - b. Quality of performance of the affiliate.

5. A report shall be made to the DBHDD Regional Office prior to the end of the first quarter and third quarter of the fiscal year that includes:
 - a. Name of the affiliate or contractor;
 - b. Contact name for affiliate or contractor;
 - c. Contact information for affiliate or contractor;
 - d. Disability group(s) served;
 - e. Specific service(s) provided;
 - f. Number of persons in service; and
 - g. Annualized amount paid to affiliate.

R. Faith or Denominationally Based Organizations who receive Federal or State Monies address issues specific to being a Faith or Denominationally Based Organization in their Policies and Practice

1. Individuals or recipients of services are informed about the following issues relative to faith or denominationally based organizations:
 - a. Its religious character;
 - b. The individual's freedom not to engage in religious activities;
 - c. Their right to receive services from an alternative provider;
 - i. The organization shall, within a reasonable time after the date of such objection, refer the individual to an alternative provider.
2. If the organization provides employment that is associated with religious criteria, the individual must be informed.
3. In no case may federal or state funds be used to support any inherently religious activities, such as but not limited to:
 - a. Inherently religious activities;
 - b. Religious instruction; or
 - c. Proselytizing.
4. Organizations may use space in their facilities to provide services, supports, care and treatment without removing religious art, icons, scriptures or other symbols.
5. In all cases, rules found at 42 CFR Parts 54, 54a and 45 CFR Parts 96, 260 and 1050 *Charitable Choice Provisions and Regulations: Final Rules* shall apply.

S. PROFESSIONAL DESIGNATIONS. When the requirement for a degree in a course of study is referenced, the degree must be from an accredited college or university.

1. Developmental Disability Professional (DDP) requirements:

DDP services rendered by a provider agency must be provided by a qualified individual DDP, employed by or under professional contract with the provider agency.

At least one agency employee or professional under contract with the agency must:

- Be a Developmental Disability Professional (DDP)
- Have responsibility for overseeing the delivery of waiver services to participants

The same individual may serve as the agency director, nurse and/or DDP, provided the employee meets the qualification and or designation of each position. However, the duties of shared roles for each position must be separately delivered and documented. A change in approved and designated DDP must be reported by the agency to the Department of Behavioral Health

and Developmental Disabilities via the DBHDD Provider Network Management Office. Information to be reported must include:

- Updated and current Resume
- Name of individual
- Name of provider agency and contact name of person requesting change of information
- Hours of work, or contract with DDP

The Developmental Disability Professional will deliver their services utilizing a Person-Centered Focus.

Each Developmental Disability Professional (DDP) has a specified schedule or contract with sufficient hours per week to meet the duties of the DDP and level of need for individuals receiving services, which includes but are not limited to:

1. Overseeing the services and supports provided to participants that include;
 - a. The agency DDP monitors and/or participates in the implementation and delivery of the Individual Service Plan (ISP).
 - b. The agency DDP supervises the delivery of service and ensures the strategies reflect the goals and objectives of the ISP.
 - c. The agency DDP monitors the progress toward achievement of goals in the ISP, and makes recommendations for modifications to the ISP, as appropriate.
2. Supervising the formulation of the participant's plan for delivery of all waiver services provided to the participant by the provider, on an annual basis subsequent to ISP development and after any ISP addendum that includes, but is not limited to;
 - a. Ensuring the implementation strategies reflect the ISP and the needs of the participant
 - b. The agency DDP participates in the development of the ISP
3. Conducting functional assessments to support formulation of the participant's plan for delivery of all waiver services that include: and
 - a. The Health Risk Screening Tool
 - b. The Supports Intensity Scale
 - c. Functional Behavioral Analysis
 - d. And others as needed or required
4. Supervising high intensity services that address health and safety risks for the participants that include.
 - a. The agency DDP is involved in reviewing and/or writing, and the implementation and effectiveness of the Behavior Support Plan
 - b. The agency DDP is involved in reviewing and/or writing, and the implementation and effectiveness of the Crisis Plan
 - c. The agency DDP is involved in identifying ongoing supports as needed (medical and/or behavioral) in collaboration with appropriate personnel

The provider will be responsible for monitoring and ensuring the DDP meets his/her above assigned responsibilities utilizing the below performance indicators.

Performance Indicators of the responsibilities listed above (1-4) are as follows:

- a. Active participation in the planning meeting documented in either the meeting minutes/notes and/or progress notes prior to ISP meeting.
- b. Documented contact with the SC prior to the ISP date.
- c. Consulted with, supervised, and provided guidance to direct support staff regarding implementation of the services.
- d. The DDP will complete documentation in any individual's record for any of the above responsibilities. This documentation should include the signature, title/credentials, timed (start and end time of delivery of service) and date.
- e. The DDP will complete, or assure the completion of required agency assessments, included, but not limited to, HRST and SIS, within the given time frame.

For additional details regarding documentation requirements, refer to New Options or Comprehensive (NOW/COMP) Medicaid manual(s) Part II, Chapter 1100.

Hours scheduled and worked must be sufficient to meet the individual needs of each participant served by the provider. The provision of DDP oversight and service provision must be documented in the participant's record. **A DDP is not scheduled to work only on a PRN basis.**

NOTE: DDP direct service provision and oversight for a participant with an approved exceptional rate is in addition to the above requirements and as specified in the letter of approval for the exceptional rate.

Required Trainings for All Developmental Disabilities Professionals

All Developmental Disabilities Professionals must be trained in all required trainings identified in Part II, DBHDD Community Standards for All Providers, Current FY DBHDD Provider Manual located at www.dbhdd.ga.gov.

Other required trainings for DDPs in their first year of employment include:

- Individual Service Planning
- Supports Intensity Scale
- Health Risk Screening Tool

The provider agency must also document the participation of each DDP in a minimum of 8 hours per year of additional DBHDD sponsored or other training in the area of developmental disabilities, not listed above or included in the Community Standards for All Providers.

The following professionals qualify to be a Developmental Disability Professional:

- i. **Advanced Practice Nurse:** A registered professional nurse licensed in the State of Georgia, who meets those educational, practice, certification requirements, OR any combination of such requirements, as specified by the Georgia Board of Nursing AND includes certified nurse midwives, nurse practitioners, certified registered nurse anesthetists, clinical nurse specialists in psychiatric/mental health, AND others recognized by the board AND who have one year experience in treating persons with intellectual/developmental disabilities in a medical setting or a community based setting for delivery of nursing services.
- ii. **Behavior Specialist:** A behavior specialist who has completed of a Master's degree in psychology, school psychology, counseling, vocational

rehabilitation or a related field which included one course in psychometric testing and two courses in any combination of the following: behavior analysis or modification, therapeutic intervention, counseling, or psychosocial assessment, AND one year of individualized treatment programming, monitoring and observing behavior; collecting and recording behavioral observations in a treatment setting and developing and implementing behavior management plans for individuals with intellectual disabilities OR developmental disabilities OR completion of a Bachelor's degree in psychology, counseling, OR a related field which included one course in psychometric testing and two courses in any combination of the following: behavior analysis or modification, counseling, learning theory or psychology of adjustment AND two years of individualized treatment programming, monitoring and observing behavior; collecting and recording behavioral observations in a treatment setting and developing and implementing behavior management plans for individuals with intellectual/developmental disabilities.

- iii. **Board Certified Behavior Analyst (BCBA):** A BCBA who has completed a Master's degree, with 225 hours of approved graduate coursework, AND 1500 hours of experience in the field with 5% of those hours being supervised by a BCBA, AND has received a passing score on the Behavior Analyst Certification Board Exam, AND maintains a prescribed number of continuing education units annually, AND has specialized training in developmental disabilities as evidenced by college coursework or practicum/internship experience OR one year of experience in providing services to individuals with intellectual/developmental disabilities.
- iv. **Educator:** An educator with a degree in education from an accredited program that includes a concentration in Special Education in college coursework OR teaching certificate in Special Education, AND one year of classroom experience in teaching individuals with intellectual/developmental disabilities.
- v. **Human Service Professional:** A human services professional with a bachelor's degree in social work OR a bachelor's degree in human services field other than social work (including the study of human behavior, human development or basic human care needs) AND with specialized training OR one year of experience in providing human services to individuals with intellectual/developmental disabilities.
- vi. **Master's or Doctoral Degree Holders:** A person with a Masters or Doctoral degree in one of the behavioral OR social sciences AND with specialized training in developmental disabilities as evidenced by college coursework OR practicum/internship experience OR one year of experience in providing services to individuals with intellectual/developmental disabilities.
- vii. **Physical or Occupational Therapist:** A physical or occupational therapist licensed in the State of Georgia, who has specialized training in developmental disabilities as evidenced by college coursework OR practicum/internship experience OR one year of experience in treating individuals with intellectual/developmental disabilities.
- viii. **Physician:** A physician licensed in the State of Georgia to practice medicine or osteopathy AND with specialized training in developmental disabilities OR one year of experience in treating individuals with intellectual/developmental disabilities in a medical setting.
- ix. **Physician's Assistant:** A skilled person qualified by academic and practical training to provide patients' services not necessarily within the physical presence but under the personal direction or supervision of a physician, AND

who has one year experience in treating individuals with intellectual/developmental disabilities in a medical setting.

- x. **Psychologist:** A holder of a Doctoral degree from an accredited university or college, AND who is licensed in the state of Georgia AND who has specialized training in developmental disabilities OR one year of experience in evaluating or providing psychological services to individuals with intellectual/developmental disabilities.
- xi. **Registered Nurse (Associate Degree or Diploma):** A registered nurse who is authorized by a license to practice nursing as a registered professional nurse, who holds an associate or diploma degree in nursing, AND who has three years of experience, two of which are in treating individuals with intellectual/developmental disabilities in a medical setting or a community-based setting for delivery of nursing services.
- xii. **Registered Nurse (Bachelor Degree):** A registered nurse who is authorized by license to practice nursing as a registered professional nurse AND who holds a Bachelor's degree in nursing with one year experience in treating individuals with intellectual/developmental disabilities in a medical setting or a community-based setting for delivery of nursing services.
- xiii. **Speech Pathologist or Audiologist:** A speech pathologist or audiologist licensed in the State of Georgia, who has specialized training in developmental disabilities as evidenced by college coursework or practicum/internship experience OR one year of experience in treating individuals with intellectual/developmental disabilities.
- xiv. **Therapeutic Recreation Specialist:** A therapeutic recreation specialist who graduated from an accredited program AND who has specialized training in developmental disabilities as evidenced by college coursework OR practicum/internship experience OR one year experience in providing therapeutic recreational services to individuals with intellectual/developmental disabilities.

2. Behavioral Health Practitioners.

Table of Practitioners for Community BH Provider Agencies:

Professional Title	Minimum Level of Education/Degree/ Experience Required	License/ Certification Required	Requires Supervision?	State Code
Physician (M.D., D.O., etc.)	Graduate of medical or osteopathic college	Licensed by the Georgia Composite Board of Medical Examiners	No. Additionally, can supervise others	43-34-20 to 43-34-37
Psychiatrist (M.D., etc.)	Graduate of medical or osteopathic college and a residency in psychiatry approved by the American Board of Psychiatry and Neurology	Licensed by the Georgia Composite Board of Medical Examiners	No. Additionally, can supervise others	43-34-20 to 43-34-37
Physician's Assistant (PA)	Completion of a physician's assistant training program approved by the Georgia Composite Board of Medical Examiners -- at least 1 year of experience in behavioral healthcare required to supervise CPRP, CPS, or PP staff	Licensed by the Georgia Composite Board of Medical Examiners	Physician delegates functions to PA through Board-approved job description.	43-34-100 to 43-34-108

Professional Title	Minimum Level of Education/Degree/ Experience Required	License/ Certification Required	Requires Supervision?	State Code
Advanced Practice Registered Nurse (APRN): Clinical Nurse Specialist/Psychiatric-Mental Health (CNS-PMH) and Nurse Practitioner (NP)	R.N. and graduation from a post-basic education program for Nurse Practitioners Master's degree or higher in nursing for the CNS/PMH -- Nurse Practitioners must have at least 1 year of experience in behavioral healthcare to supervise CPRP, CPS, or PP staff	Current certification by American Nurses Association, American Nurses Credentialing Center or American Academy of Nurse Practitioners and authorized as an APRN by the Georgia Board of Nursing	Physician delegates advanced practice functions to APRN, CNS-PMH, NP through Board-approved nurse protocol agreements.	43-26-1 to 43-26-13, 360-32
Licensed Pharmacist (LP)	Graduated and received an undergraduate degree from a college or school of pharmacy; completed a Board-approved internship and passed an examination.	Licensed by the Georgia State Board of Pharmacy	No	26-4
Registered Nurse (RN)	Georgia Board of Nursing-approved nursing education program -- at least 1 year of experience in behavioral healthcare required to supervise CPRP, CPS, or PP	Licensed by the Georgia Board of Nursing	By a physician	43-26-1 to 46-23-13
Licensed Practical Nurse (LPN)	Graduation from a nursing education program approved by the Georgia Board of Licensed Practical Nursing.	Licensed by Georgia Board of Licensed Practical Nursing	By a Physician or RN	43-26-30 to 43-26-43
Licensed Dietician (LD)	- Bachelor's degree or higher with a degree in dietetics, human nutrition, food and nutrition, nutrition education or food systems management. - Satisfactory completion of at least 900 hours of supervised experience in dietetic practice	Licensed by Georgia Board of Licensed Dieticians	No	43-11A-1 to 43-11A-19
Qualified Medication Aide (OMA)	Completion of a prescribed course conducted by the Georgia Department of Technical and Adult Education and pass examination for qualified medication aides approved by the Georgia Board of Licensed Practical Nursing.	Certified by the Georgia Board of Licensed Practical Nursing	Supervised by RN performing certain medication administration tasks as delegated by RN or LPN.	43-26-50 to 43-26-60
Psychologist (PhD)	Doctoral Degree	Licensed by the Georgia Board of Examiners of Psychologists	No. Additionally, can supervise others	43-39-1 to 43-39-20
Licensed Clinical Social Worker (LCSW)	Masters degree in Social Work plus 3 years' supervised full-time work in the practice of social work after the Master's degree.	Licensed by the Georgia Composite Board of Professional Counselors, Social Workers, and Marriage and Family Therapists	No. Additionally, can supervise others	43-10A
Licensed Professional Counselor (LPC)	Master's degree	Licensed by the Georgia Composite Board of Professional Counselors, Social Workers, and Marriage and Family Therapists	No. Additionally, can supervise others	43-10A
Licensed Marriage and Family Therapist (LMFT)	Master's degree	Licensed by the Georgia Composite Board of Professional Counselors, Social Workers, and Marriage and Family Therapists	No. Additionally, can supervise others	43-10A

Professional Title	Minimum Level of Education/Degree/ Experience Required	License/ Certification Required	Requires Supervision?	State Code
Licensed Master's Social Worker (LMSW)	Master's degree in Social Work	Licensed by the Georgia Composite Board of Professional Counselors, Social Workers, and Marriage and Family Therapists	Works under direction and supervision of an appropriately licensed/credentialed professional.	43-10A
Licensed Associate Professional Counselor (LAPC)	Master's degree	Licensed by the Georgia Composite Board of Professional Counselors, Social Workers, and Marriage and Family Therapists	Works under direction and supervision of an appropriately licensed/credentialed professional	43-10A
Licensed Associate Marriage and Family Therapist (LAMFT)	Master's degree	Licensed by the Georgia Composite Board of Professional Counselors, Social Workers, and Marriage and Family Therapists	Works under direction and supervision of an appropriately licensed/credentialed professional	43-10A
Certified Clinical Alcohol and Drug Counselor (CCADC)	Master's degree; Also requires minimum of 2 years or 4,000 hours experience in direct alcohol and drug abuse treatment with individual and/or group counseling and a total of 270 hours of addiction-specific education and 300 hours of supervised training.	Certification by the Alcohol and Drug Certification Board of Georgia; International Certification and Reciprocity Consortium / Alcohol and Other Drug Abuse (IC&RC)	Services limited to those practices sanctioned by the certifying board and shall in any event be limited to the provision of chemical dependency treatment	43-10A-7
Georgia Certified Alcohol and Drug Counselor Level III (GCADC III)	Master's degree; Also must have been certified by a national organization and have taken a written and oral examination in the past and must have been continuously certified for a period of 2 years; Must meet the standards outlined in the Ga. Code rules posted on the licensing board website: Perform the 12 core functions; Education and training; Supervised practicum; Experience and supervision	Certification by the Alcohol and Drug Certification Board of Georgia (ADACB-GA)	Services limited to those practices sanctioned by the certifying board and shall in any event be limited to the provision of chemical dependency treatment	43-10A-7
Master Addiction Counselor (MAC) National Board of Certified Counselors (NBCC)	Master's Degree Documentation of a minimum of 12 semester hours of graduate coursework in the area of OR 500 CE hours specifically in addictions. Three years supervised experience as an addictions counselor at no fewer than 20 hours per week. Two of the three years must have been completed after the counseling master's degree was conferred. A passing score on the Examination for Master Addictions Counselors (EMAC).	Certification by the National Board of Certified Counselors (NBCC) Nationally Certified Counselor (NCC) credential – must be Licensed by the Georgia Composite Board of Professional Counselors, Social Workers, and Marriage and Family Therapists	Services limited to those practices sanctioned by the certifying board and shall in any event be limited to the provision of chemical dependency treatment	43-10A-7

Professional Title	Minimum Level of Education/Degree/ Experience Required	License/ Certification Required	Requires Supervision?	State Code
Master Addiction Counselor, (MAC) through National Association of Alcohol and Drug Counselors, (NAADC)	Master's degree; 500 contact hours of specific alcoholism and drug abuse counseling training). Three years full-time or 6,000 hours of supervised experience, two years or 4,000 hours of which must be post master's degree award. Passing score on the national examination for the MAC	Certification by the National Association Alcohol & Drug Counselors' Current state certification /licensure in alcoholism and/or drug abuse counseling. Passing score on the national examination for the MAC	Services limited to those practices sanctioned by the certifying board and shall in any event be limited to the provision of chemical dependency treatment	43-10A-7
Certified Alcohol and Drug Counselor (CADC)	Bachelor' s degree; Also requires minimum of 2 years or 4,000 hours experience in direct alcohol and drug abuse treatment with individual and/or group counseling and a total of 270 hours of addiction-specific education and 300 hours of supervised training	Certification by the Alcohol and Drug Certification Board of Georgia (ADACB-GA) International Certification and Reciprocity Consortium / Alcohol and Other Drug Abuse (IC&RC)	Services limited to those practices sanctioned by the certifying board and shall in any event be limited to the provision of chemical dependency treatment	43-10A-7
Georgia Certified Alcohol and Drug Counselor II (GCADC II)	Bachelors degree; Must be certified by a national organization and have taken a written and oral examination; Must have been continuously certified for a period of 2 years; Must meet the standards outlined in the Ga. Code rules posted on the licensing board website: Perform the 12 core functions; Education and training; Supervised practicum; Experience and supervision	Certification by the Alcohol and Drug Certification Board of Georgia (ADACB-GA)	Services limited to those practices sanctioned by the certifying board and shall in any event be limited to the provision of chemical dependency treatment	43-10A-7
Certified Addiction Counselor, Level II (CAC-II)	Bachelor's degree; Requires 3 years of experience in practice of chemical dependency/abuse counseling; 270 hours education in addiction field; and 144 hours clinical supervision	Certification by the Georgia Addiction Counselors' Association	Services limited to those practices sanctioned by the certifying board and shall in any event be limited to the provision of chemical dependency treatment	43-10A-7
Certified Addiction Counselor, Level I (CAC-I)	High School Diploma/Equivalent; Requires 2 years of experience in the practice of chemical dependency/abuse counseling; 180 hours education in addiction field; and 96 hours clinical supervision.	Certification by the Georgia Addiction Counselors' Association	Services limited to those practices sanctioned by the certifying board and shall in any event be limited to the provision of chemical dependency treatment, Under supervision of a Certified Clinical Supervisor	43-10A-7

Professional Title	Minimum Level of Education/Degree/ Experience Required	License/ Certification Required	Requires Supervision?	State Code
Registered Alcohol and Drug Technician I, II, III (RADT-I, RADT-II, RADT-III)	High school diploma or its equivalent and must be enrolled in a junior college, college or university. Must document a minimum of one (1) year or two thousand (2000) hours experience of direct service (alcohol and drug counseling). Once the RADT has completed 30 college credit hours he/she is eligible to take the ICRC written exam. Upon passing the ICRC Written exam, a RADT-II certificate is issued. Once the RADT-II has completed 60 college credit hours, he/she is eligible to take the oral case presentation. Upon successful completion of the oral case presentation, receives a RADT-III certificate is issued. Upon completion of BS degree and experience a CADC will be issued	Registered/certified by the Alcohol and Drug Certification Board of	Services limited to those practices sanctioned by the certifying board and shall in any event be limited to the provision of chemical dependency treatment, Under supervision of a Certified Clinical Supervisor; CADC; CCADC, LPC, LCSW	43-10A-7
Addiction Counselor Trainees (ACT)	High school diploma/equivalent and actively pursuing certification as CAC-I, CAC-II, RADT I, II, III; CADC or CCADC or other addiction counselor certification recognized by practice acts.	Employed by an agency or facility that is licensed to provide addiction counseling	Under supervision of a Certified Clinical Supervisor (CCS); CADC; CCADC	
Certified Psychiatric Rehabilitation Professional (CPRP)	High school diploma/equivalent, Associates Degree, Bachelor's Degree, Graduate Degree with required experience working in Psychiatric Rehabilitation (varies by level and type of degree)	Certified by the US Psychiatric Rehabilitation Association (USPRA, formerly IASPRS)	Under supervision of an appropriately licensed/credentialed professional	
Certified Peer Specialist (CPS)	High school diploma/equivalent	Certification by the Georgia Certified Peer Specialist Project Requires a minimum of 40 hours of Certified Peer Specialist Training, and successful completion of a certification exam.	Services shall be limited to those not requiring licensure, but are provided under the supervision of an appropriately licensed/credentialed professional.	
Paraprofessional (PP)	Completion of Standardized Training Requirement for Paraprofessionals approved by the Department of Community Health (includes training provided by the organization and on-line training provided via Essential Learning.)	Completion of a minimum of 46 hours of paraprofessional training and successful completion of all written exams and competency-based skills demonstrations.	Under supervision of an appropriately licensed/credentialed professional	

Professional Title	Minimum Level of Education/Degree/ Experience Required	License/ Certification Required	Requires Supervision?	State Code
Psychologist/LCSW/ LPC/LMFT's supervisee/trainee (S/T)	Minimum of a Bachelor's degree and one or more of the following: <ul style="list-style-type: none"> a. Registered toward attaining an associate or full licensure; b. In pursuit of a Master's degree that would qualify the student to ultimately qualify as a licensed practitioner; c. Not registered, but is acquiring documented supervision toward full licensure (signed attestation by practitioner and supervisor to be on file with personnel office) 	Under supervision in accordance with the GA Composite Board of Professional Counselors, Social Workers, and Marriage and Family Therapists or enrolled in a practicum with an accredited educational Master's degree program which provides supervision as a part of a curriculum which is the foundation toward licensure	Under supervision of a licensed Psychologist/LCSW, LPC, or LMFT in accordance with the GA Composite Board of Professional Counselors, Social Workers, and Marriage and Family Therapists or enrolled in a practicum with an accredited educational Master's degree program which provides supervision as a part of a curriculum which is the foundation toward licensure	43-10A
Vocational Rehabilitation Specialist (VRS)	Minimum of one year verifiable vocational rehabilitation experience.	Employed by an agency that is DBHDD approved to provide ACT.	Under supervision of an ACT team leader who is either a physician, psychologist, PA, APRN, RN with a 4-year BSN, LCSW, LPC, or LMFT.	

T. WAIVERS TO STANDARDS

The organization may not exempt itself from any of these standards or any portion of the provider manual. All requests for waivers of these standards must be done in accordance with Policy #9.102 Requests for Waivers of the Standards for Mental Health, Developmental Disabilities and Addictive Diseases, found herein Part VI.

U. STANDARD TRAINING REQUIREMENT FOR PARAPROFESSIONALS

In addition to the training requirements defined in this document, the Department of Behavioral Health and Developmental Disabilities (DBHDD) requires that all behavioral health paraprofessionals complete the Standard Training Requirement. These trainings provide useful information necessary to fulfill requirements for delivering DBHDD behavioral health services and supports, while also providing paraprofessionals with access to information that will help them be more effective on the job. Demonstrated mastery of each topic area within the Standard Training Requirement is necessary in order for paraprofessionals to provide both state-funded and Medicaid-reimbursable behavioral health services.

The Standard Training Requirement for Paraprofessionals requires that paraprofessionals complete agency-based training as well as targeted, online trainings. In total, each paraprofessional must complete 46 hours of training (29 hours via online courses and 17 hours provided by the organization). In addition, a set number of training hours must be dedicated to specific subject areas. The number of required training hours is by subject area is outlined below.

Subject Area	TOTAL Required Hours	Required via Online Courses	Required via Agency-Based Training
Corporate Compliance	2	1	1
Cultural Competence	2	2	
Documentation	5	3	2
First Aid and CPR	6	0	6
Mental Illness – Addictive Disorders	8	8	0
Pharmacology & Medication Self-Admin	2	2	0
Professional Relationships	2	2	0
Recovery Principles	2	2	0
Safety/ Crisis De-escalation	10	4	6
Explanation of Services	1	0	1
Service Coordination	4	3	1
Suicide Risk Assessment	2	2	0
Total Required Hours	46	29	17

At this time, there is no annual or continued training requirement related to the Standard Training Requirement for Paraprofessionals. However, it should be noted that all providers must comply with all training requirements outlined the Standards for All Providers.

Online Courses for Paraprofessionals via Essential Learning

The required online training hours must be completed through the online training programs provided by DBHDD. DBHDD contracts with a national provider, Essential Learning, for the online training and education component of this requirement. Essential Learning provides free, 24/7 access to course content at <http://training.essentiallearning.com/GeorgiaMHAD>. This content is only available to behavioral health providers who have an executed contract or agreement with DBHDD.

In order to gain initial access to the Essential Learning courses, agencies must designate an Essential Learning liaison to assign paraprofessionals for the training. The liaison plays a key role in the successful use of the online curriculum. The liaisons have supervisor rights and can add and delete learners from the system. The liaisons may also assign courses in the Learning Catalog based on the particular need within their organization. Your organization may decide to allow learners to choose their own courses within the required topic areas or to assign learners to complete particular courses that best fit your organization's needs. Providers must ensure that the Essential Learning Courses assigned will meet compliance with the required number of hours per Subject Area (above). Once the paraprofessional has been given a username and password by the provider's liaison, s/he can go online and access the available courses and exams in the learning catalog.

The chart below displays the courses available within the Standard Training Requirement for Paraprofessionals which may be satisfied via Essential Learning. A total of 29 hours of online training is necessary to fulfill the training requirement and many subjects offer several courses that can meet the criteria.

Subject Area	Courses available to fulfill online training requirement	Online Hours available per Course
Corporate Compliance (Must complete at least 1 hour of online training)	Corporate Compliance and Ethics for Paraprofessionals	1
Cultural Competence (Must complete at least 2 hours of online training)	Cultural Diversity for Paraprofessionals	1.5
	Cultural Issues in Mental Health Treatment for Paraprofessionals	3
Documentation (Must complete at least 3 hours of online training)	Essential Components of Documentation for Paraprofessionals	6
Mental Illness – Addictive Disorders (Must choose at least 8 hours of online training)	Bipolar Disorder in Children and Adolescents	1
	Depressive Disorder in Children and Adolescents	3
	Overview of Bipolar Disorder for Paraprofessionals	2
	Mental Health Issues in Older Adults for Paraprofessionals	2
	Mood Disorders in Adults – A Summary for Paraprofessionals	1
	Overview of Family Psychoeducation – Evidenced Based Practices	1.5
	Defining Severe Persistent Mental Illness and Recovery	2
	People with Serious Mental Illness for Paraprofessionals	3
	Understanding Schizophrenia for Paraprofessionals	2
	Alcohol and the Family for Paraprofessionals	2.5
	Understanding the Addictive Process: An Overview for Paraprofessionals	2
	Co-Occurring Disorders: An Overview for Paraprofessionals	1.5
	Pharmacology and Medication Self Admin (Must choose at least 2 hours of online training)	Overview of Medications for Paraprofessionals
Medication Administration & Monitoring for Paraprofessionals		4
Professional Relationships (Must complete at least 2 hours of online training)	Therapeutic Boundaries for Paraprofessionals	2
Recovery Principles (Must choose at least 2 hours of online training)	WRAP – One on One	3
	Path to Recovery	2
Safety/Crisis De-escalation (Must complete at least 4 hours of online training)	Abuse, Neglect and Incident Reporting for Paraprofessionals	1
	Crisis Management for Paraprofessionals	3
Service Coordination (Must choose at least 3 hours of online training)	Case Management for Paraprofessionals	3
	Coordinating Primary Care Needs of Clients Paraprofessionals	7.5
	Supported Employment – Evidenced Based Practices	6
Suicide Risk Assessment (Must choose at least 2 hours of online training)	In Harm's Way: Suicide in America	1
	Suicide Prevention	2
	Suicide the Forever Decision	3
Total Hours of Available Course Content		75

Providing Services as a Paraprofessional

The following individuals must complete the Standard Training Requirement in order to provide services as a Paraprofessional:

- a. Individuals who are not licensed or do not hold an approved credential, regardless of education level. For example, an individual with a Masters in Social Work but not a license would need to complete the Standard Training Requirement.
- b. Contract employees providing outsourced services who fall within the paraprofessional criterion
- c. Individuals who have not yet completed the certification process to be Certified Peer Specialists
- d. Individuals who may be eligible in the future to be licensed or certified but who are not yet licensed or certified
- e. Individuals providing Psychiatric Residential Treatment Facility services but not staff providing services through foster care, Intensive Community Support Program, and child & adolescent group homes

Individuals who are working towards licensure and meet the qualifications of a Supervisee/Trainee as defined in the Standards for All Providers must also complete the Standard Training Requirement.

Paraprofessional staff members must complete the Standard Training Requirements within the new hire orientation guidelines for their organization but no later than **90 days after hire**. Staff may provide and bill for services during this 90 days. If the Standard Training Requirement is not completed after 90 days, the individual may not bill until s/he fulfills the requirement. Any services that are provided outside of the 90 day grace period by an uncertified paraprofessional are subject to recoupment.

If an individual would like to bill a service for which they are not an approved practitioner, they may bill as a paraprofessional (providing that a paraprofessional is an approved practitioner). In order to do so they must have completed the Standard Training Requirement. When documenting this service, the noted credential of the practitioner must match the practitioner level billed. For example, if an LPN would like to provide Community Support Individual (a service for which s/he is not an approved practitioner), s/he could bill as a paraprofessional and would therefore need to be in compliance with the Standard Training Requirement. The LPN would document his/her credentials as “LPN and PP” when billing at the paraprofessional rate.

Documentation for the Standard Training Requirement

Documentation of compliance must be available for each paraprofessional. An orientation agenda/checklist/spreadsheet with the name of the employee, date of topic, training, and number of hours must be available and is required for audit purposes. Proof of course completion should be kept in a personnel file for both agency-provided training as well as online training. This may be documented via a certificate or transcript generated online by Essential Learning or by the “live” course provider.

Auditors may verify the information provided on the tracking sheet by viewing the training certificates. If this information is not available, services billed by the paraprofessional will be subject to recoupment. The date of hire must also be available for review.

If further questions or clarifications are needed regarding the Standard Training Requirement, please email questions to: RegistrationMHDDAD@dbhdd.ga.gov

V. For DD providers utilizing Proxy Caregivers and Health Maintenance Activities:

Licensed provider agencies, including co-employer agencies, must abide by the Rules and Regulations for Proxy Caregivers Used in Licensed Healthcare Facilities, Chapter 111-8-100. The policies and procedures specified below are applicable to all providers:

Health Maintenance Activities Definition: Health maintenance activities, which are limited to those activities that, but for a disability, a person could reasonably be expected to do for himself or herself. Such activities are typically taught by a registered professional nurse, but may be taught by an attending physician, advanced practice registered nurse, physician assistant, or directly to a person and are part of ongoing care. Health maintenance activities are those activities that do not include complex care such as administration of intravenous medications, central line maintenance (i.e., daily management of a central line, which is intravenous tubing inserted for continuous access to a central vein for administering fluids and medicine and for obtaining diagnostic information), and complex wound care; do not require complex observations or critical decisions; can be safely performed and have reasonably precise, unchanging directions; and have outcomes or results that are reasonably predictable. Any activity that requires nursing judgment is not a health maintenance activity. Health maintenance activities are specified for an individual participant in written orders of the attending physician, advanced practice registered nurse, or physician assistant.

1. Written Plan of Care Requirements: Health maintenance activities are as defined in the written plan of care that implements the written orders of the attending physician, advanced practice registered nurse, or physician assistant and specifies the frequency of training and evaluation requirements for the proxy caregiver, including additional training when changes in the written plan of care necessitate added duties for which such proxy caregiver had not previously been trained. The written plan of care is established by a registered professional nurse, or by an attending physician, advanced practice registered nurse, or physician assistant. This written plan of care for health maintenance activities must be maintained in the participant's record and available for the proxy caregiver.
2. Written Informed Consent: A participant or individual legally authorized to act on behalf of the participant must complete a written informed consent designating a proxy caregiver and delegating responsibility to such proxy caregiver to receive training and to provide health maintenance activities to the participant pursuant to the written orders of an attending physician, or an advanced practice registered nurse or physician assistant working under a nurse protocol agreement or job description.
3. Requirements for Individuals Providing Health Maintenance Activities: Individuals who provide health maintenance activities in accordance with the above conditions must meet the following:
 - a. Be selected by the participant or a person legally authorized to act on behalf of the participant to serve as the participant's proxy caregiver.
 - b. Receive training by an attending physician, advanced practice registered nurse, physician assistant, or registered nurse that teaches the proxy caregiver the

necessary knowledge and skills to perform the health maintenance activities documented in the participant’s written plan of care as defined above. The training must include the knowledge and skills to perform any identified specialized procedures for the participant.

- c. Demonstrate to the trainer (i.e., attending physician, advanced practice registered nurse, physician assistant, or registered nurse) the necessary knowledge and skills to perform the health maintenance activities documented in the participant’s written plan of care as defined above. The training must include the knowledge and skills to perform any identified specialized procedures for the participant.
- 4.. Non-Covered Health Maintenance Activities: Health maintenance activities that meet any of the following are non-covered:
- a. Complex care such as administration of intravenous medications, central line maintenance, and complex wound care.
 - b. Provided by an individual without written informed consent designating that individual as a proxy caregiver and delegating responsibility to such proxy caregiver to receive training.
 - c. Provided without the written orders of an attending physician, or an advanced practice registered nurse or physician assistant working under a nurse protocol agreement of job description, respectively, pursuant to Georgia Code Section 43-34-25 or 43-34-23.
 - d. Provided without a written plan of care as defined above.

Provided by individuals who do not meet the requirements specified above.

Appendix I:

Antipsychotic Medications	
Generic	Trade
Aripiprazole	Abilify
Chlorpromazine	Thorazine
Chlorprothixene	Taractan
Clozapine	Clozaril
Fluphenazine	Permitil, Prolixin*
Haloperidol	Haldol*
Loxapine	Loxitane
Mesoridazine	Serentil
Molindone	Lidone, Moban
Olanzapine	Zyprexa
Paliperidone	Invega*
Perphenazine	Trilafon
Pimozide (for Tourette’s)	Orap
Quetiapine	Seroquel
Risperidone	Risperdal*
Thioridazine	Mellaril
Thiothixene	Navane

Trifluoperazine Trifluopromazine Ziprasidone	Stelazine Vesprin Geodon
Mood Stabilizer Medications	
Generic	Trade
Lithium Carbonate Divalproex Sodium Tiagabine Levetiracetam Lamotrigine Gabapentin Carbamazepine Oxcarbazepine Topiramate Zonisamide Verapamil Clonidine Propranolol Mexiletine Guanfacine	Eskalith or Lithonate Depakote Gabatril Keppra Lamitcal Neurontin Tegretol Trileptal Topamax Zonegran Calan Catapres Inderal Mexitil Tenex

*Also has a sustained release injectable form

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PART III

Community Service Standards Specific for Developmental Disabilities Services

**Provider Manual for
Community Mental Health,
Developmental Disabilities and
Addictive Diseases
Providers**

Fiscal Year 2012



**Georgia Department of Behavioral Health &
Developmental Disabilities**

April 2012

DBHDD

Part III

**Community Service Standards Specific for
Developmental Disabilities Services**

SECTION I

***Operational and Clinical
Standards for
Georgia Crisis Response
System (GCRS-DD)***

Fiscal Year 2012



**Georgia Department of Behavioral Health &
Developmental Disabilities**

April 2012

Department of Behavioral Health and Developmental Disabilities
Operational and Clinical Standards for Georgia Crisis Response System
(GCRS-DD)

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DESCRIPTION

The goal of this system is to provide time-limited home and community based crisis services that support individuals with developmental disabilities in the community, and provide alternatives to institutional placement, emergency room care, and/or law enforcement involvement (including incarceration). These community based crisis services and homes are provided on a time-limited basis to ameliorate the presenting crisis. The system is to be utilized as a measure of last resort for an individual undergoing an acute crisis that presents a substantial risk of imminent harm to self or others.

The Georgia Crisis Response System includes intake, dispatch, referral, and crisis services components. An essential part of this system is the assessment of the individual situation to determine the appropriate response to the crisis. Entry into the system takes place through the Single Point of Entry (SPOE) system. Intake personnel determine if an individual meets the requirements for entry into the system and initiate the appropriate dispatch or referral option. If a Developmental Disability (DD) Mobile Crisis Team is dispatched to the crisis location, this team assesses the need for a referral or crisis services. Crisis services occur through intensive on-site or off-site supports. These crisis supports are provided on a time-limited to ameliorate the crisis.

A. GENERAL REQUIREMENTS

In addition to the Georgia Crisis Response System Standards, Developmental Disabilities (DD) crisis service providers must comply with the *State of Georgia, Department of Behavioral Health and Developmental Disabilities (DBHDD) Community Service Standards Part II, Section I, Standards for All Providers* with the exception of the following:

Physical restraints also known as mechanical restraints, as defined in the *Standards for All Providers*, may not be used by the crisis services provider. As stipulated in the *Standards for All Providers*, chemical restraints may never be used under any circumstance by the Crisis Service Provider. A personal restraint also known as a manual hold or manual restraint is used in accordance with the *Standards for All Providers*.

The following standards are applicable to DBHDD or organizations that provide crisis response services to individuals, family members, care-givers, and/or DD waiver service provider agencies that activate the Georgia Crisis Response System.

1. The system is to be utilized as a measure of last resort for an individual undergoing an acute crisis that presents a substantial risk of imminent harm to self or others. The preference is not to transfer an individual to an out-of-home setting, but to provide additional supports in the home.
2. Crisis Response System staff are to coordinate with provider agencies of individuals currently receiving services, who access the Crisis Response System, on a case by case basis to assess and recommend needed changes in services.
3. Training records are to be maintained, which document that all Crisis Response System staff have participated in training and passed an examination demonstrating their competence in all crisis protocols and relevant applicable trainings as listed below:
 - a. Single Point of Entry (SPOE) staff
 - i. Mobile crisis dispatch criteria
 - ii. Telephonic crisis intervention

- b. Mobile team members and intensive support staff
 - i. Assessing the crisis
 - ii. Onsite operations
 - iii. Referral decision criteria
 - iv. Required crisis intervention curriculum
 1. Crisis Prevention Institute (CPI) *www.crisisprevention.com*
 2. Handle with Care Behavior Management System, Inc. *www.handlewithcare.com*
 3. Mindset *www.mindsetconsulting.net*
 4. Safe Crisis Management *ww.jkmtraining.com*
 5. Human Empowerment Leadership Principles (HELP) *www.capscanhelp.com*
 6. Professional Crisis Management (PCM) *ww.pcma.com*
 7. Safety- Care (QBS, Inc) *www.qbscompanies.com*
 - v. Cardiopulmonary Resuscitation (CPR)
 - vi. First aid
 - vii. Documentation standards and expectations
4. Clinical intervention decisions are made to ensure the least restrictive interventions and placements likely to be successful are utilized as evidenced by assessments that justify the need for any restrictive interventions and/or placements (including intensive in-home supports or intensive out-of-home supports).
5. Plans intended to modify behavior over time (not including crisis plans) are not developed unless appropriate behavioral assessments are completed, and the personnel who develop the plans are able to provide follow-up activities.
6. Discharge Planning should begin at intake and continue throughout utilization of the Crisis Response System. The discharge planning process should include collaboration with all applicable parties, family members/care-givers, providers, Support Coordination Agency, Planning List Administrator, Regional Intake and Evaluation (I & E) Teams. The social work staff in the Crisis Response System must coordinate this process with the oversight of the LCSW assigned to the Mobile Crisis Team.
7. Transportation must be provided by DD Mobile Crisis Teams, in-home support, and/or out-of-home support staff for an individual, who needs to be transported to the crisis homes, emergency facilities, and/or back to their place of residence once discharged from this Crisis Response System level of care.
8. The Georgia Crisis Response System serves children and adults with developmental disabilities aged 5 years and above who meet eligibility criteria as defined in Section B.

B. Intake Requirements

The Georgia Crisis Response System is designed for individuals with developmental disabilities in need of Behavioral Health and Developmental Disabilities (BHDD) crisis services. A person with developmental disabilities in need of BHDD crisis services is an individual who:

- Has documented evidence of a diagnosis of an intellectual disability prior to age 18 years or other closely related developmental disability prior to age 22 years, for individuals currently on the

planning list or in DD services; screening indicative of a developmental disability for other individuals; AND

- Presents a substantial risk of imminent harm to self or others; AND
- Is in need of immediate care, evaluation, stabilization or treatment due to the substantial risk; AND
- Is someone for whom there currently exists no available, appropriate community supports to meet the needs of the person.

The following are requirements for the Single Point of Entry (SPOE):

1. The dispatch operator for the SPOE should attempt to ameliorate the crisis situation through telephonic crisis intervention.
 - a. When successful in resolving the crisis:
 - i. For individuals without a waiver, state funds or planning list services, within 24 hours the SPOE is to make a referral to the Regional I&E Team for review.
 - ii. For individuals with a waiver, state funds or planning list services, within 24 hours the SPOE is to notify the Regional Office and DD service provider, if applicable. If the call originates from a DD service provider, the SPOE is to engage that provider during the resolution of the crisis.
 - b. When unsuccessful in resolving the crisis and face-to-face intervention is needed, the SPOE must provide documentation to support the need for the dispatch of the DD Mobile Crisis Team. The SPOE is to contact immediately the Regional Office, the support coordination agency, and the DD service provider if applicable.

2. When the DD Mobile Crisis Team is dispatched, the SPOE must provide the team pertinent clinical information including but not limited to:
 - a. Demographics
 - b. Crisis location
 - c. Crisis description
 - d. Current medical status
 - e. Status in Case Management Information System (CIS) (if applicable)
 - i. Support coordination contact information
 - ii. Planning List Administrator (PLA) contact information
 - iii. Summary of progress notes for the last 30 days
 - iv. New Options Waiver (NOW)/Comprehensive (COMP) waiver status
 - v. Current behavioral interventions

All information provided to the DD Mobile Crisis Team by SPOE must be sufficient to allow the team to ensure that appropriate staff members are dispatched to the crisis.

3. Once the SPOE (Behavioral Health Line) contacts the appropriate crisis provider within a specific region, and it is determined that the crisis provider is unable to immediately dispatch a Mobile Crisis Team, all resources available to that provider must be utilized to remedy the crisis situation within the required 1.5 hours; including the use of in-home crisis supports team.
 - a. If that crisis provider is not able to appropriately address the crisis in 1.5 hours, they are to inform the SPOE and include the reason for not being able to meet the 1.5 hour response

requirement. Upon receipt of this information, the SPOE must contact the nearest crisis provider for dispatch.

- b. The newly dispatched crisis provider may be located within the same region or across regional lines. If the mobile crisis response is provided by an out-of-area team, **and** either in-home or out-of-home supports are required after the initial crisis has been supported, the individual is to be transitioned to the in-area crisis provider for ongoing supports.
 - c. When an individual experiences a crisis outside their region of residence, the SPOE must dispatch the Mobile Crisis Team for the region where the crisis is occurring.
 - d. The Mobile Crisis Team for that region is to assess the situation to determine if additional in-home or out-of-home supports are required, subsequent to the initial stabilization.
 - e. If additional in-home or out-of-home supports are required, subsequent to the initial stabilization, the initial Mobile Crisis Team is to work in conjunction with the crisis provider within the region of residence, to insure that the individual receives the supports in their home region.
- 4 The DD Mobile Crisis Team is to request of the SPOE's (Behavioral Health Line) shift supervisor immediate access to the Consumer Information System (CIS) for the individual in crisis. The SPOE Behavioral Health Line shift supervisor is to respond, by providing CIS information for all individuals in crisis and who are listed in the CIS.

C. DD Mobile Crisis Team Requirements

1. A minimum of three team members, including one Licensed Clinical Social Worker (LCSW), a behavior specialist, and a direct support staff will respond to each dispatch of the DD Mobile Crisis Team. Other possible team members may include a registered nurse, an additional social worker (MSW), safety officer, or additional direct support staff. In addition, a physician will be available for consultation if needed.
2. All licensed or certified team members are required to comply with the DBHDD Policy, *Professional Licensing and Certification Requirements of Practice Act*, maintaining valid/current license or certification.
3. The LCSW on the DD Mobile Crisis Team is to provide at a minimum, oversight to the operation of the team and is responsible for ensuring that the appropriate team members are dispatched or are available for consultation based on the clinical data provided by the SPOE.
4. The DD Mobile Crisis Team is to:
 - a. Respond and arrive on site within 1 ½ hours of the SPOE dispatch.
 - b. Address the crisis situation to mitigate any risk to health and safety of the individual and/or others.

- c. Rule out any medical causes, through consultation with available medical professionals, which might be contributing to the crisis prior to recommending any intensive crisis supports involving behavioral interventions.
5. The DD Mobile Crisis Team members are responsible for completing comprehensive assessment(s) of the current crisis situation. This assessment process must include interviews with the individual, care providers and/or family members, observation of the current environment, and review of behavior and individual support plans. The LCSW on the team is responsible for ensuring that the assessment process is thorough and complete.
6. Reasonable and relatively simple environmental modifications that do not require continuing programmatic efforts are considered before intensive crisis supports and/or a behavior plan is recommended or implemented.
7. When the DD Mobile Crisis Team makes a disposition, the LCSW communicates all recommendations within 24 hours to all applicable parties (Families/Caregivers, Support Coordination Agencies, Provider Agencies, and/or Regional Office I & E Teams).
8. When the DD Mobile Crisis Team completes services in the home, the LCSW or a designated social worker (MSW) on the team completes a written discharge plan that must:
 - a. Minimally include:
 - i. Summary of precipitating events
 - ii. Clinical interventions
 - iii. Response to clinical interventions
 - iv. Recommendations for continued interventions
 - v. Referral for additional supports (if applicable).
 - b. Be executed and documented within a 24-hour period after a disposition has been determined.
9. Crisis Response System providers must develop and maintain DD Mobile Crisis Team protocols for On-Site Operations. The protocols must include detailed description of its processes that include at a minimum:
 - a. On-Site Stabilization, including intensive in-home supports and professional consultation
 - b. Referral and/or transport to intensive out-of-home crisis supports
 - c. Referral to hospital emergency department

D. Intensive Crisis Support Services Requirements

Intensive Crisis Supports are specialized services that provide time-limited care and intervention to an individual due to his or her need for support and protection of other(s) living with him or her. These supports provide specific intervention and case management strategies directed towards enabling the recipient to remain in the community. The outcome of these services should enhance the current family member's or provider's ability to meet the needs of the recipient.

1. With the oversight of the LCSW, the DD Mobile Crisis Team determines and documents the existing level of crisis that requires the initiation of Intensive Crisis Supports.

- a. The criteria to receive Intensive In-Home Supports include:
 - i. The DD Mobile Crisis Team is not able to mitigate the crisis in a reasonable amount of time OR
 - ii. The crisis was resolved but environmental variables and/or the individual's lack of adaptive behavioral responses make another crisis imminent AND
 - iii. The caregiver or DD service provider is not capable of providing necessary intervention and protection for the individual or others living with the individual AND
 - iv. The Intensive Crisis Supports will enable the individual to avoid institutional placement (such as a placement in a behavioral health hospital, nursing home, jail or correctional facility).
 - b. The criteria to receive Intensive Out-Of-Home Supports include:
 - i. All of the intensive in-home supports criteria AND
 - ii. The safety of others living in the home with the individual or others living in the community cannot be maintained through the use of Intensive In-Home Supports with written justification based on clinical observation and/or assessment OR
 - iii. Extensive environmental modifications are needed as a result of the crisis and the individual cannot safely reside in the home with Intensive In-Home Supports while modifications are completed.
2. When behavioral interventions are necessary, Crisis Response personnel follow applicable *Best Practice Standards for Behavioral Support Services*. For adults, *The Guidelines for Supporting Adults with Challenging Behavior in Community Settings* provides additional information to consider when conducting behavioral assessments (The standards and guidelines are found at www.dbhdd.ga.gov Provider Information: Provider Toolkit).
 3. The Crisis Response System provider must maintain and develop protocols that describe processes for the provision of both In-Home and Out-of-Home Intensive Crisis Supports. The description must include the following processes at a minimum:
 - a. Accessing Intensive Crisis Supports;
 - b. Types of Intensive Crisis Supports it plans to provide;
 - c. Procedures for utilizing Intensive Crisis Supports both in and out of the individual's home.
 4. When the individual meets the following criteria, he/she must be discharged from Intensive Crisis Support Services and the Crisis Response System service provider will complete a written discharge plan indicating at a minimum that:
 - a. The crisis has been resolved, and a plan has been developed that prevents future crises or allows current caregivers or staff to maintain safety should future crises arise AND
 - b. Family and/or provider have been trained and can implement all components of the plan AND
 - c. The individual has met the discharge criteria and the plan of discharge was developed with and reviewed with family, care-giver, and/or DD service provider OR
 - d. The individual exhibits medical conditions requiring more intensive medical care that cannot be provided through Intensive Crisis Supports.

E. Intensive In-Home Support Requirements

1. Intensive In-Home Support services include, but are not limited to the following:

- a. Implementation of behavioral intervention strategies provided under the recommendations of the DD Mobile Crisis Team, safety plans, or behavioral support plans already established for the individual; provision of one-to-one support, as necessary, to address the crisis; modeling of interventions with family and/or provider staff; assistance with simple environmental adaptations as necessary to maintain safety; and when necessary accompanying the individual to appointments related to the crisis response.
 - b. The provision of a staffing pattern up to 24 hours per day, 7 days per week, with the intensity of the Intensive In-Home Support services decreasing over 7 calendar days.
 - c. Maintenance of stakeholder's involvement in the response to the crisis, in order to restore the individual to pre-crisis supports and/or provider services.
 - d. Assurance of appropriate training to support crisis stabilization and the return of the individual to pre-crisis services and supports, to include:
 - i. Demonstration of interventions to the family/caregiver and/or existing DD service provider (if applicable) AND
 - ii. Implementation of these interventions by the family/caregiver and/or existing DD service provider (if applicable).
 - e. Provision of intensive case management services with the assistance of designated support coordinators or planning list administrators (if applicable), for assessment/evaluation for additional needs and supports, with follow-up to ensure implementation of recommended supports/services.
2. Documentation of Intensive In-Home Support services is to:
- a. Occur on a daily basis;
 - b. Include a description of the behavioral interventions utilized;
 - c. Indicate the training process and identity of the trained caregiver or staff that will support the individual upon termination of crisis supports.
3. As a time-limited response, Intensive In-Home Supports are not to exceed 7 calendar days. Extensions beyond 7 calendar days are the exception and are not typical.
- a. Exceptions to this timeframe are to be based on extraordinary circumstances assessed daily by the crisis service provider, and the support coordinator or planning list administrator if applicable.
 - b. Extensions beyond the 7calendar days are to be approved by the Regional Services Administrator for Developmental Disabilities (RSA-DD) for the applicable region. Extensions are only approved when discharge criteria noted in Section D 4a-4d have not been met as evident by observations, with assessment of outcomes related to clinical interventions documented on a daily basis.
Note: As soon as the need is indicated by the GCRSS-DD staff, the RSA-DD engages and reviews all necessary information for an individual's whose circumstances determine the need for an exception.

F. INTENSIVE OUT-OF-HOME SUPPORT REQUIREMENTS FOR CRISIS SUPPORT HOMES

The intent of Intensive Out-of-Home Supports is to stabilize the individual through nursing and behavioral supports, on a time-limited basis. Intensive Out-of-Home Supports are to be provided by Crisis Support

Homes, which are to serve no more than four adult individuals simultaneously. Individuals under the age of 18 years must not be served in a Crisis Support Home. There is currently no required licensure of Crisis Support Homes. However, each Crisis Support Home must receive Standards Compliance Review by DBHDD prior to operation.

F-1. CRISIS SUPPORT HOME PROTOCOL FOR OPERATIONS

Crisis System Response service providers must develop and maintain protocols for the Crisis Support Homes that include but are not be limited to:

- Criteria for determining when and if a referral to a Crisis Support Home is necessary
- Staffing plan to include the minimum staffing of a registered nurse, a licensed professional nurse, day, evening and night staff, a behavior specialist, and a psychologist
- Transportation plan to and from home(s)
- The availability of a licensed clinical social worker to assist crisis support home staff with case management and discharge planning services, to ensure that appropriate referrals and/or coordination of services are part of the transition back to the home environment.

In addition the protocols must meet the following:

1. As a time-limited response, Intensive Out-of-Home Supports are not to exceed a 7 calendar days. Extensions beyond 7 calendar days are the exception and are not typical.
 - a. Exceptions to this timeframe are to be based on extraordinary circumstances assessed daily by the crisis service provider and the support coordinator or planning list administrator if applicable.
 - b. Extensions beyond 7 calendar days are to be approved by the Developmental Disabilities Regional Services Administrator (RSA) for the applicable region. The following criteria must be met for consideration for an extension of the individual's length of stay:
 - i. Discharge criteria noted in Section D 4a-4d have not been met as evidenced by observations, with assessment of outcomes related to clinical interventions documented on a daily basis AND
 - ii. Environmental conditions (due to safety concerns) within the home preclude immediate discharge, AND/OR
 - iii. Extraordinary circumstances regarding the caregiver/provider that negate their ability to provide care for the individual upon discharge as determined by the DD RSA.
2. The development of a discharge plan is to be person-centered, beginning at intake and noting:
 - a. An evaluation of additional supports and services by the support coordinator for individuals with waiver services.
 - b. An evaluation of additional supports and services by the planning list administrator for individuals on the planning list.
 - c. Referral for intake and evaluation by the region I & E Team, to determine eligibility and most in need of services, for individuals not in waiver services.
 - d. Intensive Out-of -Home support staff have trained the personnel in post-crisis services placement and/or family members regarding all interventions utilized in the out-of-home crisis placement.
3. Upon discharge from the Crisis Support Homes, the individuals may:

- a. Return to his/her family home or provider placement;
 - b. Experience a permanent change in provider location. For individuals in waiver services, a permanent change in provider location will require an assessment evaluation as a result of an approved Individual Service Plan (ISP) addendum based upon the long term interests of the individual and in accordance with DBHDD policies.
4. Out-of-Home Support services and discharge planning case management are to be documented daily by appropriate personnel.
 5. Records of pre-service and annual training of Crisis Support Home staff, including names of persons trained, the training source, content, dates, length of training, and copies of certificates received and persons attending must be kept and be readily available.

F-2. CRISIS SUPPORT HOME MINIMUM FLOOR PLAN REQUIREMENTS

1. A residence must be constructed, arranged, and maintained so as to provide adequately for the health, safety, access, and well-being of the individual.
2. A Crisis Support Home must provide for common living space and private sleeping areas.
 - a. The living and sleeping areas for an individual must be within the same building.
 - b. Windows used for ventilation to the outside and exterior doors used for ventilation must be screened and in good repair.
 - c. Supportive devices must be installed as necessary to enable the individual to achieve a greater degree of mobility and safety from falling.
3. All Crisis Support Homes must provide an area that affords privacy for the individual and visitors. There must be common spaces, such as living and dining rooms, for use by the individual without restriction.
4. Common areas of the residence must be large enough to accommodate the individual without crowding. The areas must be comfortably furnished.
5. Upon request, the residence must provide a means of locked storage for the valuables or personal belongings of the individual.
6. The residence must provide laundering facilities on the premises for individual's personal laundry.
7. The following minimum standards for bedrooms must be met:
 - a. Bedrooms must have sufficient space to accommodate without crowding the individual, the individual's belongings, and the minimum furniture of a bed and dresser;
 - b. The individual's bedroom must have at least one window and a closet;
 - c. Bedrooms for individuals must be separated from halls, corridors, and other rooms by floor to ceiling walls. Hallways must not be used for sleeping;
 - d. The floor plan must be such that no person other than the occupant of that bedroom must pass through a bedroom in order to reach another room;
 - e. The bedroom occupied by the individual must have doors that can be closed. For bedrooms that have locks on doors, both the occupant and staff must be provided with keys to ensure easy entry. Double-cylinder locks (locks requiring a key on both sides) may not be used on the bedroom of an individual.

- f. A room must not be used as a bedroom where more than one half of the room height is below ground level. Bedrooms which are partially below ground level should have adequate natural light and ventilation and be provided with two useful means of egress; and
 - g. When an individual is discharged, the room and its contents must be adequately cleaned.
8. The following minimum standards apply to bathroom facilities:
- a. At least one functional toilet, lavatory, and bathing or showering facility must be provided for every four individuals residing in a Crisis Support Home;
 - b. At least one fully handicap accessible bathroom must be available;
 - c. Grab bars and non-skid surfacing or strips must be installed in all showers and bath areas;
 - d. Bathrooms and toilet facilities must have a window that can be opened or must have forced ventilation;
 - e. Toilets, bathtubs, and showers must provide for individual privacy;
 - f. Shower fixtures in bathrooms must be flush-mounted in the wall; and
 - g. All plumbing and bathroom fixtures must be maintained in good working order at all times and must present a clean and sanitary appearance.
9. All stairways and ramps must have sturdy handrails, securely fastened not less than 30 inches nor more than 34 inches above the center of the tread. Exterior stairways, decks, and porches must have handrails on the open sides unless the surface of the deck or porch is so close to ground level that it does not pose a significant risk of injury to the individual to fall from the deck or porch.
10. Floor coverings must be intact, safely secured, and free of any hazard that may cause tripping.
11. All areas including hallways and stairs must be lighted sufficiently.
12. The following exterior conditions must be maintained:
- a. Entrances and exits, sidewalks, and escape routes must be maintained free of any obstructions that would impede leaving the residence quickly in the case of fire or other emergency. All such entrances and exits, sidewalks, and escape routes must be kept free of any hazards such as ice, snow, or debris;
 - b. The yard area, if applicable, must be kept free of all hazards, nuisances, refuse, and litter; AND
 - c. The residence must have its house number displayed so as to be easily visible from the street.

F-3. CRISIS SUPPORT HOME FURNISHINGS AND FIXTURES

- 1. Furnishings of the individual in the living room, bedroom, and dining room, including furnishings provided by the individual, must be maintained in good condition, intact, and functional.
- 2. Furnishings and housekeeping standards must be such that a residence presents a clean and orderly appearance. The Crisis Support Home must provide the following bedroom furnishings based on safety:
 - a. An adequate closet or wardrobe;
 - b. Lighting fixtures sufficient for reading and other activities;
 - c. A bureau, dresser, or the equivalent;

- d. A shatter proof mirror appropriate for grooming;
 - e. A standard, non-portable bed measuring at least 36 inches wide and 72 inches long with comfortable springs and a clean mattress. The mattress must be not less than 5 inches thick or 4 inches of a synthetic construction.
3. The Crisis Support Home must provide to each individual clean towels and washcloths at least twice weekly and more often if soiled.
 4. The Crisis Support Home must provide bedding for each individual including two sheets, a pillow, a pillow case, and a minimum of one blanket and bedspread. The Crisis Support Home must maintain a linen supply for not less than twice the bed capacity.

F-4. CRISIS SUPPORT HOME PHYSICAL PLANT, HEALTH, AND SAFETY STANDARDS

1. Each Crisis Support Home must provide a safe and healthy environment for its individuals, and where subject to fire and safety standards promulgated by Office of the Safety Fire Commissioner, such Crisis Support Home must be in compliance with those standards.
2. Each Crisis Support Home must comply and remain in compliance with any and all local ordinances for fire safety in residences of that size and function. In the absence of or in addition to any such local ordinances, the following requirements must be met:
 - a. Wall-mounted electric outlets and lamps or light fixtures must be maintained in a safe and operational condition;
 - b. Cooking appliances must be suitably installed in accordance with approved safety practices;
 - c. Space heaters must not be used;
 - d. Fire screens and protective devices must be used with fireplaces, stoves, and heaters;
 - e. Sufficient AC powered smoke detectors, with battery backup, must be in place and, when activated, must initiate an alarm that is audible in the sleeping rooms. Strobe alarms must be used when required by the needs of individuals (e.g. for hearing impaired persons). NOTE: Strobe alarms should have the ability to be disarmed for individuals who have epilepsy/seizure disorders that are exacerbated by strobe lighting.
 - f. If natural gas or heating oil is used to heat the residence, or if a wood-burning fireplace is in the residence, the residence must be protected with carbon monoxide detectors;
 - g. Each residence must have at least one charged, 5 lb. multipurpose ABC fire extinguisher on each occupied floor and in the basement that must be readily accessible. These extinguishers must be checked annually by a fire safety technician and monthly by the staff of the Crisis Support Home to ensure they are charged and in operable condition; and Sufficient AC powered smoke detectors with battery backup must be in place and, when activated, must initiate an alarm that is audible in the sleeping rooms.
 - h. Exterior doors must be equipped with locks that do not require keys to open the door from the inside.
3. Water and sewage systems must meet applicable federal, state, and local standards and regulations.
4. Floors, walls, and ceilings must be kept clean and in good repair.

5. Kitchen and bathroom areas must be cleaned with disinfectant and maintained to ensure cleanliness and sanitation.
6. The storage and disposal of biomedical wastes and hazardous wastes must comply with applicable federal and state rules and standards.
7. The storage and disposal of garbage, trash, and waste must be accomplished in a manner that will not permit the transmission of disease, create a nuisance, or provide a breeding place for insects or rodents. Waste must be removed from the kitchen as necessary and from the premises at least weekly.
8. No animals must be kept at the residence;
9. Poisons, caustics, and other dangerous materials must be stored in clearly labeled and appropriate containers, safeguarded in an area away from medication storage areas and from food preparation and storage areas and secured as required by the capacity of the individuals.
10. The Crisis Support Home must be equipped and maintained so as to provide a sufficient amount of hot water for the use of the individuals. Heated water provided for use by individuals must not exceed 120 degrees Fahrenheit at the hot water fixture, unless a cooler temperature is required by the needs of the individual. A water temperature monitor or a scald valve must be installed where necessary to ensure the safety of the individuals.
11. There must be clearly accessible route(s) for emergencies throughout the residence.
12. The temperature throughout the residence must be maintained by a central heating system or its equivalent at ranges that are consistent with individual's health needs. No individual must be in any area of the residence that falls below 65 degrees or that exceeds 82 degrees Fahrenheit.
13. There must be a supply of first-aid materials available with a minimum of the following: bandages, antiseptic, gauze, tape, thermometer, and gloves.

F-5. CRISIS SUPPORT HOME SERVICES

1. Each Crisis Support Home must provide room, meals, and crisis services that are commensurate with the needs of the individuals. Services must be provided by appropriately qualified staff members.
2. Personal hygiene assistance must be given to those individuals who are unable to keep themselves neat and clean.
3. The Crisis Support Home administrator or his or her designee must teach each individual the techniques of "Standard Precautions," as appropriate to the individual's ability, or must support each individual in the performance of the techniques of "Standard Precautions," including washing his or her hands thoroughly after toileting, sneezing, or any other activity during which the individual's hands may become contaminated.
4. The routine of the residence must be such that an individual may spend the majority of his or her non-sleeping hours out of the bedroom if he or she so chooses.

5. The Crisis Support Home administrator or his or her designee must be available to any person within the Crisis Support Home, including each individual served.

F-6. CRISIS SUPPORT HOME RECORD MANAGEMENT

All records must be kept in accordance with requirements of the Department of Behavioral Health and Developmental Disabilities current Provider Manual, Part II, Section I, Community Standards for All Providers.

F-7. CRISIS SUPPORT HOME DOCUMENTATION OF SERVICES

Providers must document the following in the record of each individual based on the plan to support the individual as determined by the assessment team. The following must be on file for each individual:

1. Dates (beginning and ending) of service
2. Completed intake/evaluation documents (Medical and/or Behavioral Assessment)
3. Determined model of support
4. Discharge plan

F-8. CRISIS SUPPORT HOME INDIVIDUAL FILES AND INFORMATION

All individual files and information must be kept in accordance with requirements of the Department of Behavioral Health and Developmental Disabilities current Provider Manual, Part II, Section I, Community Standards for All Providers.

F-9. INDIVIDUAL RIGHTS IN A CRISIS SUPPORT HOME

All services delivered should be in accordance with Client's Rights Chapter 290- 4-9

F-10. ABUSE IN A CRISIS SUPPORT HOME

It is expressly prohibited to Mistreat, Abuse, Neglect, Exploit, and Seclude or Restrain any person(s) service in a Crisis Support Home. These include but are not limited to:

1. Physical Abuse- includes but is not limited to such actions as striking, pulling, pushing, twisting body parts, or inflicting any physical injury to an individual by any means. Physical abuse includes directing one individual to physically abuse another individual.
2. Sexual Abuse- includes but is not limited to sexual assault, rape, fondling, sexual exploitation or any sexual interaction.
3. Mental Abuse- includes but is not limited to any action, which creates mental anguish for the individual. These actions include but are not limited to discriminatory remarks, belittlement, derogatory name-calling, teasing, and unreasonable exclusion from conversation or activities and verbal abuse.
4. Neglect- includes but is not limited to the denial of meals, medication, habilitation and other necessities.
5. Exploitation- includes but is not limited to any illegal or improper action affecting a person or use of the person's resources for another person's profit or advantage.

6. Seclusion, is defined as placing an individual in a locked room, is prohibited. A locked room includes a room with any type of door locking device, such as a key lock, spring lock, bolt lock, foot pressure lock or physically holding the door shut.
7. Physical restraints (i.e., mechanical restraints) - are not used as punishment, for staff convenience, or through a behavioral support plan or behavioral management intervention for purposes of restricting a participant's movement. Those devices which restrain movement, but are applied for protection of accidental injury (such as a helmet for protection of fall due to frequent, severe seizures but not for purposeful head banging or other self-injurious behavior) or required for medical treatment of the physical condition of the participant (such as protection for healing of an open wound) or for supportive or corrective needs of the participant (such as physical therapy devices) are not considered physical restraints.

Refer to the Department of Behavioral Health and Developmental Disabilities current Provider Manual, Part II, Section I, Standards for all Providers for additional details.

F-11. REPORTING AND INVESTIGATION OF DEATHS AND CRITICAL INCIDENTS IN A CRISIS SUPPORT HOME

Death and/or critical incidents of individuals in service must be reported to the Department of Behavioral Health and Developmental Disabilities according to the policy found in the Department of Behavioral Health and Developmental Disabilities current Provider Manual. This policy can be located at the website: <http://dbhdd.georgia.gov/portal/site/DBHDD> (click on *Provider Information*, and the *Provider Tool Kit* for the current *Provider Manual, Policy: Reporting and Investigation of Individual Deaths and Critical Incidents for Community*).

F-12. NUTRITION SERVICES IN A CRISIS SUPPORT HOME

1. A minimum of three regularly scheduled, well-balanced meals must be available seven days a week. Meals must be served in the early morning, at midday, and the evening, with the last meal taking place no earlier than 5:00 P.M. Meals must meet the general requirements for nutrition found in the recommended Daily Diet Allowances, Food and Nutrition Board, National Academy of Sciences or a diet established by a registered dietitian. Meals must be of sufficient and proper quantity, form, consistency, and temperature. Food for at least one nutritious snack must be available and offered mid-afternoon and evening. All food groups must be available within the residence and represented on the daily menu.
2. All foods, while being stored, prepared, or served, must be protected against contamination and be safe for human consumption in accordance with accepted standards for food safety.
3. Food received or used in a Crisis Support Home must be clean, wholesome, free from spoilage, adulteration, and mislabeling, and safe for human consumption.
4. A Crisis Support Home must have a properly equipped kitchen to prepare regularly scheduled, well-balanced meals unless it arranges for meals to be provided by a permitted food service establishment. In such case, a copy of required certification related-health, safety, sanitation is available.

5. A Crisis Support Home must maintain a three-day supply of non-perishable foods and water for emergency needs for all individuals receiving services in the Crisis Support Home and staff assigned.
6. A Crisis Support Home must arrange for and serve special diets as prescribed.
7. The Crisis Support Home shows evidence of individual choice and participation in the planning of meals, as appropriate.

F-13. MEDICATION MANAGEMENT IN A CRISIS SUPPORT HOME

All medication must be kept and administered in accordance with requirements of the Department of Behavioral Health and Developmental Disabilities current Provider Manual, Part II, Section I, Community Standards for All Providers.

F-14. STANDARDS COMPLIANCE REVIEW OF A CRISIS SUPPORT HOME

Each DD Crisis Support Home delivering out-of-home intensive supports must receive a Standards Compliance Review by DHBDD prior to operation. Each DD Crisis Support Home is subject to periodic review by Division and Regional staff and the Standards Compliance Unit. Outcomes of those reviews may include, but are not to be limited to a corrective action required of provider, or a moratorium on the use of the home for out-of-home intensive supports.

F-15. EMERGENCY EVACUATION PLAN FOR CRISIS SUPPORT HOME IN CASE OF NATURAL DISASTER

In the case of a natural disaster (i.e. tornado, flood, hurricane, etc) that requires emergency evacuation of the DD Crisis Home, individuals currently receiving in the home will be transported by the Crisis Provider to the nearest and safest DD Crisis Home. This home does not have to be located within the same Region of the original home.

G. Intensive Out-of-Home Support Requirements for Temporary and Immediate Support Homes

The intent of Intensive Out-of-Home Supports is to stabilize the individual through nursing and behavioral supports on a time-limited basis. Individuals between ages 10-17 years needing this level of care must be served in a Temporary and Immediate Support (TIS) Home. The TIS Home provider must be a Licensed Child Placing Agency. TIS Home supports will be available twenty-four hours a day, seven days a week. It is critical that children and youth remain in their family home environment and thus extraordinary circumstances must exist in order to place children and youth in this level of support.

G-1. TIS HOME PROTOCOL FOR OPERATION

TIS providers must develop and maintain protocols that include but are not be limited to:

- Criteria for determining when and if a referral to a TIS Home is necessary
- Staffing plan to include the minimum staffing of an RN, behavior specialist, TIS coordinator, TIS staff, and a psychiatrist.
- Transportation plan to and from home(s)

In addition, the protocols must meet the following:

1. As a time-limited response, Intensive Out-of-Home Supports are not to exceed 7 calendar days. Extensions beyond 7 calendar days are the exception and are not typical.
 - a. Exceptions to this timeframe are to be based on extraordinary circumstances assessed daily by the support coordinator or planning list administrator.
 - b. Extensions beyond 7 calendar days are to be approved by the Developmental Disabilities Regional Services Administrator (RSA) for the applicable region. The following criteria must be met for consideration for an extension of the individual's length of stay:
 - i. Discharge criteria noted in Section D 4a-4d have not been met as evidenced by observations, with assessment of outcomes related to clinical interventions documented on a daily basis AND
 - ii. Environmental conditions (due to safety concerns) within the home preclude immediate discharge, AND/OR
 - iii. Extraordinary circumstances regarding the care-giver/provider that negate their ability to provide care for the individual upon discharge as determined by the DD RSA.
2. The development of a discharge plan is to be person-centered, beginning at intake and noting:
 - a. An evaluation of additional supports and services by the support coordinator for individuals with waiver services.
 - b. An evaluation of additional supports and services by the planning list administrator for individuals on the planning list.
 - c. Referral for intake and evaluation by the Regional I & E Team, to determine eligibility and most in need of services, for individuals not in waiver services.
 - d. Intensive Out-of-Home support staff have trained the personnel in post-crisis services placement and/or family members regarding all interventions utilized in the out-of-home crisis placement.
 - e. Coordination with the family and/or DD service provider on a plan for return to school/educational activities.
3. Upon discharge from the TIS Home, the individual may:
 - a. Return to his/her family home or provider placement;
 - b. Experience a permanent change in provider location. For individuals in waiver services, a permanent change in provider location will require an assessment evaluation as a result of an approved Individual Service Plan (ISP) addendum based upon the long term interests of the individual and in accordance with DBHDD policies.
4. Out-of-Home Support services and discharge planning case management are to be documented daily by appropriate personnel.
5. Records of pre-service and annual training of TIS Home staff, including names of persons trained, the training source, content, dates, length of training, and copies of certificates received and persons attending must be kept and be readily available.
6. The applicable Regional Office is to be immediately notified of the child/youth's admission into the TIS home.

7. The TIS provider is to collaborate with to all applicable parties (Families/Caregivers, Support Coordination Agencies, Provider Agencies, and/or Regional Office I & E Teams) in order to establish a comprehensive discharge plan. A discharge plan may include “step downs” to a TIS host home model and then back to family or provider with scheduled maintenance respite in place. The TIS host home provider will be required to follow DBHDD and agency policies and procedures. Host Home provider will be required to follow plan of support determined by the assessment team. Additional support will be provided if authorized.

G-2. TIS HOME RECORD MANAGEMENT

All records must be kept in accordance with requirements of the Department of Behavioral Health and Developmental Disabilities current Provider Manual, Part II, Section I, Community Standards for All Providers.

G-3. TIS HOME DOCUMENTATION OF SERVICES

Providers must document the following in the record of each individual based on the plan to support the individual as determined by the assessment team. The following must be on file for each individual:

1. Dates (beginning and ending) of service
2. Completed intake/evaluation documents (Psychiatrist, Medical and/or Behavioral Assessment)
3. Determined model of support
4. Discharge plan

G-4. TIS HOME INDIVIDUAL FILES AND INFORMATION

All individual files and information must be kept in accordance with requirements of the Department of Behavioral Health and Developmental Disabilities current Provider Manual, Part II, Section I, Community Standards for All Providers.

G-5. INDIVIDUAL RIGHTS IN A TIS HOME

All services delivered should be in accordance with Client’s Rights Chapter 290- 4-9

G-6. ABUSE IN A TIS HOME

It is expressly prohibited to Mistreat, Abuse, Neglect, Exploit, and Seclude or Restrain any person(s) service in a Crisis Support Home. These include but are not limited to:

1. Physical Abuse- includes but is not limited to such actions as striking, pulling, pushing, twisting body parts, or inflicting any physical injury to an individual by any means. Physical abuse includes directing one individual to physically abuse another individual.
2. Sexual Abuse- includes but is not limited to sexual assault, rape, fondling, sexual exploitation or any sexual interaction.
3. Mental Abuse- includes but is not limited to any action, which creates mental anguish for the individual. These actions include but are not limited to discriminatory remarks, belittlement, derogatory name-calling, teasing, and unreasonable exclusion from conversation or activities and verbal abuse.
4. Neglect- includes but is not limited to the denial of meals, medication, habilitation and other necessities.

5. Exploitation- includes but is not limited to any illegal or improper action affecting a person or use of the person's resources for another person's profit or advantage.
6. Seclusion, is defined as placing an individual in a locked room, is prohibited. A locked room includes a room with any type of door locking device, such as a key lock, spring lock, bolt lock, foot pressure lock or physically holding the door shut.
7. Physical restraints (i.e., mechanical restraints) – are not used as punishment, for staff convenience, or through a behavioral support plan or behavioral management intervention for purposes of restricting a participant's movement. Those devices which restrain movement, but are applied for protection of accidental injury (such as a helmet for protection of fall due to frequent, severe seizures but not for purposeful head banging or other self-injurious behavior) or required for medical treatment of the physical condition of the participant (such as protection for healing of an open wound) or for supportive or corrective needs of the participant (such as physical therapy devices) are not considered physical restraints.

Refer to the Department of Behavioral Health and Developmental Disabilities current Provider Manual, Part II, Section I, Standards for all Providers for additional details.

G-7. REPORTING AND INVESTIGATION OF DEATHS AND CRITICAL INCIDENTS IN A TIS HOME

Death and/or critical incidents of individuals in service must be reported to the Department of Behavioral Health and Developmental Disabilities according to current fiscal year Provider Manual Part VI Policies Reporting Consumer Deaths and Critical Incidents and Investigating Consumer Deaths and Critical Incidents.

G-8. NUTRITION SERVICES IN A TIS HOME

1. A minimum of three regularly scheduled, well-balanced meals must be available seven days a week. Meals must be served in the early morning, at midday, and the evening, with the last meal taking place no earlier than 5:00 P.M. Meals must meet the general requirements for nutrition found in the recommended Daily Diet Allowances, Food and Nutrition Board, National Academy of Sciences or a diet established by a registered dietitian. Meals must be of sufficient and proper quantity, form, consistency, and temperature. Food for at least one nutritious snack must be available and offered mid-afternoon and evening. All food groups must be available within the residence and represented on the daily menu.
2. All foods, while being stored, prepared, or served, must be protected against contamination and be safe for human consumption in accordance with accepted standards for food safety.
3. Food received or used in a TIS Home must be clean, wholesome, free from spoilage, adulteration, and mislabeling, and safe for human consumption.
4. A TIS Home must have a properly equipped kitchen to prepare regularly scheduled, well-balanced meals unless it arranges for meals to be provided by a permitted food service establishment. In such case, a copy of required certification related-health, safety, sanitation is available.

5. A TIS Home must maintain a three-day supply of non-perishable foods and water for emergency needs for all individuals receiving services in the Crisis Support Home and staff assigned.
6. A TIS Home must arrange for and serve special diets as prescribed.
7. The TIS Home shows evidence of individual choice and participation in the planning of meals, as appropriate.

G-9. MEDICATION MANAGEMENT IN A TIS HOME

All medication must be kept and administered in accordance with requirements of the Department of Behavioral Health and Developmental Disabilities current Provider Manual, Part II, Section I, Community Standards for All Providers.

H. Quality Assurance and Standard Compliance Requirements

In conjunction with DBHDD, the Providers of the DD Crisis Response System should develop performance indicators and outcome measures for each stage of the Georgia Crisis Response System. Once baseline data has been collected, DBHDD will develop specific performance indicators and outcome goals for the system. These indicators and outcomes will allow DBHDD to monitor the crisis response system and make quality improvement decisions based on data collected.

1. Providers of the DD Crisis System must develop a quality assurance system that will generate monthly reports to include, but not limited to, the following:
 - a. Reason for crisis call
 - b. Site of crisis (including DBHDD Region)
 - c. Demographic information of the individual in crisis (including Medicaid status)
 - d. Provider (include a category of none)
 - e. Family Involvement
 - f. Final outcome of crisis incident
 - g. Dispatch team response time
 - h. Services received (include a category of none, behavioral health services)
 - i. Waiver or planning list status (if yes on planning list, include level of planning list: if yes on waiver, indicate which waiver, including NOW, COMP, ICWP, SOURCE, CCSP, Unknown)
 - j. Support coordination agency, if applicable
 - k. Incidences of mobile crisis team dispatch to emergency rooms
 - l. Incidences of intensive in-home and out-of-home crisis supports
 - m. Number of days of use of intensive in-home and out-of-home crisis supports
 - n. Recidivism of individuals and providers in relation to utilization of Georgia Crisis Response System
 - o. Referrals by crisis service providers to Child Protection Services and Adult Protection Services
2. The Crisis Response System service provider must participate in data collection and generate monthly quality assurance reports for submission to DBHDD- Division of Developmental Disabilities, Outcomes and Quality Assurance Office.

I. STAFFING REQUIREMENTS

Qualifications and Standards of Crisis Response System provider professional staff:

1. Qualifications of Professional Social Worker (as defined for the purposes of the Georgia Crisis Response System must meet the following standards):
 - a. Clinical social work licensure (LCSW) issued by the State of Georgia that is current and unrestricted AND
 - b. Advanced skill in crisis intervention, conducting assessments and/or evaluations, and developing interventions using accepted standards of care AND
 - c. Knowledge of federal, state, and local programs that have been developed for people with developmental disabilities including eligibility criteria and how to access these services AND
 - d. Advocacy experience and knowledge of the Individuals with Disabilities Education Act (IDEA), and the Americans with Disabilities (ADA) Act and their legal mandates as they relate to special education programs and the rights of people with disabilities.
2. Professional Social Worker Standards:
 - a. Social workers must adhere to the values and ethics of the social work profession, utilizing the National Association of Social Workers (NASW) Code of Ethics as a guide to ethical decision making.
 - b. Social workers must adhere to clinical practice guidelines outlined in the NASW Standards for Clinical Social Work in Social Work Practice.
 - c. In accordance with the NASW Standard for Continuing Professional Education and the Georgia State Composite Board's licensure requirements for Continuing Education Units, clinical social workers should obtain any applicable certifications for crisis intervention curricula approved by DBHDD.
3. Qualifications of Registered Nurse (as defined for the purposes of the Georgia Crisis Response System must meet the following standards):
 - a. Must be a Registered Nurse with an unrestricted license to practice nursing in the state of Georgia AND
 - b. Have experience in caring for individuals with developmental disabilities who are in crisis.
4. Professional Registered Nurse Standards:
 - a. The Registered Nurse is committed to promoting health through assessment, nursing diagnosing, planning, intervention, evaluation and treatment of human responses when faced with a crisis. The Registered Nurse employs a purposeful use of self as its art and a wide range of nursing, psychosocial and neurobiological theories and research evidence as its science.
 - b. The Registered Nurse will adapt the American Nurses Association Code of Nursing standards and use these standards as comprehensive holistic assessment prior to engaging in any plan to resolve a crisis. The Registered Nurse will be directly involved in all aspect of crisis intervention by utilizing the nursing process.
5. Qualifications of Licensed Practical Nurse (as defined for the purposes of the Georgia Crisis Response System must meet the following standards):
 - a. Must be a Practical Nurse with an unrestricted license to practice nursing in the state of Georgia under the supervision of a Registered Nurse AND
 - b. Have experience in caring for individuals with developmental disabilities who are in crisis.

6. Professional of Licensed Practical Nurse Standards:
 - a. The Licensed Practical Nurse must accept the responsibilities as an accountable member of the health care team AND
 - b. Shall function within the limits of educational preparation and experience as related to assigned duties AND
 - c. Function with other members of the health care team in promoting and maintaining health, preventing diseases and disabilities in order to obtain optimal health, utilizing the nursing process under the supervision of the Registered Nurse.
7. Qualifications of Behavioral Specialist (as defined for the purposes of the Georgia Crisis Response System must meet the following standards):
 - a. Possess a minimum of a Masters degree in psychology, behavior analysis, education, social work or a related field AND
 - b. Possess specialized training and education in behavioral analysis and positive behavioral supports for people with developmental disabilities by provision of evidence of a minimum of thirty-five (35) hours of training and education in behavior analysis and behavioral supports for individuals with developmental disabilities, which may include college transcripts and/or copies of training certificates or evidence of national certification as a Board Certified Behavior Analyst through documentation of a certificate from the Behavior Analyst Certification Board AND
 - c. Have at least two years experience in behavioral supports evaluation and services for people with developmental disabilities.
8. Behavior Specialist Standards: Behavior Specialists are to adhere to the *Best Practice Standards for Behavioral Support Services*
9. Qualifications of Physician:
 - a. Graduate of medical or osteopathic college; AND
 - b. Licensed by the Georgia Composite Board of Medical Examiners

J. Definitions

1. Crisis Services: Occur through intensive on-site or off-site supports. This system will be an alternative to emergency room care, law enforcement involvement, and/or institutional placement. Crisis services are time-limited and present-focused in order to address the immediate crisis and develop appropriate links to alternate services.
2. Crisis Support Home: A home that serves up to four (4) individuals who are experiencing an emotional/behavioral change and/or distress that leads to a disruption of essential functions, which have not responded to Intensive-In-Home Support services.
3. Developmental Disability: An individual is determined to have developmental disability by a professional licensed to make this determination. The developmental disability is attributable to a significant intellectual disability, or any combination of a significant intellectual disability and physical impairments. The developmental disability manifests before the individual attains age 22 years and is likely to continue indefinitely.

4. Intensive Case Management: is a time-limited service that connects the individual in crisis to the necessary services and supports to ameliorate the crisis situation, coordinates with stakeholders to assure the development of a discharge plan from crisis support services, and ensures follow up on recommended supports/services.
5. Mobile Crisis Team: The mobile crisis team is composed of personnel with differing levels of expertise and training. Depending on the crisis, different team compositions may be dispatched. A minimum of three team members, including a behavior specialist, licensed clinical social worker, and a direct support staff, will respond to each mobile dispatch.
6. Safety Officer: An individual who provides support related to safety issues during the provision of GCRS-DD service. This individual is to have safety related training and dressed in a safety related uniform. A GCRS-DD safety officer must not carry any form of a weapon (such as a gun, any form of a “billy club”, baton”, hand cuffs, taser gun),
7. Temporary Intermediate Support (TIS) Home: A TIS Home is to serve no more than four children ages 10 thru 17 years of age, who are diagnosed with a developmental disability and are undergoing an acute crisis that presents a substantial risk of imminent harm to self or others. Placement in a TIS home is to only occur as a last result and after a clinical determination for this level of placement has occurred.

Part III

**Community Service Standards Specific for
Developmental Disabilities Services**

SECTION II

***Operational Standards for
Host Home/Life-Sharing***

Fiscal Year 2012



**Georgia Department of Behavioral Health &
Developmental Disabilities**

April 2012

DBHDD



Department of Behavioral Health and Developmental Disabilities

Host Home/Life-Sharing Standards

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GENERAL PROVISIONS

Introduction

Host /Life-Sharing means living with and sharing life experiences with supportive persons who form a caring household. A Host Home /Life-Sharing residential setting is recognized as being both a close personal relationship and a place to live.

Host Home/Life-Sharing is based on the importance of enduring and permanent relationships as the foundation for learning life skills, developing self-esteem and learning to exist in interdependence with others. The Host Home/Life- Sharing experience provides an opportunity for each individual with developmental disability to grow and develop to his or her greatest potential and to participate in everyday community life. This is an important feature of a Host Home/Life-Sharing arrangement. Host Home/Life-Sharing also provides individualized attention based on the needs of the individual with developmental disabilities.

Life-Sharing is a process. A key to successful Life-Sharing is finding a family or person who is willing to share their lives with an individual with developmental disabilities. The matching process between people who want to Life-Share is critical to predicting future success of the relationship.

Purpose

The purpose of these Standards is for the protection, health, safety and well being of individuals with developmental disabilities, through the formation, implementation and enforcement of minimum requirements for Host Home/Life-Sharing as a residential service option.

Applicability

These Standards apply to Host Home /Life Sharing for adults with developmental disabilities.

These Standards contain the minimum requirements that are to be met to receive funding for individuals approved to receive community residential services by the Division of Developmental Disabilities (DD), of the Department of Behavioral Health and Developmental Disabilities (DBHDD).

These Standards apply to profit, nonprofit and publicly funded agencies approved as developmental disability residential providers offering Host Home/Life-Sharing service option.

The Department of Behavioral Health and Developmental Disabilities (DBHDD) is to enroll and approve each Community Residential Alternative (CRA) agency administering one or more Host Home /Life-sharing residential setting as part of the waiver provider enrollment process. The Support Coordination Agency or DBHDD designee for any individual choosing this residential option is to inspect the home using the Division of Developmental Disabilities approved Site Inspection tool prior to an individual with developmental disability living or receiving Host Home/Life-Sharing care in this setting.

Exemptions

These rules do not apply to the following facilities:

1. Private homes of persons providing care to a relative with developmental disability.
2. A community home licensed by Georgia Healthcare Facility Regulations (HFR) as a Community Living Arrangement.

3. Approved Foster Homes for Children operating under a Child Placement Agency licensed by Georgia Office of Residential Child Care.
4. A home operating under permit by the Georgia Healthcare Facility Regulations (HFR) as a Personal Care home exclusively serving people with mental illness, addictive diseases, or domiciliary care residents.
5. Residences in which a person lives with his or her family.
6. Boarding homes or rooming homes that provide personal services other than lodging and meals.
7. Facilities offering temporary or emergency shelter, such as those for the homeless or victims of family violence.
8. Respite homes
9. Emergency receiving, evaluation, and treatment facilities that provide medical and nursing services that are approved by the state and regulates under the more specific authorities.
10. Facilities providing residential services for federal, state or local correctional institutions under the jurisdiction for the criminal justice system.
11. Hospice that serve terminally ill persons.
12. Therapeutic substance abuse treatment facilities and residence that are not intended to be an individual's permanent residence.
13. Group residences organized by or for persons who choose to live independently and manage their own care and who share the cost of service including but not limited to attendant care, transportation, rent utilities and food preparation.
14. Charitable organizations providing shelter and other services without charging any fee to the resident and without billing other agencies for service provided.
15. A single person residence owned and operated by an agency.
16. Residences in which a person lives under his or her own lease or warranty deed, in which the agency providing services do not manage the person's residence and the resident, is not required to move when the agency providing services changes.
17. Apartments or other clustered residential arrangements where staff is available that are developed as permanent housing for adult with mental illness, in which an individual lives within his or her residential arrangement with immediate support of staff

Definitions

The following words and terms, when used in these Standards, have the following meanings, unless the content clearly indicates otherwise:

Agency - A legally constituted organization administering one or more Host Home /Life-Sharing residential settings.

Alternate care – Temporary Host Home/Life-Sharer care not to exceed 30 days for an individual in their Individual plan year.

Community Residential Alternative (CRA) – Services which are targeted for individuals who require intense levels of residential supports in small group setting of four or less, foster homes, or Host Homes and include range of interventions with particular focus on training and support in one or more of the following areas: eating, drinking, toileting, personal grooming and health care, dressing, communication, interpersonal relationships, mobility, home management and use of leisure time.

DBHDD – The Department of Behavioral Health and Developmental Disabilities

DCH – The Department of Community Health

Developmental Disability – A disability that is present in early life and prior to age 22 with related conditions similar to the limitations in everyday life functions present for someone with developmental disabilities.

Host Home– The private home of an individual or a family, whether owned or leased, in which residential supports are provided to one or two adult individuals, defined as 19 years of age and above with developmental disability. The home owner or lessee is not to be an employee of the same DBHDD approved provider agency, which provides the Host Home services. Individuals are not to be related to the occupant owner or lessee by blood or marriage. The occupant owner or lessee is not to be the guardian of any person served on their property nor the agent in such person’s advance directive for health care.

The term does not include a home if there are more than two individuals, including individuals receiving alternate care or respite care, living in the home at any one time, who are not family members, relatives or non-relatives of the family member. The total number of family members, relatives and non-relatives living in the home at any given time may not exceed six. This number does not include the individual(s) being served.

Individual – A person with developmental disability who resides, or receives residential care, in a Host Home/Life-Sharing residential setting and who is not a relative of the owner or the family members. The term does not include family members.

ISP – Individual Service Plan

Regional Office – Regional offices are the field operations offices of the Department of Behavioral Health and Developmental Disabilities.

Relative- A parent, child, stepparent, stepchild, grandparent, grandchild, brother, sister, half -brother, half-sister, aunt, uncle, niece or nephew.

GENERAL REQUIRMENTS

Waivers

A waiver of a specific section, subsection or paragraph of these subsections may be requested by writing to the Regional Office of Behavioral Health and Developmental Disabilities in accordance with Division Policy: *Request for Waiver of the Standards* at the website:

<http://dbhdd.georgia.gov/portal/site/DBHDD> (click on *Provider Information* and *Provider Tool Kit* for the current *Provider Manual*).

A waiver will be considered if all of the following criteria are met:

1. The waiver does not jeopardize the health, safety or well-being of any of the individuals in the home.
2. The waiver is based on the best interests and needs of the individuals.

3. Noncompliance with the guideline is of greater benefit to the individual than compliance with the Operational Procedures.
4. There is not an alternative method to meet the intent of the Operational Procedures.
5. There are special circumstances that make the home different from other homes complying with the Operational Procedures.
6. The waiver does not violate any other State regulation or statute.
7. There is only one provider per Host Home/ Life-Sharing environment.

Maximum capacity

No more than two (2) individuals with developmental disabilities served may live in the household.

Responsibility for Compliance

If the agency is the legal entity approved as a Developmental Disabilities Provider to provide Host Home/ Life-Sharing, the agency is responsible for compliance to the following:

1. Host Home/Life-sharing Standards located at the website: **<http://dbhdd.georgia.gov/portal/site/DBHDD>** (click on *Provider Information*, then the *Provider Tool Kit*).
2. *COMP Supports Waiver Program, Part II and Part III, and Part I Policies and Procedures for Medicaid PeachCare for Kids*, located at website: **www.mmis.georgia.gov**
3. The current *Provider Manual, Part II, Section I, Standards for all Providers* located at the website: **<http://dbhdd.georgia.gov/portal/site/DBHDD>** (click on *Provider Information*, then the *Provider Tool Kit*).

Self-Assessment of the Host Home/Life-Sharing Residential Setting

The agency is to complete a self-assessment of each Host Home site annually, to measure and record compliance with the Host Home/Life Sharing Standards.

To measure and record compliance, the agency is to utilize the Host Home/Life Sharing Standards, located at the website: **<http://dbhdd.georgia.gov/portal/site/DBHDD>** (click on *Provider Information*, then the *Provider Tool Kit*, for the current *Provider Manual, Part II, Section I, Standards for all Providers*).

A copy of the agency self-assessment results and a written summary of corrections made are to be kept in the Host Home/Life –Sharing residential setting for at least one (1) calendar year.

Home Study Requirements

The agency is to make a thorough evaluation of each prospective Host Home family (or current Host Home/Life-Sharing Residential Setting). The evaluation is to be documented in the study report, which is to be updated as changes in the required home study information occur, and include at least the following:

1. Full legal name of applicant, date of assessment, the family address and telephone number.
2. Description of the home and community, including, but are not limited to:
 - Type of home (i.e. ranch, 2 stories)
 - Rooms in the home (Include basement and attic)
 - Number of steps to the front and back door if applicable
 - Handicap Accessibility Features if any
 - Sleeping arrangements for the potential placement(s)

- Description of the neighborhood. List accessible community services and activities (Include access to hospitals/urgent care facilities, churches, schools, Physicians, YMCA etc.)
 - Public Transportation (Document distance from home to public transportation)
 - Physical Standards of the home, including:
 - a. Fire extinguishers (Note type, number and location)
 - b. Smoke and/or carbon monoxide detectors (Note functionality, number and location)
 - c. Is there a swimming pool? Is it secured by fence or gate?
 - d. Is there a locked box/space (note where medications will be locked and hazardous chemicals will be kept)
 - e. Do you have pets? Type and how many?
3. A description of family members/individuals living in the home, including:
- Date and Place of birth
 - Physical description
 - Family background and history
 - Current relationships with immediate and extended family members or other persons residing in the home
 - Educational background
 - Relationship to applicant(s)
4. A statement as to whether or not there are firearms kept in the home and if so, all firearms owned and in the home are unloaded, secured and locked in a cabinet with ammunition stored in a separate locked cabinet. If firearms are stored in an official gun cabinet, ammunition may also be stored in the same gun cabinet; however, the ammunition must be kept in a locked container or locked in a separate compartment of the gun cabinet.
5. Availability of Supervision:
- Describe the work schedule of all members of the household
 - Current relationship with extended family members
 - Support network in place for the Life-Sharing family
 - Willingness to cooperate with the DBHDD approved agency
6. Family Dynamics:
- Interest and Hobbies (include clubs, groups, associations etc.)
 - Personality of each member of the household
 - Interaction and relationship with neighbors
 - Examples of ways each person in household tend to interact with others in the home
 - Examples of ways each family member react to stress and coping strategies used
 - Family meal-time interaction (include what meals family eat together if applicable)
 - Family activities after work/school to bedtime
 - Description of a typical Saturday, Sunday, Holiday and vacations
 - Church or other religious relationship
 - Acceptance of an individual(s) of another culture/ethnicity. (Include response to various cultural issues i.e. religious practices, eating habits, holiday traditions)
 - Attitudes on potential placement(s) dating
 - Alcohol or drug use in the family (Include history and where alcohol is stored)
 - Anticipated adjustment of each Life-Sharing member to a potential placement

7. Experience and Expectations:
 - The motivation for Life-Sharing including but not limited to attitudes towards an individual with developmental disability
 - Document the following:
 - a. Whether or not the potential Life-Sharing family worked for another provider (in or out of state)
 - b. Whether or not the potential Life-Sharing family ever been denied
 - c. Whether or not the potential Life-Sharing family been investigated for any serious reportable incident
 - Knowledge of developmental disabilities, attitudes and skills
 - Methods of discipline used by applicant if applicable
 - Discuss training and compliance requirements (Include Host Home/ Life-Sharing Operating Procedures, DBHDD Provider Manual, DCH Waiver Manual and Agency Policy and Procedures)
 - Attitudes towards family involvement of the potential placement
 - Description of experience with working with individuals with MRDD, if applicable
8. A description of the type of individual desired by the prospective Life- Sharer
9. A general health examination of each member living in the prospective Host Home/Life-Sharing residential setting
10. Screening for tuberculosis and communicable disease for each member living in the prospective Host Home/Life-Sharing residential setting
11. Criminal Records Check/Clearance
12. Who will be transporting the individual(s) and how would transportation be provided
13. A minimum of three (3) character references;

At least one reference is to be from an extended family member not residing with the prospective Host Home/Life-Sharing family,

And

If any member of the potential Host Home/ Life-Sharing family has either served previously as a provider for another agency, and/or been employed within the past five (5) years in a job involving the care of individuals with DD, at least one reference must be from the former agency or employer. In addition, documentation must be provided if any member of the potential Host Home/Life-Sharing family has been terminated as a provider/agency and any adverse actions taken by DBHDD or another state entity.

14. Proof of homeowner's, renter's insurance or personal property insurance
Note: Insurance must be kept current.
15. Proof of potential Life-Sharer's home ownership (ex. mortgage statement) or current lease
16. Signed statement from the potential Life-Sharer (s) indicating the receipt and review of the Host Home/ Life-Sharing Standards and the Policy: *Enrolling, Matching and Monitoring Host Homes for Community Providers Serving Individuals With DD.*
17. The home study is to be completed, signed and dated by a designated employee of the agency or professional under contract with the agency and reviewed, signed and dated by the Agency Director or Developmental Disabilities Professional (DDP)

18. Documentation of any recommendation regarding approval as a prospective Life-Sharer, including description of identified training or resources needed, and that the prospective Life sharers possess the capacity to provide room, board and watchful oversight
19. Notification of Approval. Prospective Host Home/Life-Sharer(s) will be notified in writing as to whether or not they have been approved by the agency

Inspection of Homes

The agency will complete a site inspection of each home the agency has approved to operate.

All inspections and investigations by DBHDD may be unannounced and without prior notice. The Host Home/Life-Sharing provider or any adult living in the home (excluding the individual(s) served) must be present during any inspection of the home. The inspector must have access and authority to examine quality of care and services delivery, the individual's records, physical premises, including the condition of the home, grounds and equipment, food, water supply, sanitation, maintenance, housekeeping practices and any other areas necessary to determine compliance with these Standards.

The inspector has the authority to interview the host home provider, any adults living in the home, the individual and the individual's family. Interviews with the individual will be confidential and conducted privately unless otherwise specified by the individual.

M.A.N.E.

It is expressly prohibited to Mistreat, Abuse, Neglect or Exploit any person(s) receiving host/life sharing service. Mistreatment, abuse, neglect and exploitation is defined as, but not limited to:

Physical Abuse- includes but is not limited to such actions as striking, pulling, pushing, twisting body parts, or inflicting any physical injury to an individual by any means. Physical abuse includes directing one individual to physically abuse another individual.

Sexual Abuse- includes but is not limited to sexual assault, rape, fondling, sexual exploitation or any sexual interaction.

Mental Abuse- includes but is not limited to any action, which creates mental anguish for the individual. These actions include but are not limited to discriminatory remarks, belittlement, derogatory name calling, teasing, unreasonable exclusion from conversation or activities and verbal abuse.

Neglect- includes but is not limited to the denial of meals, medication, habilitation and other necessities.

Exploitation- includes but is not limited to any illegal or improper action affecting a person or use of the person's resources for another person's profit or advantage.

Reporting and Investigation of Deaths and Critical Incidents

Death and/or critical incidents of individuals in service will be reported to the Department of Behavioral Health and Developmental Disabilities according to the policy found in the Department of Behavioral Health and Developmental Disabilities current Provider Manual, at the website:

<http://dbhdd.georgia.gov/portal/site/DBHDD> (click on *Provider Information*, and the *Provider Tool Kit* for the current *Provider Manual, Policy: Reporting and Investigation of Individual Deaths and Critical Incidents for Community Services*)

Criminal History Check/Clearance

National Crime Information Center criminal records check (NCIC) and Georgia Crime Information Center (GCIC) state criminal history record check/clearance documentation is required for all Host Home contractors and any adults living temporary or permanently, who have direct care, treatment, or custodial responsibilities for participants served by the agency.

The requirements apply to any person seventeen (17) years of age or older who moves into the home and any person who reaches the age of eighteen (18) years, after the individual lives in the home.

Any person who is a visitor in the home is not required to have a criminal records check/clearance but must not have unsupervised contact with the individual(s) receiving services.

Only Cogent/GAPS or DHS-DFCS Offices will be used to obtain GCIC/NCIC fingerprint results. For more information regarding GAPS enrollment, registration, print and locations go to Cogent's website www.ga.cogentid.com

Criminal history record check/clearance is to have been completed no more than one (1) year prior to an individual living or receiving alternate care in the home.

A copy of the final criminal history reports is to be kept in the provider agency record. The agency must have a policy and procedure for ongoing criminal history monitoring. *Refer to the Provider Manual, Part II, Section I, Standards for all Providers* at the website. <http://dbhdd.georgia.gov/portal/site/DBHDD> (click on *Provider Information* and *Provider Tool Kit* for the current *Provider Manual*).

Individuals that are served are excluded from criminal background check/clearance.

Character References

A minimum of three (3) character references are required.

At least one reference is to be from an extended family member not residing with the prospective Host Home/ Life-Sharing family; and if the prospective Host Home/Life-Sharing family has either served previously as a provider for another agency, and/or been employed within the past five (5) years in a job involving the care of individuals with MRDD, at least one (1) reference must be from the former agency or employer.

Individual Funds and Property

The provider agency is to have a written policy that establishes procedures for the protection and adequate accounting of individual funds and property, and for advising the individual concerning the use of the funds and property.

The policy may not prohibit or interfere with the individual's right to manage her or his own finances.

An individual's personal funds include but are not limited to savings/checking account and other investment accounts, earned income and the remaining portion from SSI payment for day-to-day living expenses.

An individual's funds and property are to be used for the individual's benefit.

An up-to-date financial and property record is to be kept for each individual. This record is to include the following:

1. Personal possessions and funds received by or deposited with the family or agency.
2. Disbursements made to and for the individual.

If the agency or Host Home/Life-Sharing family assumes the responsibility for an individual's financial resources, the following is to be maintained for each individual:

1. A separate record of financial resources including the dates and amounts of deposits and withdrawals.
2. For a withdrawal when the individual is given the money directly, the record will indicate that the funds were given directly to the individual.
3. Documentation, by the actual receipt or expense record, of each single purchase made on behalf of the individual carried out by the family member or agency staff.

There may not be commingling of the individual's personal funds with agency or household funds.

There may not be borrowing of the individual's personal funds by family members or agency staff.

Driver License and other Access to Transportation

For providers transporting individuals in their personal vehicles, at least one adult member of the Host Home/Life-Sharing household will have a valid Georgia Driver's License and access to a properly operating vehicle covered under Georgia Vehicle Insurance requirements.

A *Driving History Report (MVR)* is required for any member of the household responsible for transporting the individual. There must be no more than two chargeable accidents, moving violations or DUI's in a three (3) year period, within the last five (5) years of the seven (7) year Motor Vehicle (MVR) period.

Providers residing near public transportation and who are currently using this mode of transportation are required to submit documentation verifying that the home has access to public transportation within a one-fourth (1/4) mile walking distance from the Host Home/Life-Sharing residence.

ENROLLING HOST HOMES

Current and New DBHDD providers must meet the following requirements prior to enrolling a Host Home as a CRA service option:

1. DBHDD provider must be a provider of DD Community Residential Alternative (CRA) services

AND

2. DBHDD provider must be in business for twelve (12) months delivering Developmental Disabilities (DD) Community Residential Alternative services

AND

3. DBHDD providers cannot enroll any Host Home/Life-Sharing residence until the CRA service/site in the initial provider application have successfully achieved full accreditation and/or complete compliance with the Standards Compliance Review, for a minimum of six (6) months. Provisional status of any type will not be accepted.

DBHDD provider agencies are required to make a thorough evaluation of each prospective Host Home family/individual, and document this evaluation in a Host Home study report. This will be completed and/or updated as changes in the required home study information occur or when there is a vacancy to be filled.

Note:

- 1. Only one (1) DBHDD approved CRA provider agency may enroll and provide CRA services at any Host Home site.**
- 2. Host Home providers cannot be the owner of a Personal Care Home (PCH) or Community Living Arrangement (CLA), either of which provide services to COMP waiver participants.**

Based on the Host Home study report and any supporting documents, the DBHDD provider agency will notify the potential Host Home provider in writing as to whether or not the Host Home provider has been deemed appropriate to work with their organization.

Each Host Home must have a site specific Medicaid Provider (CRA) number assigned by the Department of Community Health (DCH) before placement of any person into that particular Host Home.

DBHDD provider agencies must submit the Host Home study, all supporting documentation, and Host Home provider's evidence of required competency-based training, along with the DBHDD and DCH application for a site specific number to DBHDD Office of Provider Network Management for review.

Supporting documents for the Host Home study include the following:

1. A general health examination of each member living in the potential Host Home
2. Evidence of screening for tuberculosis and communicable disease for each member living in the potential Host Home
3. National Criminal records check/clearance
4. A minimum of three (3) character references
5. Proof of homeowner's, renters insurance or personal property insurance
6. Statement as to whether or not there are firearms in the home
7. Documentation of home ownership (ex. current mortgage statement) or renter's lease. Document(s) must be in the name of the potential Host Home provider.
8. The home study will be completed, signed and dated by a designated employee of the agency or professional under contract with the agency and reviewed, signed and dated by the Agency Director or Developmental Disabilities Professional (DDP).
9. Signed statement from potential Host Home provider indicating the receipt and review of the Host Home/ Life-Sharing Standards.

The adult family member who will have primary responsibility to the individual and for providing services to the individual will have at least the following training *prior* to the DBHDD provider agency submission of an application for a site specific Medicaid provider number:

1. Person-Centered Values, Principles And Approaches
2. Human Rights and Responsibilities
3. Recognizing and Reporting Critical Incident
4. Individual Service Plan
5. Confidentiality Of Individual Information, Both Written And Spoken
6. Fire Safety
7. Emergency and Disaster Plans and Procedures
8. Techniques Of Standard Precautions
9. Basic Cardiac Life Support (BCLS)
10. First Aid and Safety
11. Medication Administration and Management/Supervision Of Self-Medication
12. Agency Policy And Procedures

The DBHDD provider agency must submit evidence of the type of training, content, dates, length of training, and/or copies of certificates. A signed attestation between the agency and the potential host home provider, which indicates the receipt of trainings, must also be submitted.

Host Home applications must not be submitted for any location that is currently licensed as a PCH or CLA. Licensed PCH or CLA providers must relinquish their license prior to making application to become a Host Home. A Host Home study must be submitted, along with documentation of the surrender of the perspective license and the required trainings (by evidence of training certificate or signed attestation indicating receipt of training), to DBHDD Office of Provider Network Management.

PROCEDURE FOR MATCHING INDIVIDUAL AND HOST HOME PROVIDER

When an individual is identified for potential placement in a Host Home, provider agencies must forward a summary of the Host Home study report to Support Coordination or the Planning List Administrator. A summary of the Host Home study may include, but is not limited to: the address and access to local services; the current living arrangement; names and ages of the family/individuals residing in the home; family/individuals' previous work history, education and religious affiliation, membership or participation in community organizations; the DBHDD provider recommendations.

DBHDD provider agencies will discuss the prospective placement with the Host Home family/individual, and prepare the family/individual for the placement of a particular person with developmental disabilities by anticipating the adjustments and problems that may arise during placement, and providing any specialized training and support.

The Host Home study report must be reviewed by all stakeholders involved in placement planning to ensure an appropriate match between the individual and the Host Home provider.

Submission Of Information To The Division Of Developmental Disabilities

The DBHDD provider agency must submit specified information to the Division of Developmental Disabilities pertaining to administrative cost and payment to the Host Home /Life-Sharing Provider

The requirements for administrative costs of the CRA provider agency and the agency's payment to the Host Home/Life-Sharing provider are as follows:

1. The budget and payment to the Host Home/Life-Sharing provider for each individual in each Host Home/Life-Sharing services enrolled by the DBHDD provider agency must support the amount of payment to the Host Home/Life-Sharing provider that allows for the provision of the CRA services specified in the ISP of the individual, and ensures the health and safety of the individual in the Host Home/Life-Sharing arrangement.
2. The budget and agreed payment of the Host Home/Life-Sharing provider must be submitted to the Division of DD prior to any individual moving into a Host Home/Life-Sharing residential setting, whenever there is an enhancement or decrease in the individual's residential allocation, and on an annual basis (by June 30). Host Home/Life-Sharing providers of individuals with exceptional rates receive a higher payment based on enhanced services provided by the Host Home/Life-Sharing provider.
3. Each individual's budget submitted to the Division of DD must include, but is not limited to the individual's name and Medicaid number, address and contact information of the Host Home/Life-Sharing.

Provider agencies must comply with Division of Developmental Disabilities Policy: *Management/Supervision/Safeguarding of Possessions, Valuables, Personal Funds and Day-To-Day Living Expenses in Developmental Disabilities Residential Services* in the current Provider Manual at the website <http://dbhdd.georgia.gov/portal/site/DBHDD/> (click Provider Information and Provider Tool Kit).

1. The CRA Provider is to make available to individuals, who reside in agency operated Host Homes /Life-Sharing residence a day-to-day living expenses agreement upon admission, annually, or as needed. The day-to-day living expenses agreement is reviewed at the annual ISP. The day-to-day living expenses agreement includes a statement of all associated housing and food costs; and any estimated medical, dental, and clothing fees or charges assessed to the individual, to the extent that those funds are available. Any changes in charges for day-to-day living expenses are provided to the individual served and the agency operated Host Home/Life-Sharing Provider, in writing, 60 days prior to changes in charges. Copies of each day-to-day living expenses agreement are maintained in the record of the person served.
2. Day-to-day living expenses agreement must be signed by the CRA Provider agency and Host Home/Life Sharing Provider and submitted to the Division of Developmental Disabilities annually (by June 30th) or whenever there is a change of the Host Home/Life-Sharing Provider serving the individual, or prior to any individual moving into the home.
3. Day-to-day living agreements are to be mailed to:
Division of Developmental Disabilities
Attn: Sherry Newton, Administrative Operational Manager
2 Peachtree Street, Suite 22-413
Atlanta, GA 30303

PROCEDURE FOR MONITORING HOST HOMES

DBHDD provider agencies will ensure compliance with the Host Home/ Life-Sharing Standards, DCH COMP Waiver and current Fiscal Year (FY) DBHDD Provider Manual.

DBHDD provider agency will complete an initial Site Inspection of each Host Home/Life-sharing residential setting the agency has approved to operate. The Support Coordinator or DBHDD Regional Office designee will conduct a follow-up site inspection.

Support Coordinator and/or the Planning List Administrator will conduct home visits, at least on a monthly basis, to monitor the person's progress in the specific Host Home/Life-Sharing setting, and to ensure that Host Home/Life-Sharing services is delivering the supports in accordance with the individual's ISP.

DBHDD provider agency will conduct home visits at least monthly, in order to verify that the Host Home is delivering care, room and watchful oversight in a safe and healthy environment. The DBHDD provider agency is to evaluate and document the following during each visit:

1. Available services, supports, care and treatment. This includes, but is not limited to the service needs addressed in the ISP.
2. Human and Civil Rights are maintained.
3. Oversight of Self-Administering of Medication Administration (if applicable) or that the administering of medication follows federal and state laws, rules and regulations.
4. Person Centered Focus is Evident in Documentation.
5. Information and documentation management is protected, secure, organized and confidential.
6. The host home environment demonstrates respect for the individual(s) served and is appropriate to the supports provided. This includes, but is not limited to, the physical environment, review of disaster and fire safety plan, required training, community inclusion, personal funds, and vehicle transportation requirement.

This evaluation is to be shared with the Host Home family/individual and made available for review by the Support Coordinator or DBHDD staff as evidenced by the signature of the Host Home family/individual and the DBHDD provider agency. A copy of each monthly visit and written summary of corrections are to be kept in the Host Home.

The DBHDD provider agency will complete an annual summary of each monthly home visit. The summary is to include, but is not limited to all items identified in the above sections 1-6. A copy of the annual summary and a written summary of corrections are to be kept in the home for each fiscal year (FY).

DBHDD Regional Offices and designated staff from the Division of DD are to provide technical assistance to DBHDD provider agencies enrolling host homes, as needed.

The Division of DD will conduct quarterly Quality Assurance reviews of provider agencies some of which will be contracting host homes. Reviews may include, but are not limited to, Support Coordinator ratings of 3's and 4's, external quality reviews, and critical incidents. Based on these reviews, the Division of DD will recommend and/or implement the following, which includes, but is not limited to, provision of technical assistance to the provider and/or host home, the movement of the individuals from the host home, full standards compliance review, and/or moratorium on the enrollment of host homes for a specific DBHDD provider agency.

TERMINATION OF CONTRACT BETWEEN THE HOST HOME AND CRA PROVIDER AGENCY

When a Host Home provider no longer wants to provide services to the individual and/or wants to end its subcontract with the DBHDD provider agency, they must give at least thirty (30) days written notice to:

1. The individual(s) served
2. The DBHDD provider agency under contract

When a Host Home provider initiates termination and end its subcontract with the provider agency, the following applies:

1. The Host Home provider must relinquish CRA service provision for the individual(s) supported to the contracted DBHDD provider agency and assist the DBHDD provider agency with the movement of the individual(s).
2. The Host Home provider must not serve the same individuals they previously served when contracting with another DBHDD provider agency.

The Host Home provider will be expected to continue working for thirty (30) days unless otherwise determined by the DBHDD provider agency or DBHDD.

If an emergency occurs and services must be terminated immediately, the Host Home provider must give immediate notice to all parties listed above.

The DBHDD provider must submit both DBHDD and DCH Change of Information forms to DBHDD Office of Provider Network Management to deactivate the Host Home provider number.

TRANSFERENCE OF A HOST HOME(S)

The DBHDD provider agency and Host Home provider must cooperate as requested by DBHDD to effectuate the smooth and reasonable transition of the care and services for individuals as directed by DBHDD. This includes, but is not limited to, the transfer of the individual records, personal belongings, and funds of all individuals as directed by DBHDD.

DBHDD reserves the right under all Host Home agreements to transfer a Host Home to another DBHDD provider agency on the following grounds:

1. DBHDD termination of the contract/letter of agreement, or agreement with the DBHDD provider agency.
2. DBHDD provider agency termination of the contract/letter of agreement.

3. The Individual or Family/Representative terminates the relationship with the contracting provider agency and the contracting provider agency is willing to terminate the site number.

In either case above, the Host Home provider must be in agreement to contract with another DBHDD provider agency if they want to serve the same individual(s).

Prior approval for the transfer of the Host Home to an alternative DBHDD provider agency must be given by the designated DBHDD, Regional Coordinator.

INDIVIDUAL RIGHTS

Informing and Encouraging Exercise of Rights

Each individual, or the individual's parent, guardian or advocate (if appropriate) is to be informed of the individual's rights upon admission and annually thereafter. Individuals are to receive this information through their primary form of communication.

A statement signed and dated by the individual, or the individual's parent, guardian or advocate if appropriate, acknowledging receipt of the information on individual rights upon admission and annually thereafter, will be kept.

Each individual is to be encouraged to exercise his or her individual rights.

Rights

An individual may not be deprived of rights.

Rights of the Individual

1. An individual may not be neglected, abused, mistreated or subjected to corporal punishment.
2. An individual may not be required to participate in research projects.
3. An individual has the right to manage his or her personal financial affairs.
4. An individual has the right to participate in program planning that affects him or her.
5. An individual has the right to privacy in bedrooms, bathrooms and during personal care.
6. An individual has the right to receive, purchase, have and use personal property.
7. An individual has the right to receive scheduled and unscheduled visitors, communicate, associate and meet privately with their family and persons of the individual's choice.
8. An individual has the right to reasonable access to a telephone and the opportunity to receive and make private calls, with assistance when necessary.
9. An individual has the right to unrestricted mail privileges.
10. An individual who is of voting age will be informed of the right to vote and will be assisted to register and vote in elections.

11. An individual has the right to practice the religion or faith of the individual's choice.
12. An individual has the right to be free from excessive medication.
13. An individual may not be required to work at the home except for the typical upkeep of the individual's bedroom and in the upkeep of family areas and yard. For example: Repair of a clogged drain, seeding of lawns, etc., would not be considered typical upkeep.

Civil Rights

An individual may not be discriminated against because of race, color, religious creed, disability, handicap, ancestry, national origin, age or sex.

Civil Rights policies and procedures are to be developed and implemented in accordance to all State and Federal legislation. Civil rights policies and procedures are to include the following:

1. Nondiscrimination in the provision of services, admissions, placement, referrals and communication with non-English speaking and nonverbal individuals.
2. Physical accessibility and accommodation for individuals with physical disabilities.
3. The opportunity to lodge civil rights complaints.
4. Informing individuals of their rights to register civil rights complaints.

STAFFING

Staffing Qualifications and Responsibilities

Provider agencies rendering Community Residential Alternative Services (CRA) must have staffing that meets the following requirements, in addition to any applicable licensure requirements:

1. A designated agency director who must:
 - Have either a bachelor's degree in a human service field (such as social work, psychology, education, nursing, or closely related field) or business management and two years of experience in service delivery to persons with developmental disabilities, with at least one year in a supervisory capacity; or
 - Have an associate degree in nursing, education or a related field and four (4) years of experience in service delivery to persons with developmental disabilities, with at least one year in supervisory capacity

Duties of the Agency Director include, but are not limited to:

- Overseeing the day-to-day operation of the agency;
 - Managing the use of agency funds;
 - Ensuring the development and updating of required policies of the agency;
 - Managing the employment of staff and professional contracts for the agency;
 - Designating another agency staff member to oversee the agency, in his or her absence.
2. At least one agency employee or professional under contract with the agency, who must:

- Have the responsibility for overseeing the delivery of Community Residential Alternative Services to participants.
3. At least one agency employee or professional under contract with the agency who must:
Be a Developmental Disability Professional (DDP) (for definition, see the COMP Manual at the website: www.mmis.georgia.gov)

Duties of the DDP include, but are not limited to:

- Overseeing the services and supports provided to participants;
- Supervising the formulation of the participant's plan for delivery of Community Residential Alternative Services;
- Conducting functional assessments; and
- Supervising high intensity services.

Note: The same individual may serve as both the agency director and the Developmental Disability Professional.

4. Direct Care Staff, must:

- Be 18 years or older
;
- If transporting an individual served or family, have a valid Class C license as defined by the Georgia Department of Driver's Services and no major or multiple traffic violations if transporting participants (s);
- Be provided with a basic orientation prior to direct contact with individuals and show competence in:
 - a. The purpose and scope of CRA services, including related Host Home/Life-Sharing Standards;
 - b. Confidentiality of individual information, both written and spoken;
 - c. Rights and responsibilities of individuals;
 - d. Requirements for recognizing and reporting suspected abuse, neglect, or exploitation of any individual:
 - i. To BHDD
 - ii. Within the organization
 - iii. To appropriate regulatory or licensing agencies; and
 - iv. To law enforcement agencies

5. For any additional requirements refer to:

- *COMP Supports Waiver Program, Part II and Part III, and Part I Policies and Procedures for Medicaid PeachCare for Kids*, located at website: www.mmis.georgia.gov

And

- The current *Provider Manual, Part II, Section I, Community Standards for all Providers*, at the website: <http://dbhdd.georgia.gov/portal/site/DBHDD/> (click Provider Information and Provider Tool Kit).

Direct Care And/Or Professional Staffing

The adult family member in the Host Home/Life-Sharing is responsible for the 24- hour care of the individual(s) served.

Direct care and/or professional staff may be utilized to provide *intermittent or brief* support to the Host/Life-Sharing family. Intermittent or brief staffing should be within the maximum Community Residential Alternative (CRA) rate and would not qualify for an Exceptional Rate.

The provider is to submit Exceptional Rate Requests to the Regional Service Administrator for Developmental Disabilities under the following circumstances:

- 1) The individual has significant medical and /or behavior problems, which are assessed as barriers, and threatens the individual's stability in a Host Home/ Life-Sharing community setting. **And**
- 2) The significant medical and /or behavior problems demand the availability of continued enhanced direct care and/or professional staffing, to support the individual's stability in a community setting.

The Exceptional Rate Requests for enhanced direct care and/or professional staffing, must document a clear demonstration of enhanced intensity and the type of service beyond what a Host Home/ Life-Sharing family could provide with training.

Note: A Waiver of Standards Request is not to be submitted for Exceptional Rate Requests pertaining to the need for continued enhanced direct care and/or professional staffing, which address the above parameters.

TRAINING

Pre Service/Annual Training

Prior to the DBHDD provider agency's submission of an application for a site specific Medicaid provider number, the adult family member who will have primary responsibility to the individual and for providing services to the individual is to have at least the following training:

1. Person-Centered Values, Principles And Approaches
2. Human Rights and Responsibilities
3. Recognizing and Reporting Critical Incidents
4. Individual Service Plan
5. Confidentiality Of Individual Information, Both Written And Spoken
6. Fire Safety
7. Emergency and Disaster Plans And Procedures
8. Techniques Of Standard Precautions
9. Basis Cardiac Life Support (BCLS)
10. First Aid and Safety
11. Medication Administration and Management/Supervision Of Self-Medication
12. Agency Policies And Procedures

Prior to direct contact with the individual, the adult family member who will have the primary responsibility to the individual and for providing services to the individual is to receive at least the following training:

1. The Purpose, Scope Of Services, Supports, Care And Treatment Offered, Including Related Policies And Procedures

2. Holistic Care Of The Individual
3. Promoting Positive, Appropriate And Responsive Relationships With Persons Served And Their Families
4. Medical, Physical, Behavioral And Social Needs, As Well As Characteristics Of Persons Served
5. The Utilization Of Positive Communication, Positive Behavioral Supports And Crisis Intervention Techniques
6. Ethics, Cultural Preference And Awareness
7. Service, Support, Care and Treatment Specific Appropriate To the Care of Person Served

All trainings specified above must also be provided to the Host Home/Life-Sharing adult family member on an annual basis.

Record of Training

Records of pre-service and annual training, including name of person trained, the training source, content, dates, length of training, and copies of certificates received and persons attending will be kept and be readily available.

PHYSICAL HOME SAFETY

All living quarters will be maintained and not threaten the health or safety of occupants.

Special Accommodations

A home serving an individual with a physical disability, blindness, a visual impairment, deafness or a hearing impairment will have accommodations to ensure the safety and reasonable accessibility for entrance to, movement within and exit from the home based upon each individual's needs.

Adaptive equipment will be provided if needed for the individual to move about and function in the home (i.e. wheelchairs, walkers, low shelves, cabinets, countertops, special doorbells and telephone devices for individuals who have a hearing impairment, and tactile guides for individuals who have visual impairment).

Poisons

Poisonous materials will be kept locked or made inaccessible to individuals if all individuals living in the home are unable to safely use or avoid poisonous materials

Poisonous materials may also be kept unlocked and accessible to individuals if all individuals living in the home are able to safely use or avoid poisonous materials.

Documentation of each individual's ability to safely use or avoid poisonous materials will be in each individual's ISP.

Poisonous materials will be stored in their original, labeled containers.

Poisonous materials will be kept separate from food, food preparation surfaces and dining surfaces.

Heat Sources

Heat sources, such as hot water pipes, fixed space heaters, hot water heaters, radiators, wood and coal burning stoves and fireplaces, exceeding 120°F that are accessible to individuals, will be equipped with protective guards or insulation to prevent individuals from coming in contact with the heat source.

Heat sources do not require guards or insulation if all individuals living in the home understand the danger of heat sources, and have the ability to sense and move away from the heat source quickly. Documentation of each individual's understanding and ability will be in each individual's ISP.

Sanitation

Clean conditions will be maintained in all areas of the home.

There may not be evidence of infestation of insects or rodents in the home. Chemicals used in the control program must be selected, stored and used safely. The chemical must be selected on the basis of the pest involved and used only in the manner prescribed by the manufacturer.

Trash will be removed from the premises on a routine basis.

Ventilation

Living areas, dining areas, individual bedrooms, kitchens and bathrooms will be ventilated by at least one operable window or by mechanical ventilation. Exceptions are home theater rooms.

Lighting

Rooms, hallways, interior stairways, outside steps, outside doorways, porches, ramps and fire escapes, that are used by individuals will be lighted to assure safety and to avoid accidents.

Surfaces

Floors, walls, ceilings and other surfaces will be free of hazards, as determined by the needs of the individual resident.

Running Water

A home will have hot and cold running water under pressure.

Hot water temperatures in bathtubs and showers that are accessible to individuals must be within 10- 120 degree Fahrenheit.

Water and sewage systems will meet federal, state, and local standards and regulations.

Heating and Air Conditioning Systems

Heating and Air Conditioning Systems will be operational and maintained to provide adequate heat and air conditioning throughout the home.

Telephone

A home will have an operable telephone that is easily accessible. The individual must have adequate privacy while using the telephone.

Emergency Telephone Numbers

The telephone must be immediately available in case of emergency. Telephone numbers of the nearest hospital, police department, fire department, ambulance and poison control center will be readily accessible in the home.

Screens, Windows and Doors

Windows, including windows in doors, will be securely screened when windows or doors are open.

Screens, windows and doors will be in good repair.

Handrails

An interior stairway exceeding two steps that is accessible to individuals, ramp and outside steps exceeding two steps, will have a well-secured handrail.

First Aid Materials

Each home will have antiseptic, an assortment of adhesive bandages, sterile gauze pads, tweezers, tape, and scissors.

Exterior Conditions

An outside walkway that is used by individuals will be free from ice, snow, obstructions and other hazards.

The yard and outside of the home will be well maintained and free from unsafe conditions.

Individual Bedrooms

An individual's bedroom may not be located in basements, attics, stairway, hall or any room commonly used for other than bedroom purposes.

A bedroom will have at least one exterior window that permits a view of the outside.

Bedroom windows will have clean and/or operable drapes, curtains, shades, blinds or shutters.

Bedrooms will have doors at all entrances for privacy.

In bedrooms, each individual will have the following:

A bed of size appropriate to the needs of the individual. Cots and portable beds are not permitted. Bunk beds are not permitted for individuals 18 years of age or older.

A clean, comfortable mattress and solid foundation.

Clean bedding, including a pillow, linens and blankets appropriate for the season.

1. A chest of drawers.
2. Closet or wardrobe space with clothing racks and shelves accessible.

An individual may not share a bedroom with anyone of an opposite sex in the home.

Bathrooms

There will be at least one toilet and one bathtub or shower in the home.

Privacy will be provided for toilets, showers and bathtubs by partitions or doors.

At least one bathroom area will have a sink, wall mirror, soap, toilet paper, individual clean paper or cloth towels and trash receptacle.

A clean washcloth, bath towel and operable toothbrush will be provided for each individual.

Kitchens

Each home will have a kitchen area with a clean and operable refrigerator, sink, cooking equipment and cabinets for storage.

Utensils used for eating, drinking and preparation of food or drink will be washed and rinsed after each use.

Laundry

Individual bed linens, towels, washcloths and clothing will be kept clean.

Swimming Pools

An in-ground swimming pool will be fenced with a gate that is locked when the pool is not in use.

An aboveground swimming pool will be made inaccessible to individuals when the pool is not in use.

Firearms

All firearms owned and in the home are unloaded, secured and locked in a cabinet with ammunition stored in a separate locked cabinet. If firearms are stored in an official gun cabinet, ammunition may also be stored in the same official gun cabinet. **However, the ammunition must be kept in a locked container or locked in a separate compartment of the gun cabinet.**

Yard

The yard surrounding the home must be safe and maintained.

FIRE SAFETY

Unobstructed Stairways, Halls, Doorways and Exits

Stairways, halls, doorways and exits from rooms and from the home will be unobstructed.

No interior locks, keyed locks or dead bolts in the Host Home/Life-Sharing residence will prohibit free access to exit from the home.

Flammable and Combustible Materials

Flammable and combustible supplies and equipment will be utilized safely and stored away from heat sources.

Furnaces

Furnaces filters will be cleaned or replaced at least annually. Written documentation of the cleaning or changing of filters will be kept.

Portable Space Heaters

Portable space heaters defined as heaters that are not permanently mounted or installed, may not be used while individuals are in the Host Home.

Wood and Coal Burning Stoves

The use of wood and coal burning stoves is permitted only if the stove is inspected and approved for safe installation by a licensed and/or bonded contractor specialized in this area. Written documentation of the inspection and approval is to be kept.

Wood and coal burning stoves, including chimneys and flues, will be cleaned at least every year. Written documentation of the cleaning will be kept.

If natural gas or heating oil is used to heat the residence, or if a wood-burning fireplace is in the residence, the residence will be protected with sufficient carbon monoxide detectors listed by Underwriters Laboratories, Inc. Information on Underwriters Laboratories, Inc. may be found at <http://www.ul.com/consumers/monoxide.html>

Fireplaces

Fireplaces will be securely screened and/or equipped with protective guards while in use.

Smoking

Smoking is a fire hazard. The Host Home/Life Sharing residence may choose to allow or not allow smoking. If the Host Home/Life-Sharing chooses to allow smoking it must reduce the risk of fire by:

1. Prohibiting smoking in any area where flammable liquid, gases or oxidizers are in use or stored;
2. Prohibiting residents from smoking in bed; **and**
3. Prohibiting unsupervised smoking of individuals unless unsupervised smoking is documented in the ISP.

Smoke Detectors

Each Host Home will be protected with sufficient smoke detectors listed by Underwriters Laboratories, Inc., which when activated will initiate an alarm, that is audible in sleeping rooms. Information on Underwriters Laboratories, Inc. may be found at http://www.ul.com/fallsafety/smoke_alarms.html

An operable smoke detector must also be located in the attic. (An area with pull down steps is considered an attic.)

Each smoke detector will be tested each month to determine if the detector is operable.

Fire Extinguishers

There must be at least one operable fire five pound (5lb.) multipurpose ABC fire extinguisher on each floor; including basements. All fire extinguishers must be located in accessible locations.

All fire extinguishers must be examined monthly to determine that:

1. Fire extinguishers are accessible and in a designated location;
2. Seals or tamper indicator are not broken;
3. The extinguishers have not been physically damaged; and
4. The extinguishers do not have any obvious defects.

Disaster/Severe Weather Emergency and Fire Drills

The agency will have that support the Host Home /Life-Sharing residential setting's emergency notification and preparedness processes. This includes, but is not limited to a three-day supply of non-perishable foods and water for emergency needs and supplies for an emergency preparedness kit for the household.

For information on creating an emergency preparedness kit visit the following website:

<http://www.gema.ga.gov> or <http://ready.ga.gov>

A written disaster/severe weather and fire safety plan will be developed for each household. The plan will be reviewed and updated annually or as needed. The plan will include general fire safety, evacuation procedures, responsibilities during drills or actual events, the designated meeting place outside the home, the use of fire extinguishers, notification of local fire and emergency response teams and if applicable, smoking safety procedures if an individual of household member smokes. A written record of the training will be kept readily available.

Fire drills will be conducted every month at alternate times. At least two drills per calendar year will be during sleeping hours. All fire drills will be documented and kept readily available.

The plan should also address medical emergencies, natural disasters (i.e. tornado), power failures, loss of heat or air conditioning, continuity in critical medical care needs of individuals supported, and notification of individuals' natural supports as soon as the situation renders this possible. Components of the plan will be maintained, tested, inspected, drilled and reviewed for risk reduction on a quarterly basis. Disaster and severe weather emergency drills are conducted at least once per quarter at various times throughout the year, including one drill during typical sleep hours of the household.

PROGRAM

Implementation of Individual Service Plan

The Host Home/Life-Sharing family will cooperatively participate with the individual's support team in the development and implementation of the individual's service plan.

The Host Home/Life-Sharing dynamics is enduring, offering dependability, consistency, trustworthiness and security. The Host Home/Life-Sharing family joins together in celebration of anniversaries, birthdays and in simple day-to-day interactions, joys and accomplishments. They also mourn together in their losses at times of illness and death. The Host Home/Life-Sharing family should encompass extended families and promote the individual's maturing relationship with his or her own natural birth family.

The Host Home /Life-Sharing individual(s) should be active participants in their community. Community integration could be facilitated by the contracting family's own friends, civic interests, neighbors, recreational and hobby activities, and religious affiliations. This expands and includes the individual's family, friends and special interests.

Record Management

All records will be kept in accordance with requirements of the Department of Behavioral Health and Developmental Disabilities current Provider Manual found at the website:

<http://dbhdd.georgia.gov/portal/site/DBHDD/> (click Provider Information and Provider Tool Kit).

A copy of the Individual Service Plan will be in the Host Home/ Life-Sharing residence along with case notes per direction in the Individual Service Plan along with DCH documentation requirements.

Providers must document the following in the record of each participant receiving Community Residential Alternative Services:

1. Specific activity, training, or assistance provided;
2. Date and the beginning and ending time when the service was provided;
3. Location where the service was delivered;
4. Verification of service delivery, including first and last name and title (if applicable) of the person providing the service and his or her signature;
5. Progress towards moving the participant towards independence by meeting the participant's ISP, which includes person-centered goals, desired outcomes in the participant's actions plan, and the amount/type of assistance/support in the Current Service Summary and the Health and Safety sections of the ISP.

Each Host Home/Life-Sharing residence provider is to retain a copy of the home study, including any updates, annual self-assessment of the home and required monthly meeting/quality assurance minutes for review by the state.

HEALTH

Individual Health Care Examinations

The individual served will have a health care examination within 12 months prior to living in the Host/Life-Sharing Home and annually thereafter.

The health exam will be completed and documented on the Annual Health Form found in the Provider Manual found at the website: <http://dbhdd.georgia.gov/portal/site/DBHDD/> (click on Provider information and the Provider Manual for the current year).

Refusal of Health Care

If an individual refuses routine health care examinations or treatment, the refusal and continued attempts to train the individual about the needs of health care will be documented in the individual's record.

If an individual has a serious medical condition, reasonable efforts will be made to obtain consent from the individual or substitute consent in accordance with applicable law.

Host Home / Life-Sharing Family Health Care Examinations

Family members and persons living in the Host Home / Life-Sharing residence will have a health care examination within 12 months prior to any individual in service living in the home and annually thereafter.

The health care examination documentation will be completed, signed and dated by a licensed physician, certified nurse practitioner or licensed physician assistant.

The general health care examination will include:

1. A general health care examination
2. Tuberculin skin testing by Mantoux method with negative results every 2 years for family members 1 year of age or older; or, if a tuberculin skin test is positive, an initial chest X-ray with results noted. Tuberculin skin testing may be completed and certified in writing by a registered nurse or licensed practical nurse instead of a licensed physician.
3. A signed statement that the person is free of communicable diseases or specific precautions to be taken if the person has a communicable disease.
4. Information of medical problems, which might interfere with the health of the individuals.

Communicable Diseases

If an individual or family member has a serious communicable disease (relating to specific identified reportable diseases, infections and conditions) and /or medical problems which might interfere with the health, safety or well-being of the individual(s), specific instructions and precautions to be taken for the protection of the individuals will be specified in writing by a licensed physician. If specific instructions/precautions are not ensured, then the individual will not be appropriate for placement in the identified Host Home/Life-Sharing residential setting.

The physician's written instructions and precautions will be followed.

MEDICATIONS

Storage of Medications

Prescriptions and nonprescription medications of individuals will be kept in their original containers, except for medications of individuals who self-administer medications and keep their medications in personal daily or weekly dispensing containers.

Prescription and potentially toxic nonprescription medications stored in a refrigerator will be kept in a separate locked container or made inaccessible to the individuals, unless it is documented in each individual's assessment that each individual in the home can safely use or avoid toxic materials.

Prescriptions and nonprescription medications of individuals will be locked and stored under proper conditions of sanitation, temperature, moisture and light.

Discontinued prescription medications of individuals will be disposed of in a safe manner. Documentation of the date and manner disposed will be recorded.

Labeling of Medications

The original container for prescription medication of individuals will be labeled with a pharmaceutical label that includes the individual's name, the name of the medication, the date the prescription was issued, the prescribed dose and the name of the prescribing physician.

Medication Training

Host Home /Life-Sharing Family members who assist with or supervise self-medication for individual(s) will receive training about the administration, side effects and contraindications of the specific medication in accordance with state laws and regulations

NUTRITION

Protection of Food

Food received or used in the home will be clean, wholesome, free from spoilage, adulteration, and misbranding, and safe for human consumption.

All foods, while being stored, prepared, or served, will be protected against contamination and be safe for human consumption in accordance with accepted standards for food safety.

Three Meals a Day

At least three meals a day will be available to the individuals and in accordance with any specific dietary needs identified in the individual's Individual Service Plan.

Quantity of Food

The quantity of food served for each individual will meet minimum daily requirements as recommended by the United States Department of Agriculture, unless otherwise recommended in writing by a licensed physician.

Food Groups

At least one meal each day will contain at least one item from the dairy, protein, fruits and vegetables and grain food groups, unless otherwise recommended in writing by a licensed physician for individuals.

BEHAVIOR MANAGEMENT GUIDELINES

Positive Behavior Supports are intended to provide guidelines for managing challenging behavior(s) of individuals with Developmental Disabilities residing in Host Home.

Policies developed within Host Home regarding positive behavior supports are expected to comply with guidelines set forth in the Guidelines for Supporting Adults with Challenging Behaviors in Community Settings applicable to all providers under contract or Letter of Agreement (LOA) with the Department of Behavioral Health and Developmental Disabilities.

These guidelines are available at the website: <http://dbhdd.georgia.gov/portal/site/DBHDD/>. (click on Provider Information, then Provider Tool Kit)

Documentation of annual policy review for appropriate update and revisions will be readily available to all reviewers.

Behavior Support Plans should be incorporated in the Individual Service Plan (ISP) and every attempt will be made to anticipate and de-escalate the behavior using methods of intervention less intrusive than restrictive procedures.

Plans should be developed by appropriately qualified individuals with expertise in behavioral supports evaluation and services for people with developmental disabilities. The individual, Host Home/Life-Sharing family and other vested stakeholders will be involved in the development of the behavior support plan.

Replacement behavior acquisition training and/or family education training on Positive Behavior Supports are required to show the effectiveness of the plan.

Written documentation of person/staff trained will be kept and readily available. This documentation must include the date and signature of the trainer evidencing that the individual has competently completed the training.

Seclusion and Mechanical Restraint

Seclusion, defined as placing an individual in a locked room, is prohibited. A locked room includes a room with any type of door locking device, such as a key lock, spring lock, bolt lock, foot pressure lock or physically holding the door shut.

Physical restraints (i.e. mechanical restraints) **are not** used as punishment, for staff convenience, or through a behavioral support plan or behavioral management intervention for purposes of restricting a participant's movement. Those devices which restrain movement, but are applied for protection of accidental injury (such as a helmet for protection of fall due to frequent, severe seizures but not for purposeful head banging or other self-injurious behavior) or required for medical treatment of the physical condition of the participant (such as protection for healing of an open wound) or for supportive or corrective needs of the participant (such as physical therapy devices) are not considered physical restraints.

ALTERNATE CARE

Provision for Host Home/Life-Sharing Setting

Alternate care must be offered to the Host Home/Life-Sharing family through other Host Homes managed by the **SAME** agency. Alternate care is to be offered to each Host Home/Life-Sharing family annually, not to exceed 30 units of CRA services.

The alternate care Host Home/Life-Sharing setting will meet all and the Standards for Host Home/Life-Sharing. Each CRA agency administering one or more Host Home/Life-Sharing residential settings must have, at minimum, of one (1) vacancy available at all times for alternate care.

Only one (1) Alternate Care home may be used and identified for each individual accessing this provision.

The ISP must identify the following:

1. The need for Alternate Care.
2. The Alternate Care home physical location and contact information. The Alternate Care home must be site specific.
3. The allotted number of days for the use of the Alternate Care home (not to exceed 30 units of CRA services annually).

If Alternate Care provisions are utilized, the individual's Prior Authorization (PA) must indicate:

1. The primary Host Home/Life-Sharing site
2. The amount of CRA units
3. Alternate Care site and
4. The amount of CRA units

For example, there might be 294 units at Host Home site, and 30 units at Alternate Care Site. In cases where the maximum of 30 units of Alternate Care will not be utilized, a PA change is required to add the units back to the main Host Home/Life Sharing site.

The annual maximum number of units for CRA services per year must **NOT** be exceeded.

VACATION

Vacation billing must not exceed thirty (30) days in a calendar year for individual (s) choosing to go on a vacation with the Host Home/Life- Sharing family.

DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL DISABILITIES (DBHDD)

REQUEST for CONVERSION FORM

DBHDD will allow for conversion from a licensed Personal Care Home (PCH) or licensed Community Living Arrangement (CLA) to a Host Home only under the following four conditions:

- (1) The home is under a subcontracting relationship **AND**
- (2) The Home is occupied by the owner **AND**
- (3) The current occupancy must be two or less **AND**
- (4) The license must be in the name of the proposed Host Home provider.

Instructions: The approved provider, who is requesting to convert from a CLA or PCH to a Host Home/Life-Sharing site, must complete the [REQUEST FOR CONVERSION FORM](#)

REQUIRED INFORMATION FOR COMPLETION OF THE REQUEST FOR CONVERSION FORM

1. **Type of Change: Check either PCH or CLA, whichever is applicable to your current site.**
2. **Current Provider Identification**
 - a. Provider's complete full name or business name as it is currently on file with DBHDD.
 - b. Provider's complete address that is currently on file with DBHDD:
3. **Licensed Home Information**
 - a. Provide the name or location name. (Note: For any name change, the provider must submit a certified copy of the legal document(s) showing the old and new names.)
 - b. **Mailing Address/Location Address Information**
 - Mailing Address: Check "Mailing Address" if the provider would like correspondence sent to an address other than the mailing address that is currently on file. A Post Office Box **is** acceptable as the mailing address.
 - Location Address: Check "Location Address" if the provider is making a change in the physical address of the service site. A Post Office Box **is not** acceptable as the physical location address. A change in physical address must be communicated to the Regional Office and a site visit performed for the services. (Note: For any name change, the provider must submit a certified copy of the legal document(s) showing the old and new names.)
 - c. **Telephone Number and FAX Number:** Include the "Telephone Number" of the home. If applicable, include the "Fax Number."
 - d. **E-Mail Address:** Include the "E-Mail Address" of the approved provider.
 - e. **Medicaid Provider Number:** Include the "Site Specific Medicaid Provider Number."
 - f. **Number of Individuals currently residing in the home:** Indicate the "number" of individuals residing in the home.
4. **Attestation Statements (Required)**

Sign and date this form attesting to the accuracy of the requested changes. An authorized representative of the agency must sign this form to confirm the requested change(s).
5. **Regional Office Response**

Return this form with any necessary attachments to: **Provider Enrollment Unit
Office of Provider Network Management
Department of Behavioral Health and Developmental Disabilities
2 Peachtree Street, 23rd Floor
Atlanta, Georgia 30303
Fax: 404-463-6678**

DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL DISABILITIES (DBHDD)

REQUEST for CONVERSION FORM

THIS FORM IS TO BE COMPLETED BY APPROVED DBHDD PROVIDERS REQUESTING A CHANGE FROM A LICENSED HOME TO A HOST HOME/LIFE-SHARING SITE.

1. Type Of Change:	FROM: <input type="checkbox"/> Community Living Arrangement (CLA) <input type="checkbox"/> Person Care Home (PCH)	TO: <input type="checkbox"/> Host Home/ Life- Sharing
2. Current Provider Information:		
<ul style="list-style-type: none"> ▪ Agency Name (Provide the name <u>or</u> location name): _____ ▪ Name Change: ____ Yes ____ No ▪ Required: Report the complete date on which any name change is effective: ____/____/____ (For any name change submit a certified copy of the legal document(s) showing the old and new names.) 		
3. Licensed Home Information:		
a. CLA or PCH Name:		
Address:		
City:	State:	Zip:
b. _____ Mailing Address _____ Location Address		
<ul style="list-style-type: none"> ▪ Address Change: ____ Yes ____ No ▪ Required: Report the complete date on which any address change is effective: ____/____/____ (For any change of address, submit a certified copy of the legal document(s) showing the old and new names.) 		
c. Telephone Number of the Home (_____) _____ Fax (if applicable): (_____) _____		d. E-mail Address: _____
e. Medicaid Provider Number: _____		f. Number of Individuals currently residing in the home: _____

DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL DISABILITIES (DBHDD)

REQUEST for CONVERSION FORM

4. Attestation Statements	
<u>Provider CEO/Director</u>	
I certify that I have examined the above information and that it is true, accurate, and complete. I understand that any misrepresentation or concealment of material information may subject me to liability under civil and criminal law.	
Provider CEO/Director's Name (Print):	
Provider CEO/Director's Signature:	Date:
<u>Subcontractor Attestation Statement</u>	
I acknowledge that I am currently in a subcontracting relationship with licensed home noted above section #2. I am aware of and/or have requested the change of the above licensed home to a host home.	
Subcontractor's Name (Print):	
Subcontractor's Signature:	Date:
5. Regional Office Response	
I have reviewed this request and I support the change.	
Regional Services Administrator-DD or Regional Coordinator's Name (Print):	
Regional Services Administrator-DD or Regional Coordinator Signature:	Date:

Part III

Community Service Standards Specific for Developmental Disabilities Services

SECTION III

Operational Standards for Family Support Services

Fiscal Year 2012



**Georgia Department of Behavioral Health &
Developmental Disabilities**

April 2012

DBHDD

Department of Behavioral Health and Developmental Disabilities
Operational Standards for Family Support Services

I. Introduction

The Family Support Operating Procedures provide the guidelines for Family Support programs under contract with the Department of Behavioral Health Developmental Disabilities (DBHDD), Division of Developmental Disabilities (DD), regarding the provision and purchase of Family Support services and goods.

A. Purpose

Family Support services are aimed to:

1. Keep families together until the individual with a disability chooses to live independently,
2. Enhance a family's ability to meet the many needs of the family member with a disability,
3. Improve the quality of supports to families while minimizing the need and cost of out-of home placement to allow families to participate in recreational and social activities and
4. Make a positive difference in the life of the person with a disability as well as the lives of all family members.

While the family is the principal target of Family Support Services, a family's eligibility for services is determined by the presence of a member with a developmental disability.

B. Definitions

Contractor - The provider/agency responsible for administration and provision of Family Support authorized goods and services, in adherence to the Letter of Agreement with Department of Behavioral Health and Developmental Disabilities Division of Developmental Disabilities and the *Family Support Operating Procedures*.

Developmental Disability – A developmental disability means a diagnosis of an intellectual disability prior to age 18 years or a severe, chronic disability, other than mental illness, that is manifested during the developmental period before the age of 22 years, such as cerebral palsy, epilepsy, autism, or other neurological impairments of intellectual functioning or adaptive functioning.

Family - A group of persons living together as a unit, in which there is at least one individual diagnosed with a developmental disability, with his or her family. Family is inclusive of birth or adoptive parents, members of the extended family, a full guardian, legal custodian or a person acting in place of a parent or family member and living as a family unit.

Family Support - An array of goods and services aimed at providing families with individualized support services and/or goods needed to continue the care of a family member with developmental disabilities residing in the family home. Family Support Services is not a crisis program. These services are provided to families with the goal of preventing crises that can result in the need for out-of-home placements or higher intensity services.

Individual Family Support Plan (IFSP) - The Individual Family Support Plan (IFSP) is a person centered, written participation agreement, signed by the individual and/or family, a representative of the contracted Family Support agency, and the designated Family Support Coordinator.

Institutionalization - A restrictive environment (such as an Intermediate Care Unit or hospital), which offers specialized care or incarceration.

II. Eligibility Determination for Family Support Services

The two (2) eligibility criteria that must be met for the receipt of Family Support Services are a diagnosis of developmental disability by an individual residing in a family unit and financial need.

A. Criteria: Diagnosis of Developmental Disability

A family that has a member with a developmental disability will be determined eligible for services by a Contractor of Family Support Services evaluation process utilizing the following criteria:

1. The individual identified is three (3) years or older with a developmental disability.
2. The eligible individual with a developmental disability has the desire to or have continued home care or the family with a member who is eligible, wishes to return to or continue home care of the individual, but requires support and /or assistance to do so.
3. The authorized services and goods for which the individual or family is eligible, is sufficient to support and/or assist in the individual's return to home care or the continuation of care in the home setting.

The Individualized Family Support Application form is to be attached to documentation indicating developmental disability status (See Appendix I)

The contractor of Family Support services will submit to the Region the approved documentation (Individualized Family Support Application, with documents identifying the developmental disability determination) for the recipient of Family Support. The Region will acknowledge the receipt of the documentation, determine the final approval (if applicable) and monitor the service delivery (see Appendix II).

Note: Children who are 0 to 3 years of age may be served if *Early Intervention: Babies Can't Wait* funding has been exhausted in the region where the family resides.

B. Criteria: Financial Need

Authorized goods and services are to be provided on a "sliding fee" basis. The fee schedule is to be set by the Family Support Provider/Agency and approved by the Regional Office.

Documentation of family income and resources will be obtained in order to determine if funds will be allocated. The family is eligible only if the member with a developmental disability is residing in the home or if Family Support funds are to be used to prepare the home and family for the return of the member with a developmental disability from an alternate placement of care.

An eligible family referred and deemed eligible will be served by Family Support within the limits of the funding available. Prioritizing eligible families will be the responsibility of the contracted Family Support Provider, utilizing the required inter-disciplinary team and family assessment process with consideration of the following factors:

1. The degree of the family's financial ability to obtain services;
2. The degree of critical need to support the family's functioning and well-being;
3. The status of the family's plan to accept the member with a developmental disability back into the home from out-of-home placement (if applicable).

Referrals to a Family Support Service Provider/Agency for funding purposes may be accepted from a variety of sources (such as public and private providers, disability specific, generic and other program recipients, as well as self-referrals). The Regional DBHDD I & E team are responsible for designating a point of receipt for all Family Support referrals.

The Family Support Service Provider/Agency must approve or disapprove each family's application within thirty (30) days after receipt of the application.

III. Individualized Service Plans

The goal of Family Support is to sustain and enhance the quality of family/home life so that the individual with developmental disabilities can remain within a nurturing family in his/her home. Support and service provision may be directed to the person with the developmental disability or his/her family members. The task is to determine what authorized goods and services need to be provided to assure that this goal is accomplished. Documentation of the need for goods and services is to be made considering the following components:

1. The comprehensive needs of the individual with a developmental disability,
2. The needs of the family as primary caregiver and
3. The community supports necessary to meet the identified needs.

A. Documentation of the Need for Goods and Services

When the family is determined in need of authorized goods and services, and Family Support funds are to be utilized, the written service plan is to document the following components:

1. A person-centered description of the individual, the family and its support network, the physical environment, and current services. (**Note:** A plan that has been in place prior to the implementation of this document is to be updated to include at a minimum “what is important to” and “what is important for” the individual with a developmental disability);
2. A description of the needs of the family, based on the assessment described above;
3. A written statement of the goods and services that are projected for Family Support funding, with an estimated duration of need and annual cost.
4. A written agreement (See Appendix III- *Family Support Agreement*) signed by the individual or parent(s) and by a representative of the administering Family Support Provider/Agency, which describes how Family Support funds are to be utilized on the family's behalf.

Note: All Funding Sources And Services Available Through Existing Programs Must Be Documented As Not Available Prior To Utilization Of Family Support Funds.

B. Plan Review

Any plan which includes the special provisions of Family Support funds is to be reviewed, consistent with time lines required for that plan, but no less than once every six (6) months following the initial plan development date and more often if determined needed. Parameters for the review process are as follows:

1. For each plan that includes the use of Family Support funds, the need for review or changes in the plan may be made by the Family Support /Agency or by the family. Families should be informed at the time of the initial assessment of the planned review cycle and of their right to participate and request changes.
2. If changes are made in the family's service plan, the reason for the changes is to be included in the record.
3. A parent or individual and a representative of the administering Family Support Service Provider/Agency must sign the amended agreement, with the understanding that the agency retains the flexibility to each referred family on an “as needed basis.”

IV. Authorized Goods and Services

The following is a listing of goods and services which may be purchased with Family Support funds either by contracted provider or directly from a family depending on funding allocations. All goods and services purchased with Family Support funding must be provided in accordance with the Family Support Operating Procedures (*Provider Manual, Current Fiscal Year, Part I: Section II, DD Individual Eligibility, Service Definitions and Service Guidelines For Developmental Disability Services*, located at dbhdd.georgia.gov Provider Information, in the Provider Tool Kit).

A. Respite Care - A service designed to relieve a family/care giver of physical or emotional stresses associated with the care of the member with a developmental disability by the provision of temporary care of the member with a developmental disability in or out of the home. This service may also include care of other young children who are members of the family, when necessary for the primary care giver(s) to devote exclusive time to attend to the care and well being of the member with a developmental disability.

Each contracted Family Support Service /Agency is to maintain a “List of Approved Respite Providers.” Prior to receiving any Family Support funding, respite care providers must be on a Family Support Provider /Agency’s “List of Approved Respite Providers.” For additional requirements regarding respite provider requirements and this registry, see the Administration/Records section in these Family Support Operating Procedures.

B. Community Living Support - An array of services to assist an individual with the developmental disability to perform activities of daily living. These services include the following:

1. Assistance with, and/or training in activities of daily living, such as bathing, dressing, grooming, feeding, toileting, transferring and other similar tasks;
2. Accompanying individuals and facilitating their participation in visits for medical care, therapies, personal shopping, recreation and other community activities. (This category includes staff to serve as interpreters and communicators, as well as the transportation costs to provide such services.)
3. Training and assisting in household cares, such as meal preparation, clothes laundering, bed-making, housekeeping, shopping, simple home repair, yard care and other similar tasks;
4. Assisting with therapeutic exercises, supervising self-administration of medication and performing other services essential to health care at home and
5. Training and support in the areas of social, emotion, physical and special; intellectual development. This category includes mobility training, as well as programming, intervention and/or consultation to reduce inappropriate or maladaptive behaviors.

C. Community Access - An array of services that support an individual with a developmental disability in being involved in their community, based on his/her needs, wants and preferences. The goal of services is to help the person learn or improve their skills in personal care, being independent, socializing with others, adjusting to community life, using resources in their community, and becoming independent outside his/her home or family home. The purpose of these services is to increase the individual's skills and contacts in community living.

D. Dental Services - The full array of services designed to care for the teeth, oral cavity and maxillofacial area, provided by or under the direct supervision of a licensed dentist; in-patient or outpatient.

B. Medical Care - Services provided by or under the direct supervision of a licensed physician or by other licensed or certified health care professionals, when recommended by a licensed physician. The array of Medical Care services are inclusive of diagnosis/evaluation, service provision and consultation with other medical/health care providers or non-medical service providers, as recommended by a licensed physician. Services may be inpatient or outpatient.

C. Specialized Clothing - Services that include the assessment of need, design, construction, fitting and cost of an article of clothing, which is necessitated by the handicapping condition of the individual with the developmental disability.

D. Specialized Diagnostic Services - Specific investigative procedures determined as needed by the family and inter-disciplinary team and are necessary to complete the assessment of needs of the individual with disabilities and/or family. Such specific

investigative procedures assessed as needed are not provided by the interdisciplinary team.

- E. Recreation/Leisure Activities** - Activities and or goods designed to support the participation of the individual with a developmental disability in recreational/leisure activities in the home and/or community.
- F. Environmental Modifications** - Changes, additions or repairs to the personal home of the family/caregiver that are designed to increase their ability to enhance the development/functioning, health or well being of the individual with a developmental disability. These modifications changes, additions or repairs are not structurally permanent.
- G. Specialized Equipment** - Adaptive and therapeutic devices specifically prescribed to meet the habilitative needs of the individual with a developmental disability or devices and equipment needed by the family to better provide for the specific needs of the family member with a developmental disability.
- H. Therapeutic Services** - A direct intervention service provided by a specifically trained therapist aimed at reducing or eliminating physical manifestations of a developmental disability or in improving/acquiring specific skills precluded by the developmental disability. An assessment/evaluation is required for the provision of these services. Therapeutic services are inclusive of audiology, physical therapy, occupational therapy and speech therapy.
- I. Counseling** - Services utilizing a varied number of specific psycho-social approaches, clinical or non-clinical, for the individual with a developmental disability and/or his/her family. These services are aimed at assisting the individual with a developmental disability in coping with life circumstances.
- J. Parent/Family Training** - Information and training for parents/family members to enhance understanding and to better address the needs of the family member who has a developmental disability. Training may be provided as a one-time experience or on-going experience. This training may be delivered in or out of the home setting.
- K. Specialized Nutrition** - An array of services that include assessment, planning, counseling, supervision and provision of specific dietary, nutritional and feeding needs of the individual with a developmental disability. These services are to be provided by a nutritionist qualified by state standards.
- L. Supplies** - Any number of items that may require frequent usage due to the individual's developmental disability. These supplies may not be specialized or specific to the needs of the individual with the developmental disability, but maybe necessary to the on-going operation or maintenance of specialized devices or any number of items that are needed by the family, to better provide for the disability specific needs of the family member with the developmental disability. The need for

such supplies must be clearly documented in the Individual Family Support Plan (IFSP).

- M. Behavioral Consultation and Support** - Professional services which train and support the family in avoiding and/or responding appropriately to behaviors which may create barriers to the individual a developmental disability ability to remain in the home and community; and/or direct individual services intended to address problematic behaviors.
- N. Financial and Life Planning Assistance** - Professional services which assist the family in planning for future services and/or financial needs of the family member with a developmental disability.
- O. Exceptional Disability Related Living Costs** - This service is to be utilized to pay living expenses that are higher than normal due to the nature of the person's developmental disability or to cover unexpected emergency costs. For example, a person who is heat sensitive may require air conditioning during the summer months. The family support budget may include extra costs to cover the higher electrical bills during the summer months so as not to stress the family's household budget. This might also cover higher electrical bills caused by the individual with a developmental disability being on special monitoring machines.

Exceptional Disability Related Living Costs may be approved on a one time, emergency basis, or for ongoing needs. When approved on an ongoing basis, the contracted Family Support Provider must document continued need at least every six (6) months.

- P. Homemaker Services** – Light household work or tasks provided in the home, which are:
1. Necessitated by the lack of a family member capable of performing such tasks or
 2. By the incapacity or absence of the family member who normally performs the tasks and
 3. Are not available through an existing program such as the Community Care Waiver.
- Q. Transportation** – Travel and travel related costs (including subsistence costs) associated with the receipt of a service identified in the plan, and documented by the provider to be necessary to meet the needs of the family.
- R. Other Services:** Any other service not listed above, which, in the opinion of the family and inter-disciplinary team, is necessary to meet the needs of an eligible individual/family, for which a written request is submitted to and approved by DBHDD-Regional Coordinator or the Regional Services Administrator for Developmental Disabilities.

V. Provider /Agency: Contractor Responsibilities

A. Administration

The Contractor retains ultimate responsibility for appropriate administration and for all documentation. This is inclusive of eligibility determination and development of the Individual Family Support Plan. Coordination with all relevant and involved agencies is also the responsibility of the Contractor.

B. Family Support Coordination

A single point of entry for contact with the Family Support Provider/Agency must be established and publicized within the service area so that families will be provided adequate information at the time of their inquiry.

The Contractor will appoint a staff person(s) to act as Coordinator(s) for Family Support. The person(s) appointed may perform administrative tasks and function as a service coordinator for participating families. The administrative and service coordinator duties may be shared among more than one staff person.

As representatives of an organization contracted with the DBHDD Division of Developmental Disabilities, coordinators and staff persons are to practice cultural diversity competency evident by the articulation of an understanding of the social, cultural, religious and other needs, and differences unique to the individuals and families seeking Family Supports, adhering to Family Support Operating Guidelines (*Provider Manual, Current Fiscal Year, Part I: Section II, DD Individual Eligibility, Service Definitions and Service Guidelines For Developmental Disability Services*, located at dbhdd.georgia.gov Provider Information, in the Provider Tool Kit).

C. Reporting

The Contractor will submit reports, which may be required by the Regional Office. These reports may include an annual report that provides a statistical summary of expenditure, client data and a narrative summary of achievements of Family Support. Monthly reporting and other requirements of the contract between the Family Support Provider / Agency and the State of Georgia, Department of Behavioral Health and Developmental Disabilities must be met.

D. Records

The Contractor is responsible for maintaining all financial records including service vouchers/purchase orders that are relevant to service provision per each applicant and recipient of Family Support. Records are to be maintained in an easily accessible place for monitoring/auditing purposes.

The Contactor is responsible for maintaining an updated “List of Approved Respite Providers”.

E. Grievances/Appeal Process

The Contractor is responsible for insuring that an individual/family is notified in writing of the reasons for denial, discontinued or reduced benefits. The Contractor established client appeal procedures are to be made available in writing to the participating families upon application for services. The Regional Services Administrator for Developmental Disabilities (RSA-DD) is to be made aware for the Contractor’s grievances/appeal processes.

Individualized Family Support Application

Section I: Demographic Information

Applicant Name: _____ Date of Application: _____

Medicaid #: _____ Date of Birth: _____

Gender (Male or Female): _____ Social Security Number: _____

Family/Caregiver Name _____

Phone #: Day: _____ Evening: _____ Other: _____

Address: _____ City: _____

State: _____ Zip Code: _____ County: _____

Race/Ethnicity: () American Indian or Alaska Native () Asian or Pacific Islander

() Black or African American (Not Hispanic) () Hispanic or Latino () White (Not Hispanic)

() Multi-Racial/Ethnic Group () Other

Section II: Diagnostic Information

Developmental Disability Diagnosis:

Age at Time of Diagnosis: _____

Supporting Documentation Verifying Disability (Check the Documentation That Applies and Attach a Copy of the Documentation to This Application):

___ DD I&E Assessment

___ Adaptive Behavior Score

___ Psychological Evaluation

___ Functional Limitations

___ School IEP

___ Medical Verification

___ IQ Score

___ Social Security Disability Determination

___ Other: _____

Section III: Financial Information

1. The degree of the family's financial ability to obtain services: _____

Individualized Family Support Application

2. The degree of critical need to support the family’s functioning and well-being; _____

3. The status of the family’s plan to accept the member with a developmental disability back into the home from out-of-home placement (if applicable)._____

Section IV: Current Service Information

1. Is this person currently enrolled in a Medicaid waiver program: () Yes () No

2. If “Yes”, please check the appropriate Medicaid waiver program: () NOW () COMP

() ICWP () SOURCE () CCSP () GAP () Katie Beckett () GIA

3. List the Medicaid waiver services that are currently received:

4. Have these resources been exhausted? () Yes () No

5. Do you want this person to continue living in your home? () Yes () No

6. Are you looking for out of home placement? () Yes () No

7. If “Yes”, what type of out of home placement? _____

Section V: Agreement Section

I hereby confirm that the information given at the time of application is true to the best of my knowledge.

Responsible Party Signature: _____

Responsible Party Printed Name: _____

Relationship: _____ Date: _____

Individualized Family Support Application

Section VI:

For Agency/Provider Office Use Only

Date Application Received: _____

Disposition for Family Support:

() Eligible For Family Support Services (Forward Application and Supporting Documents to the Regional RSA-DD)

() Ineligible For Family Support Services

Provider Agency - Name: _____

Provider Staff - Name: _____

Title: _____ Contact Number: _____

E-Mail Address: _____

Provider Staff - Signature: _____ Date: _____

Section VII:

For Regional Office Use Only

Date Application Reviewed: _____

Disposition for Family Support:

Eligible Status confirmed: () Yes

() No - State the reason: _____

Regional Staff's Name: _____ Title: _____

Regional Staff's Signature: _____ Date: _____

Provider:

Date of Notification:

Individualized Family Support Application

For Office Use Only:

Provider

Regional Office

Comments:

Appendix II

Guidelines for Approval of the Family Support Referral by the Regional Office

An individual/family applies for Family Support at a Family Support Provider based on support needed to continue the care of a family member with developmental disabilities residing in the family home. The steps for approval include:

1. An Individualized Family Support Application is submitted to the Regional Office (see Appendix I).
2. The assigned Regional Office staff reviews the application. Areas of review:
 - Section I (Individual's Information).
 - Section II (Developmental Disability Diagnosis Status) and the attached Supporting Documentation Verifying Disability
 - Section III Financial Information
 - Section IV (Current Services Summary)
 - The Family Support Agreement (See Appendix III)
3. The assigned Regional Office staff acknowledges receipt and review of the document by e-mail to the provider staff, within ten (10) working days (See Appendix I)

FAMILY SUPPORT AGREEMENT

_____ (“Applicant”) has submitted an application on behalf of the family of _____ (“Individual”) for Family Support services.

The _____ (“Provider”), a Family Support Provider / Agency contracting with DBHDD Region _____, has agreed to provide certain services.

This is an agreement between Applicant, on behalf of Individual and his/her family (as defined in the Family Support Guidelines) and the Provider/Agency regarding Family Support Services. The family is eligible only if the member with a developmental disability is residing in the home, or if the Family Support funds are to be used to prepare the home and the family for the return of the member with a developmental disability from an alternate care placement.

Applicant agrees as follows:

- The Applicant understands and acknowledges that Family Support services are provided only in the event that such services are not available or cannot be funded through other programs (including but not limited to Medicaid, Medicare, charitable organizations, etc.)
- The Applicant has provided complete and accurate information to Provider / Agency regarding Applicant’s and Individual’s efforts to obtain services through other programs, and regarding Applicant’s and Individual’s financial and other resources and needs. The Applicant represents that no other resources are available for the services the Applicant has requested as Family Support.
- The Applicant represents that all money received through Family Support services will be used solely for the purpose(s) documented on the Applicant’s Individual Family Support Plan. The Applicant understands and acknowledges that Family Support funds cannot be advanced to the Applicant or to any provider of services under any circumstances.
- The Applicant understands and acknowledges that he/she must present receipts or other documentation to verify any expenses for which he/she requests payment or reimbursement. Any misrepresentations of expenses or other attempt to misappropriate these funds is strictly prohibited and is subject to legal action.

FAMILY SUPPORT AGREEMENT

- The Applicant understands and acknowledges that any misrepresentation of Applicant's/ Individual's needs, resources, efforts to obtain services elsewhere, expenses incurred as part of the Family Service Plan and any attempt to misappropriate Family Support funds will result in immediate discontinuation of services, and the Applicant will be responsible to pay back any funds received based on such misrepresentation(s) or misappropriation(s).
- Applicant understands and acknowledges that any individual providing respite services as part of Family Support must be on a region maintained "List of Approved Respite Providers" prior to providing any respite services. (They cannot be reimbursed for any services provided prior to being approved.)
- Applicant understands and acknowledges that Family Support services are neither an entitlement nor a grant, and are provided as services to assist in maintaining a cohesive family unit and to assist the Individual to live at home in the community. The continued need for Family Support services will be re-evaluated no less than every six (6) months.
 - The Applicant agrees to use the Family Support services in compliance with all applicable guidelines (Attached hereto as Annex B).
 - The Provider agrees as follows:
 1. Provider will develop an Individual Family Support Plan (IFSP) for Applicant and Individual. Provider will develop the IFSP in consultation with Applicant and to the extent possible, with the Individual.
 2. Provider will set fees for Family Support goods and services on a "sliding fee" basis in consideration of Applicant's resources, and in compliance with any applicable DBHDD fiscal rules and regulations.
 3. Provider will designate a Family Support Coordinator as a single point of contact to work with Applicant and Individual in obtaining Family Support.
 4. Provider will review the IFSP every six (6) months, and at such time as there has been a significant change in Applicant's/ Individual's resources or needs.
 5. Provider will inform Applicant in writing of Applicant's rights to participate in the IFSP and IFSP reviews, and to appeal a denial, discontinuance, or reduction in benefits.
 - Both parties agree as follows:
 1. The Provider and Applicant will sign both copies of this agreement and return one signed copy to the appropriate BDHDD Regional Office. A copy will be kept on file by the Provider for State Review, as needed.
 2. This Agreement contains the entire agreement of the parties and there are no other promises or conditions in any other agreement whether oral or written. This Agreement supersedes any prior written or oral agreements between the parties.
 3. This Agreement may not be amended or modified except in writing signed by both parties.

FAMILY SUPPORT AGREEMENT

- 4. The failure of either party to enforce any provision of this Agreement shall not be construed as a waiver or limitation of that party’s right to subsequently enforce and compel strict compliance with every provision of this Agreement.
- 5. This Agreement is a required part of the Individual Family Support Plan; no Family Support funds may be expended prior to both parties’ signing this Agreement.
- 6. This agreement will terminate upon written notice of either party.

Individual’s Printed Name and Date of _____

Birth:

Printed Name of Applicant: _____

Relationship to : _____

Signature of Applicant: _____

Date of Applicant’s Signature: Month: _____ Date: _____ Year: _____

Applicant’s Complete Address: _____

Applicant’s Contact Telephone/Cell _____ / _____

Number(s):

Name of Provider / Agency: _____

Printed Name of Provider / Agency _____

Official:

Title of Provider / Agency Official: _____

Provider / Agency Official Signature: _____

Date of Official’s Signature: Month: _____ Date: _____ Year: _____

Provider / Agency’s Complete Address: _____

Provider / Agency ’s

Contact Telephone/Cell Number(s): _____ / _____

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PART IV

Community Service Standards Specific for Behavioral Health Services

**Provider Manual for
Community Mental Health,
Developmental Disabilities and
Addictive Diseases
Providers**

Fiscal Year 2012



**Georgia Department of Behavioral Health &
Developmental Disabilities**

April 2012

DBHDD

Part IV

**Community Service Standards Specific for
Behavioral Health Services**

SECTION I

***Operational and Clinical
Standards for Assertive
Community Treatment (ACT)
Teams***

Fiscal Year 2012



**Georgia Department of Behavioral Health &
Developmental Disabilities**

April 2012

DBHDD

**Georgia's
Program Operations Manual
For Assertive
Community Treatment
(ACT) Teams**



Georgia Department of Behavioral Health & Developmental Disabilities
Frank E. Shelp, M.D., M.P.H., Commissioner
Division of Mental Health
Two Peachtree Street NW, 23.415, Atlanta, Georgia 30303-3142~404-657-2273~FAX
404-463-7149

This manual is available on the Georgia Department of Behavioral Health and Developmental Disabilities website:

www.dbhdd.ga.gov

Assertive Community Treatment is identified by the Substance Abuse and Mental Health Services Administration as an evidence based practice that consistently demonstrates positive outcomes and is considered by experts as a recommended treatment option for individuals with serious and persistent mental illness.

Georgia's Program Operations for ACT Teams

ACT Program Operations:

The Georgia's Program Operations Manual for ACT Teams serves to guide ACT program start-up and implementation by clearly defining what is the expected minimum program requirements for each state ACT agency. A successful ACT program model implementation is demonstrated by improvements in consumer outcomes which are accomplished by close adherence to the evidence based practice of ACT operations (Herinchx et al., 1997; McHugo et al.,1999).

The DBHDD is invested in keeping you informed on the efforts for improving the quality of care and services provided to this particular adult population. We are committed to a clearly articulated philosophy (assertive outreach, integrated mental health and substance abuse treatment, stage-wise interventions, comprehensive services, and a long-term perspective) consistent with the ACT model.

There are 13 sections of the ACT Program Operations Manual. At the beginning of each section, the overall purpose and rationale for that section is explained and an explanation regarding program components will be discussed.

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I. Introduction

ACT is an Evidence Based Practice that is consumer-centered, recovery-oriented, and a highly intensive community based service for individuals who have severe and persistent mental illness.

Core Customer:

- The individual's mental illness has significantly impaired his or her functioning in the community.
- The individual has been unsuccessfully treated in the traditional mental health service system because of his/her high level of mental health acuity.
- The use of the traditional clinic based services for the individual in the past or present have usually been greater than 8 hours of service per month.
- The recipient may have experienced chronic homelessness and/or criminal justice involvement; and may have had multiple or extended stays in state psychiatric/public hospitals.

ACT provides access to a variety of interventions twenty-four (24) hours, seven days a week. The service utilizes a multidisciplinary mental health team from the fields of psychiatry, nursing, psychology, social work, substance abuse, and vocational rehabilitation; additionally, a Certified Peer Specialist is an active member of the ACT Team providing assistance with the development of natural supports, promoting socialization, and the strengthening of community living skills (DBHDD, 2011)

The ACT Team works as one organizational unit providing community based interventions that are rehabilitative, intensive, integrated, and stage specific. Services emphasize social inclusiveness through relationship building and the active involvement in assisting individuals to achieve a stable and structured life style. The service providers must develop programmatic goals that clearly articulate the use of best/evidence-based practices for ACT recipients using co-occurring and trauma-informed service delivery and support. Practitioners of this service are expected to maintain knowledge and skills according to the current research trends in best/evidence-based practices. ACT is a unique treatment model in which the majority of mental health services are directly provided internally by the ACT program in the recipient's natural environment. ACT services are individually tailored with each consumer to address his/her preferences and identified goals, which are the basis of the Individualized Recovery Plan (DBHDD, 2011).

The Essential Characteristics of Assertive Community Treatment Programs

- ACT is identified for individuals who have been diagnosed with a severe and persistent mental illness in which the mental illness has interrupted his or her ability to live in the community successfully. Due to the person's mental health conditions, he or she is a higher user of acute psychiatric hospitals and/or emergency/crisis services and/or incarcerations (Allness & Knoedler, 2003; Phillips et al., 2001).
- The process of recovery is embraced because each person with mental illness is believed to have the ability to live a healthy and productive life when proper guidance, skills, and supports are provided.
- The consumer group is often over-represented among the homeless and in jails and correctional facilities, and has been unfairly thought to resist or avoid involvement in treatment. However this is not the case, the use of traditional mental health services has not been beneficial for the person (Lamberti, Weisman, & Faden, 2004).
- ACT services are delivered by utilizing a multidisciplinary mental health team from the fields of psychiatry, nursing, psychology, social work, substance abuse, and vocational rehabilitation. The team is directed by a team leader who is an integrated part of the multidisciplinary team providing face to face and community based services to ACT individuals (Allness & Knoedler, 2003).
- ACT support staff will work in shifts to cover 24 hours per day, seven days a week to provide intensive services. It is recommended that the ACT Team provide for some individuals at least 5 face-to-face contacts per week based on the persons mental health acuity. The ACT model addresses having frequent but shorter length of contacts with participants. According to NAMI (Allness & Knoedler, 2003) the average length of services per consumer per week is 2 or more hours.
- Multiple contacts may be as frequent as two to three times per day, seven days per week, and are based on consumer need and a mutually agreed upon plan between the consumer and ACT staff. Many, if not all, staff share responsibility for addressing the needs of all consumers requiring frequent contact. The expected total number of contacts per consumer per month is 12 face to face contacts (Sherman & Ryan, 1998; DBHDD 2011).
- ACT services are individually tailored by addressing the preferences and identified goals of each consumer. Services and Supports are individually tailored emphasizing social inclusiveness through relationship building and the active involvement in assisting individuals to achieve a stable and structured life style. The approach with each consumer emphasizes relationship-building and active consumer involvement to make improvements in functioning, to better manage

symptoms, to achieve individual goals, and to maintain optimism (Allness & Knoedler, 2003).

- Georgia's Assertive Community Treatment programs will include a comprehensive and integrated set of medical and psychosocial services provided in non-office settings 80% of the time by a mobile multidisciplinary team. The ACT team will provide any number of elements necessary for a person's recovery (Teague, Bond, & Drake, 1998; SAMSHA).
- It is expected that 90% or more of the consumers have face to face contact with more than one staff member in a 2 week period (Teague, Bond, & Drake, 1998; SAMSHA; DBHDD 2011).
- ACT consumers will receive an array of services in order to meet individualized treatment goals. Individuals with SPMI (Serious Persistent Mental Illness) have a wide range of needs, such as developing a capacity for independent living; obtain employment or a meaningful activity, improving the quality of their family and social relationships, and managing anxiety and other negative moods (Allness & Knoedler, 2003).
- ACT services are delivered in an ongoing rather than time-limited framework to aid the process of recovery and ensure continuity of caregiver. Serious mental illnesses are episodic disorders and many consumers benefit from the availability of a longer-term treatment/service approach and continuity of care. This allows consumers opportunities to re-compensate, consolidate gains, sometimes slip back, and then take the next steps forward until they achieve recovery (McHugo et al., 1999; Herinckx et al., 1997).
- The ACT team will be involved in 95% or more of the hospital admissions and hospital discharges. The ACT team will be fully engaged in hospitalizations and discharges by collaborating with hospital personnel. The consumers ACT treatment plan should address the suggestions made by hospital personnel (DBHDD, 2011; SAMHSA).
- It is expected that individuals receiving ACT will achieve housing stability and have a decrease in the debilitating effects from the mental illness. Also, the individual will be assisted by the ACT team in social integration and functioning in order to increase community tenure. The individual will be assisted in defining what is his or her self-defined recovery plan should be (Allness & Knoedler, 2003; SAMSHA).

- The ACT team is expected to work with collateral contacts at least 2 to 4 times a month with or without the consumer present to provide support and skill training as necessary to assist the consumer in his or her recovery (i.e., family, landlord, employers, support systems, probation officers). If the consumer is not an engaged participant in this contact, the service shall not be billed (DBHDD, FY'11; (McHugo et al., 1999; Teague et al., 1998; SAMSHA).

There is an expectation that ACT consumers will experience a decrease in frequency and/or duration of hospitalizations, crisis services, and/or incarcerations (Lamberti, Weisman, & Faden, 2004; Herinckx, et al., 1997). The agency will be monitored by the State ACT Coordinator from DBHDD by submitting a monthly outcomes report on the number of individuals hospitalized and/or incarcerated and the number of consumers who received competitive employment and/or housing. If the agency appears to have a pattern of consumers being hospitalized and/or incarcerated, the agency will receive technical assistance in order to coordinate an action plan (DBHDD, 2011). Also, the ACT agency will receive an ACT Fidelity Review minimally once a year to evaluate if the ACT agency is operating at Full Fidelity.

- There will be an external review organization will conduct audits utilizing a authorization process that verifies there is a proper match between consumer need and the services provided. This involves identification of over-utilization *and* under-utilization of services through careful analysis of consumer functional and behavioral status, resources, and participation in the recovery process. It also ensures the services provided as defined in the DBHDD Provider Manual address consumers' therapeutic needs as demonstrated by provider documentation in the areas of assessment, individual recovery and resiliency plans, and progress notes.

II. Intake Process, Admission, and Discharge Criteria

Intake Process

Georgia's ACT teams are expected to take the initiative to develop collaborative intake processes with their relevant community and institutional referral sources to determine an individual's eligibility for admission and to effectively prioritize and engage new consumers. Georgia ACT teams must have clearly written admission criteria that are consistent with the DBHDD guidelines. According to best practices, the ACT program is expected to respond to any referral resource within a 72 hours period..

During initial program implementation, each state ACT team will stagger consumer admission's to gradually build up to full capacity. Even though Fidelity to the Dartmouth Assertive Community Treatment Scale states that the ACT Agency is not to admit no more than 6 consumers a month, the state of Georgia expects the ACT agency to admit more than 6 consumers a month until the agency has 40 consumers enrolled. The ACT agency is expected to have 40 consumers by July 1, 2011. After 40 consumers are admitted in to ACT, the tapering of admissions will be no more than 6 per month in order

to meet full fidelity requirements. This admission expectation is based on the necessity to maintain a stable service environment for existing consumers, while meeting the needs of newly admitted consumers who are usually in need of higher intensity of services from the team. Each team will gradually build up capacity to serve 100-120 consumers to meet full fidelity requirements (SAMSHA; Teague et al., 1998).

Admission Criteria

Admission decisions are based on considerations that are included in the Provider Manual for Community Mental Health, Developmental Disabilities, and Addictive Diseases Providers for the Department of BHDD. The admission criteria. (2011) defines 5 domains that a consumer must meet to qualify for ACT. The ACT model has demonstrated effectiveness for “consumers in greatest need” (Taube, Morlock, Burns, & Santos, 1990). DBHDD defines targeted ACT consumers as:

1. Individuals with severe and persistent mental illness that seriously impairs the ability to live in the community. **Priority** is given to people recently discharged from an institutional setting with schizophrenia, other psychotic disorders, or bipolar disorder, because these illnesses more often cause long-term psychiatric disability.
and
2. Individuals with significant functional impairments as demonstrated by the need for assistance in 3 or more of the following areas which despite support from a care giver or behavioral health staff continues to be an area that the individual cannot complete:
 - a. Maintaining personal hygiene;
 - b. Meeting nutritional needs;
 - c. Caring for personal business affairs;
 - d. Obtaining medical, legal, and housing services;
 - e. Recognizing and avoiding common dangers or hazards to self and possessions;
 - f. Persistent or recurrent failure to perform daily living tasks except with significant support or assistance from others such as friends, family, or relatives;
 - g. Employment at a self-sustaining level or inability to consistently carry out homemaker roles (e.g., household meal preparation, washing clothes, budgeting or childcare tasks and responsibilities);
 - h. Maintaining a safe living situation (e.g., evicted from housing, or recent loss of housing, or imminent risk of loss of housing).**and**
3. Past (within 180 days of admission) or current response to other community-based intensive behavioral health treatment has shown minimal effectiveness (e.g. Psychosocial Rehabilitation, CSI, etc).^{*} Admission documentation must include evidence to support this criterion.
4. Individuals with **two or more of the following issues** that are indicators of continuous high-service needs (i.e., greater than 8 hours of service per month):
 - a. High use of acute psychiatric hospitals or crisis/emergency services including mobile, in-clinic or crisis residential (e.g., 3 or more admissions in a year) or extended hospital stay (60 days in the past year) or psychiatric emergency services.

- b. Persistent, recurrent, severe, or major symptoms that place the individual at risk of harm to self or others (e.g., command hallucinations, suicidal ideations or gestures, homicidal ideations or gestures, self harm).
- c. Coexisting substance use disorder of significant duration (e.g., greater than 6 months) or co-diagnosis of substance abuse.
- d. High risk for or a recent history of criminal justice involvement related to mental illness (e.g., arrest and incarceration).
- e. Chronically homeless (e.g., 1 extended episode of homelessness for a year, or 4 episodes of homelessness within 3 years).
- f. Residing in an inpatient bed (i.e., state hospital, community hospital, CSU) or in a supervised community residence, but clinically assessed to be able to live in a more independent living situation if intensive services are provided, or requiring a residential or institutional placement if more intensive services are not available.
- g. Inability to participate in traditional clinic-based services (must provide evidence of multiple agency trials if this is the only requirement met on the list).

* If the individual meets one or more of the criteria below, criteria #3 above is waived. All other requirements (criterion 1, 2, & 4) must be met:

- a. Individual is transitioning from a state forensic unit or group home on a Conditional Release order; or
- b. Within the last 180 days, the individual has been incarcerated 2 or more times related to a behavioral health condition; or
- c. Within the last 180 days, individual has been admitted to a psychiatric hospital or crisis stabilization unit 2 or more times.

Continued Stay/Discharge/Transitioning Criteria

ACT provides services that are delivered in a continuous rather than time limited framework for persons with longer-term episodic disorders. This time-unlimited structure allows the ACT team to address relapse possibilities that might occur for the consumer when he or she is beginning the transition process to less intensive practices. The ACT team will be provided up to a 4 week period to transition the consumer, however, even if a consumer and the ACT team recognize current treatment accomplishments, the consumer may begin to show signs of decompensation during this transitioning period. The transition period can be a scary time for the consumer but this is normal. If the consumer appears to need a continued stay for another authorization period, the ACT team may request if consumer meets continuing stay criteria in the provider manual. The ACT team will incorporate discharge/transition planning with activities that prepare the consumer for a greater sense of self reliance, when the consumer perceives self to be ready.

Consumers should not be forced out of the program prematurely. In appropriate circumstances, consumers may transition to less intensive services, but arrangements must be made to maintain contact with the consumer until the transfer is complete. All too often consumers are not discharged for reasons of recovery or goal achievement but are dropped due to conflicts with staff or because the complexity of the problems and issues require too much staff time.

In circumstances when a consumer wants to “fire” the ACT team, it is important that the ACT team be willing to listen and to accommodate the consumer’s preferences regarding services. If the consumer still requests discharge, their request must be honored.

The consumer should be given all necessary help to arrange alternative services and given priority for readmission to current ACT provider or another ACT provider if they so choose.

The discharge and transitioning criteria as described for Best Practices and/or from the Provider Manual for Community Mental Health, Developmental Disabilities, and Addictive Diseases Providers for DBHDD:

1. Individual no longer meets admission criteria (DBHDD, 2011);

OR

2. Individual has substantially met individually established goals for discharge. Program staff will arrange for transfer to a less intensive service and maintain contact with the consumer until transfer is complete (DBHDD, 2011);

OR

3. Individual has successfully demonstrated an ability to function in all major role areas (i.e., work, social, self-care) without ongoing assistance from the program, and without significant relapse when services are withdrawn (over approximately a two-year period) (Allness & Knoedler, 2003);

OR

4. Individual has moved or will move outside the geographic area of ACT's geographical responsibility. The ACT team shall partner with the consumer to arrange for transfer of mental health service responsibility to an ACT program or another provider. The ACT team shall maintain contact with the consumer until this service transfer is implemented (Allness & Knoedler, 2003);

OR

5. Individual has declined or refused services and request discharge and not in imminent danger of harm to self or others (DBHDD 2011);

OR

6. Individual requires services not available in this level of care (DBHDD, 2011).

Note: During discharge/ transition, the ACT Team will provide at least 3 face-to-face contacts per week for most individuals on an ongoing basis. All individuals participating in ACT transitioning must receive a minimum of 4 face-to-face contacts per month. The Team must see each individual at least once a month for symptom assessment and medication management. A transition plan must be adequately documented in the Individualized Recovery Plan and clinical record (DBHDD, 2011).

The ACT team can provide these transitioning services for up to 4 weeks:

- Psychosocial Rehabilitation
- Community Support
- Behavioral Health Assessment
- Service Plan Development
- Diagnostic Assessment
- Physician Assessment (specific to engagement only)
- Individual Counseling (engagement only)

Documentation of Discharge/Transitioning shall include:

- The reasons for discharge as stated by both the consumer and the ACT team.
- The consumer's discharge bridging services in which he or she will be engaged
- A written final evaluation summary of the consumer's progress toward the goals set forth in the treatment plan.
- Discharge diagnosis (s) both medical and psychiatric
- Living arrangement
- Summary of consumer's progress for all areas of his or her life
- Written description of how the consumer defines how he or she has met recovery goals
- A plan developed in conjunction with the consumer for follow-up treatment after discharge.
- The signature of the consumer, the team leader, and the psychiatrist.

III. Service Intensity and Capacity Frequency of Client Contact

ACT Teams must be designed to deliver services in various environments, such as homes, schools, homeless shelters, and street locations. The provider should keep in mind that individuals may prefer to meet staff at a community location other than their homes or other conspicuous locations (e.g. their place of employment or school). Staff who drive a vehicle that is clearly marked as a state or agency vehicle need to remember that a breach of confidentiality may occur if the ACT staff member does not have consent to meet consumer in an agency marked vehicle. Staff should be sensitive to and respectful of individuals' privacy/confidentiality rights and preferences in this regard to the greatest extent possible (e.g. if staff must meet with an individual during their work time, mutually agree upon a meeting place nearby that is the least conspicuous from the individual's point of view).

- The service delivery by ACT teams must consider confidentiality. An ACT staff member will address with the consumer the privacy and confidentiality issues regarding his/her treatment in the community. ACT staff members need to remember that wearing visible name tags, wearing stethoscope in to consumers

building or desired location, driving agency car/van, wearing nursing scrubs, and any other identifiable items does impede on consumers rights for confidentiality.

- At least 80% of all service units must involve face-to-face contact with consumers. Eighty percent (80%) or more of face-to-face service units must be provided outside of the program office locations that are comfortable and convenient for consumers (including the individual's home, based on individual need and preference and clinical appropriateness) (Teague et al., 1998; SAMSHA).
- Some individuals may need at least 5 face-to-face contacts per week because of his or her mental health acuity. Some consumers may not need 5 contacts in a week. But, all individuals participating in ACT must receive a minimum of 12 face-to-face contacts per month. Also, it is expected that 90% or more of consumers have face to face contact with more than one staff member in a 2 week period (DBHDD, 2011; Teague et al., 1998; SAMSHA).
- In addition to a minimum of 12 face to face contacts a month, one of those 12 contacts a month must be for symptom assessment and management of medications (McGrew et al., 1994; Teague et al., 1998; DBHDD, 2011).

Frequency of Collateral Contacts

The ACT team is expected to work with collateral contacts (i.e., family, landlord, employers, support network, probation officers) at least 2 to 4 times a month with or without the consumer present to provide support and skill training is necessary to assist the identified resource and/or consumer in establishing needed supports/services. These formal and informal support persons and the ACT team can work together to meet the wide range of needs the consumer may have, such as developing a capacity for independent living, obtaining employment or some other meaningful activity, improving the quality of their family and social relationships, and managing anxiety and other negative moods.

All identified partners must have a release of confidentiality signed by the consumer. The services provided to the collateral contacts are not billable when the consumer is not engaged in the interaction. (ACT Teams must have a release of confidentiality signed by the consumer for each collateral contact.)

Staff Coverage

- ACT teams maintain a small consumer-to-clinician ratio, of no more than 10 consumers per staff member. This does not include the psychiatrist, program assistant/s, transportation staff, or administrative personnel. Staff-to-consumer ratio takes into consideration evening and weekend hours, needs of special populations, and geographical areas to be served.
- Staff-to-client ratios may also need to be adjusted in settings where safety is an issue and staff must pair up to work in a particular setting. However, the overall staff-to-client ratio should be no less than 1 FTE for every 10 consumers.
- Services must be available by ACT Team staff skilled in crisis intervention 24 hours a day, 7 days a week with emergency response coverage, including psychiatric services (SAMSHA; DBHDD, 2011).
- Answering device, services, referring or forwarding lines to the Georgia Crisis and Access Line do not meet the expectation of “emergency response.” Crisis services are available to ACT consumers and provided by ACT staff (SAMSHA; DBHDD, 2011).
- The team must be able to rapidly respond to early signs of relapse and de-compensation and must have the capability of providing multiple contacts daily to individuals in acute need. Best practice recommends that a limited geographic area be served by each ACT team so that ACT team members can typically respond to a potential crisis within 30 minutes.

The ACT team shall be available to provide treatment, rehabilitation, and support activities seven days per week, 24 hours a day. It is important for the ACT agency to consider achieving regularly operating and scheduling of staff to work two eight-hour shifts with a minimum of two staff on the second shift (afternoon/evening), thus providing services at least 12 hours per day /weekdays. When the agency reaches 100 consumers, the depth of staff working morning/afternoon and evening shifts will assist in continuity of care for the consumer. The ACT agency should schedule ACT staff for on-call duty to provide crisis and other services the hours when staff members are not working assigned shifts. Additionally, the availability of the ACT psychiatrist during 24 hours is not always feasible so an alternative psychiatric back-up should be arranged.

Continuity of Care

ACT teams shall establish mechanisms to provide continuity of care and ensure collaboration with other service-providers (e.g., to facilitate transition to other services, in-patient admissions when necessary, and access to other community and institutional services). Of particular concern is access to crisis stabilization and crisis residential care.

The major premise of ACT is that consumers are capable of playing a vital role in the management of their illnesses and in making progress towards achieving their goals. Providers accept the responsibility of getting information to the consumers so that they

can become more effective participants in their treatment process. All consumers receiving ACT services are offered choices and the team will abide by the consumers preferences when offering and providing services.

Note: ACT recipients who also receive a DBHDD Residential Service may not receive ACT-provided skills training which is a part of the “residential” service is. The ACT provider shall be in close coordination with the Residential provider such that there is no duplication of services supports/efforts (DBHDD, 2011).

IV. Staff Requirements

ACT Staffing Plan per 100 Consumers

Position	FTE	Minimum Dedicated Hours per week	**Required Agency Employees	Consumer Capacity
Team Leader	1.0	40	X	
Psychiatrist	.4	16		
RN	1.0	40	X	
SA Practitioner	1.0			.50 if >50 Dually Diagnosed Consumers
Licensed or Associate-Licensed Clinician under supervision	1.0	40	X	
CPS	1.0			.50 with > 50 consumers
Vocational Specialist	1.0			.50 with > 50 consumers
Para Professional	1.0			
Other	2.5			
Total	10			100

*At least 2/3 (i.e. 7 of 10) staff must be Agency Employees (not “contracted:/1099).

The following practitioners can provide Assertive Community Treatment:

- Practitioner Level 1: Physician/Psychiatrist
- Practitioner Level 2: Psychologist, APRN, PA
- Practitioner Level 3: LCSW, LPC, LMFT, RN
- Practitioner Level 4: LMSW; LAPC; LAMFT; Psychologist/LCSW/LPC/LMFT’s Supervisee/trainee with at least a Bachelor’s degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology, functioning within the scope of the practice acts of the state; MAC, CAC-I, CAC-II, CADC, CCADC, GCADC (II, III); PP, CPRP, CPS, or Addiction Counselor Trainees with Master’s or Bachelor’s degree in one of the helping professions such as social work, community counseling, counseling, psychology, or

criminology (addictions counselors may only perform counseling functions related to treatment of addictive diseases).

- Practitioner Level 5: CPS, PP, CPRP, CAC-I, RADT (I, II, or III), Addiction Counselor Trainees with high school diploma/equivalent under supervision of one of the licensed/credentialed professionals above.

Assertive Community Treatment Team Members Composition must include:

- Team Leader: (1 FT Employee required) A fulltime Team Leader who is the clinical and administrative supervisor of the team and also functions as a practicing clinician on the team; this individual must have at least 2 years of documented experience working with adults with a SPMI and following qualifications to be an “independently licensed practitioner:” It is expected that the practicing ACT Team Leader provides services in the community at least 50% of the time. The Team Leader must be a FT employee and dedicated to only the ACT team (DBHDD, 2011; SAMSHA). The Team Leader must be a FT employee and dedicated to only the ACT team. and can be licensed as one of the following:
 - Physician
 - Psychologist
 - Physician’s Assistant
 - APRN
 - RN with a 4-year BSN
 - LCSW
 - LPC
 - LMFT
- Psychiatrist :(.40 FTE required) A full or part time Psychiatrist who provides clinical and crisis services to All ACT team consumers, works with the team leader to monitor each individual’s clinical and medical status and response to treatment, and directs psychopharmacologic and medical treatment. The psychiatrist to ACT consumer ratio must not be greater than 1:100 and the psychiatrist must provide a minimum of 16 hours per week of direct support to the ACT team/ACT consumers. Effective 7/1/11, the psychiatrist must participate at least one time/week in the ACT team meetings (DBHDD, 2011; SAMSHA).
- Registered Nurse: One Fulltime Employee Registered Nurse who provides nursing services in the community and on location for all ACT team consumers and works with the team to monitor each individual’s physical health, clinical status and response to treatment. The nurse is responsible for conducting psychiatric assessments, assessing physical health, providing a range of medical treatment, education to consumers on adherence to treatment and prevention of medical issues, nutrition, and providing a range of rehabilitation and support services. The nurse is expected to be dedicated to the ACT Team, participate in overall treatment goals, and plans in collaboration with consumer and ACT team. The nurse is to be included with the on-call staff rotation providing crisis

intervention. The ACT team nurse is expected to consult with community agencies and families for coordination of care. At least one ACT RN must be dedicated to a single ACT team. “Dedicated” means that the RN works with only one team at least 40 hours/week and is a full-time employee of the agency (not a subcontractor/1099 employee) (DBHDD, 2011; SAMSHA).

- *Certified Peer Specialist*: One FTE who is fully integrated into the team and promotes consumer self-determination and decision-making and provides essential expertise and consultation to the entire team to promote a culture in which each consumer’s point of view and preferences are recognized, understood, respected and integrated into treatment, rehabilitation and community self-help activities. The CPS will conduct a Wellness and Recovery Action Plan with each consumer on an ongoing basis. Each Certified Peer Specialist has the ability to serve as an advocate, life coach, or mentor; develop community support; assist in the development of rehabilitation goals; facilitate resolution of issues; or provide education on the importance of maintaining personal wellness and recovery.

The CPS is expected to complete a Wellness Recovery Action Plan (WRAP) with each consumer. The WRAP is an on going collaboration between the consumer and the CPS. The WRAP is considered to be the CPS comprehensive assessment tool.

Key elements of WRAP consist of:

- Wellness Toolbox
- Daily Maintenance Plan
- Identify Triggers and an Action Plan
- Identify Early Warning Signs and an Action Plan
- Identify When Things Are Breaking Down and an Action Plan
- Crisis Plan
- Post Crisis Plan

The WRAP is designed and managed by the consumer and the CPS. The goal of developing a WRAP is to empower the consumer in acknowledging he or she has personal strengths and recovery is possible. The WRAP guides the consumer in exploring behaviors and supports that have been or would be useful in decreasing and preventing intrusive or troubling feelings and behaviors. The ACT team will assist the consumer with increasing personal empowerment, improving quality of life, and assisting the consumer in achieving his/her own life goals and dreams (Copeland; 2009).

- *Substance Abuse Specialist*: (1/2 FTE minimum) A 1/2 to fulltime equivalent substance abuse practitioner who holds a CACI (or an equally recognized SA certification equivalent or higher) and assesses the need for and provides and/or accesses substance abuse treatment and supports for team consumers. If any single team serves 50 or more individuals with a co-occurring SA issue, then there must be 1 FTE on the team. The ACT team provides most of the substance abuse treatment services for consumers with serious mental illness and co-existing

substance abuse disorders. The most effective assessment and treatment approaches employ an integrated treatment model in which mental health and substance abuse treatment are provided simultaneously. The Substance Abuse Specialist must be knowledgeable regarding evidence based practices for dually diagnosed individuals. The use of Motivational Interviewing, Stage-wise treatments, and Integrated Dual Diagnosed Treatment are all interventions that can be implemented. The Substance Abuse Specialist is expected to see each dually diagnosed consumer 1 time a week and to ensure that 50% of the total dually diagnosed consumers receive one monthly dual diagnosis treatment based group (SAMSHA; DBHDD, 2011).

- *Vocational Specialist:* (1/2 to 1 FTE) One of these staff must be a Vocational Specialist. A Vocational Specialist is a person with a minimum of one year verifiable vocational rehabilitation experience. This person may be a ½ FTE if the team serves less than 50 individuals (DBHDD, 2011; SAMSHA; Allness & Knoedler, 2003).

Vocational Specialists primarily participate in core principles of Individual Placement and Support (IPS) and can refer/connect ACT consumers to Supported Employment Services. The vocational specialist's roles are:

- To integrate Supported Employment in to the ACT Treatment Plan once consumer has a desire to work..
- To interact with the Supported Employment Specialist and coordinate services together and develop a Memorandum of Understanding (MOU) between the ACT provider and the Supportive Employment provider if these are different services provided by a different agency.
- To focus on community jobs that pay at least minimum wage and is of interest to the consumer. The vocational specialist provides outreach, education, and support to employers who may be interested in hiring people with mental illness.
- To maintain continuous follow-along supports for the consumer even after employment and as long as the consumer desires assistance from the vocational specialist
- To assists consumers to develop a vocational or employment plan that leads to entry into the labor market. Vocational plans should be developed after an assessment of aptitudes, abilities and interests.
- To provide support to ensure that consumers can keep their jobs or remain in their chosen educational programs. The support needed may involve education or problem solving for consumers, employers and co-workers. Supports can also involve coordination and advocacy to ensure consumers have access to necessary community supports, such as income, housing, medical benefits and counseling.

(SAMSHA; Allness & Knoedler, 2003)

- *A second licensed or licensed associate team member:* (1 FT employee) A full-time practitioner licensed to provide psychotherapy/counseling under the practice acts or a person with an associate license who is supervised by a fully licensed clinician, and provides individual and group support to team consumers (this position is in addition to the Team Leader). An associate licensed professional **Can Not** be a team lead.
- *Para-Professional:* (2 FTEs) Two paraprofessional mental health workers who provide rehabilitation and support services under the supervision of a Licensed Clinician. For example:
 - (1/2 to 1 FTE) One of these staff must be a Vocational Specialist. A Vocational Specialist is a person with a minimum of one year verifiable vocational rehabilitation experience. This person may be a ½ FTE if the team serves less than 50 individuals.
 - (1 to 1 ½) FTE Other Paraprofessional
- *Program/Administrative Assistant:* The program/administrative assistant (minimum one FTE) is responsible for organizing, coordinating, and monitoring all non-clinical operations of ACT, including: managing medical records; operating and coordinating the management information system; maintaining accounting and budget records for consumer and program expenditures; and providing receptionist activities, including triaging calls and coordinating communication between the team and consumers. This position is recommended based on best practices but **not a requirement** (Allness & Knoedler, 2003).
- *Primary Practitioner:* **This is not an added position** but a title given to a consumers primary ACT staff member who leads and coordinates the activities of the Individual Treatment Team (ITT) (review Allness & Knoedler, 2003 for explanation about ITT) and is the ITT member who has primary responsibility for establishing and maintaining a therapeutic relationship with a consumer on a continuing basis, whether the consumer is in the hospital, in the community, or involved with other agencies. In addition, he or she is the responsible team member to be knowledgeable about the consumer's life, circumstances, and goals and desires. The primary practitioner develops and collaborates with the consumer to write the person-centered treatment plan, ensures that changes are made as the consumer's needs change, and advocates for the consumer. The primary practitioner works with other community resources to coordinate activities and to integrate other agencies or service activities into the overall service plan with the consumer. The primary practitioner provides individual supportive therapy and provides primary support and education to the family and/or support system and other significant people. The primary practitioner shares these service activities with other members of the ITT who are responsible to perform them when the primary practitioner is not working (Allness & Knoedler, 2003).

Staff Supervision

The team leader shall assume responsibility for supervising and directing all staff activities. This supervision and direction shall consist of:

- Individual, side-by-side sessions in which the supervisor accompanies an individual staff member to meet with consumers in regularly scheduled or crisis meetings to assess staff performance, give feedback, and model alternative treatment/service approaches.
- Participation with team members in daily organizational staff meetings and regularly scheduled treatment/ planning meetings to review and assess staff performance and provide staff direction regarding individual cases.
- Regular meetings with individual staff to review their work with consumers, assess clinical performance, and give feedback.
- Regular reviews, critiques, and feedback of staff documentation (i.e., progress notes, assessments, treatment/service plans, treatment/service plan reviews).
- Written documentation of all clinical supervision provided to ACT team staff.

Staff Training Requirements

The DBHDD requires ACT Providers and ACT Teams to receive technical assistance from the central office on ACT implementation, the organizational structure of ACT, team roles, and achieving full fidelity. Also, the central office may develop separate and mandated training through the term of the contract.

Paraprofessional Required Training

Georgia's Department of Behavioral Health and Developmental Disabilities (DBHDD) has specified a minimum standard training requirement for staff who are not licensed/certified practitioners and/or do not have one of a number of recognized credentials but who provide reimbursable services for an approved provider agency. Provider employees who are not licensed professionals or holders of an approved credential are hereafter referred to as paraprofessionals. Individuals who are credentialed as Georgia Certified Alcohol and Drug Counselors (GCADC, II or III) or Registered Alcohol and Drug Technicians (I, II or III) are exempt from the paraprofessional training requirement and do not have to take the courses/tests.

The Minimum Standard Training Requirement is the minimum standard necessary for paraprofessionals to provide state funded or Medicaid reimbursable services. Organizations may choose to require more training to fulfill their organization's specific needs.

Essential Learning, LLC (EL) has been used to provide online, 24/7 access to course content for paraprofessionals. The EL courses provide usable information necessary to fulfill requirements for delivering DBHDD behavioral health services and supports, while also providing paraprofessionals with access to information that will help them be more effective on the job. For general information about EL, please visit www.essentiallearning.com.

Minimum Standard Training Requirement for Paraprofessionals

- Corporate Compliance
- Cultural Competence
- Documentation
- First Aid/CPR
- Mental Illness – Addictive Disorders
- Pharmacology & Medication Self-Admin
- Professional Relationships
- Recovery Principles
- Safety/ Crisis De-escalation
- Explanation of Services
- Service Coordination
- Suicide Risk Assessment

The Minimum Standard Training Requirement for Paraprofessionals is designed to include subject matter that may be satisfied using Essential Learning online courses in addition to courses provided at the organization level. Proof of course completion via a certificate, generated either online by Essential Learning or by the “live” course provider, is necessary to receive credit toward meeting the standard training requirement.

V. Staff Meetings and Planning Service

The ACT team shall conduct Treatment Team Meetings, Individual Treatment Team Meeting, Treatment Planning Meeting, and a Treatment Planning Review Meeting at regularly scheduled times per a schedule established by the team leader. These meetings will be conducted in accordance with the following procedures:

- Treatment Team Meetings (referred to as the Daily Organization/Morning Meeting in the NAMI start-up manual) is a **daily** staff meeting held at regularly scheduled times under the direction of the team leader or an appointed designee. The meetings are conducted at least 4 times a week to meet Full Fidelity.

However, the DBHDD service guidelines require at least a minimum of 3 meetings a week. Each consumer is discussed briefly in order to review the service contacts which occurred the previous day and the status of the consumer. The meetings will review the service contacts which are scheduled to be completed during the current day and revise as needed based on consumer needs. The daily staff assignment discussed to carry out the day's service activities. Also, the meeting will be used to revise treatment plans and plan for emergency and crisis situations as needed. The daily log and the daily staff assignment schedule are used during the meeting to facilitate completion of these tasks. All consumers within ACT receive care from a multidisciplinary team and providers of ancillary services who work collaboratively on the mental health team. Collaboration suggests that team members regularly communicate about the consumer's progress and are not merely component parts.

It is expected that all ACT programs coordinate all elements of treatment and rehabilitation to ensure that everyone is working toward the same goals in a collaborative manner (Allness & Knoedler, 2003).

- Daily Staff Assignment Schedule is a **daily timeline** summarizing all consumer treatment and service contacts. Based on the consumers individualized needs will depend on which team member will be doing face to face. This daily staff schedule itinerary for all consumer's activities for that day, what will be conducted by specific team members, where colleagues are, and how to reach them if issues or situations arise. Because consumers needs often change, the daily staff schedule addresses personalized care which is not based on a team member seeing the same consumer each week at the same time. For example, the day prior, a consumer admitted to the CPS that she is using substances. In the next day morning meeting, the daily schedule would incorporate the CAC to begin treatment with the consumer.
- Individual Treatment Team (ITT) is a group of three to five ACT staff members who are comprised of both clinical and rehabilitation skills and expertise. According to best practices, the team is organized **at least thirty days after admission**. The ITT members are assigned by the team leader and the psychiatrist to work collaboratively with a consumer and his/her family and/or natural supports in the community. The ITT team is considered the primary team at that time based on the consumer's needs and goals. For example, the consumer verbalized during the comprehensive assessment that he desires to obtain employment, wants to address his substance abuse, and feels ashamed about his mental illness. The primary ITT would consist of vocational specialist, substance abuse specialist, and the certified peer specialist. All teams must include the primary practitioner, psychiatrist, and at least one clinical or rehabilitation staff person who shares case coordination and service provision tasks for each consumer.

The ITT has continuous responsibility to be knowledgeable about the consumer's life, circumstances, goals and desires. The team will collaborate with the consumer to develop and write the treatment plan; to offer options and choices in the treatment plan; to ensure that immediate changes are made as a consumer's needs change; and to advocate for the consumer. The ITT is responsible to provide much of the consumer's treatment, rehabilitation, and support services. ITT members are assigned to take separate service roles with the consumer as specified by the consumer and the ITT in the treatment plan. Please review NAMI Start-up Manual by Allness and Knoedler (2003) for further discussion about ITT.

- Treatment Planning Meeting a regularly scheduled meeting conducted under the supervision of the team leader and the psychiatrist. The purpose of this meetings is for the entire ACT staff and the consumer and his/her family/natural supports, to thoroughly prepare for their working together. The meeting is conducted **after the Comprehensive Assessment is completed** and the team will meet together to present and integrate the information collected through the assessment in order to learn as much as possible about the consumer's life, his/her experience with mental illness, and the type and effectiveness of the past treatment they have received. The presentations and discussions at this meeting make it possible for all staff to be familiar with each consumer and his/her goals and aspirations and for each consumer to become familiar with each ITT staff person.
- Treatment Plan Review a thorough, written summary describing the consumer's and the ITT's evaluation of the consumer's progress/goal attainment, the effectiveness of the interventions, and satisfaction with services since the last person-centered treatment plan. DBHDD requires treatment plan review to occur at **least every 3 months (or as needed)** treatment plan review be conducted and revised as indicated. The Treatment Plan Review is utilized to capture the consumer's progress toward goals for problems that they are currently being treated for. The review is performed periodically during treatment and addresses the justification for continued stay at the current level of care or justification for a transfer to different level of care.

ACT Meeting Grid

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Type of Meeting	Tasks/Description/Purpose	Who is Present	How often
<p>Treatment Team Meeting Usually conducted in the morning</p>	<ul style="list-style-type: none"> ▪ Discussion on every csr; even if briefly . ▪ Lasts 1 hour ▪ Meeting covers: medical, medication, SA, crisis or relapse signs for SA/MH issues, supports, upcoming appointments, progress, needs, & vocational. ▪ Daily Staff Assignments ▪ Daily Log ▪ Weekly csr schedules and schedule changes: Based on csr needs which the team member might need to see csr that day. ▪ Building team cohesiveness, brain storming, and supporting each other. 	<ul style="list-style-type: none"> ▪ The Entire Team and Psychiatrist at least once a week 	<ul style="list-style-type: none"> ▪ Minimal 3 times a week ▪ DACTS gives an agency a score of a 5 when the Tx team meets 4 to 5 times a week.
<p>Treatment Planning Meeting</p>	<ul style="list-style-type: none"> ▪ Discuss comprehensive assessment. ▪ Orient csr ACT services. ▪ Review what consumer wants out of treatment. ▪ Introduce csr to his/her ITT members. ▪ Answer csr questions. ▪ Make recommendations for the treatment plan. ▪ Discuss resources, barriers, goals, needs, and deficiencies. 	<ul style="list-style-type: none"> ▪ Newly enrolled Consumer ▪ The entire team and Psychiatrist 	<p>Upon completion of comprehensive assessment and prior to the ITT meeting</p>

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<p>Individual Treatment Team (ITT) Meeting</p>	<ul style="list-style-type: none"> ▪ Discussion on identified consumers. ▪ Explore how ITT team will reach recovery goals and treatment needs. ▪ Devise Treatment Plan ▪ Write a progress note with who attended the meeting, outcome of the meeting, and who is on the csr ITT Team. 	<p>3-5 people who best fit the consumers needs</p>	<p>Meeting occurs after the comprehensive assessment is completed and the Treatment Planning Meeting has already occurred.</p> <p>Meet as needed</p> <p>ITT team may change every 3 months depending on consumers needs.</p> <p>Prior to Discharge and transitioning consumer</p> <p>Team may need to meet with csr if issues arise.</p>
<p>Treatment Plan Review</p>	<ul style="list-style-type: none"> ▪ Update treatment plan – the Primary Case Manager will update treatment plan in this meeting. ▪ A written summary describing the consumer’s and the ITT’s evaluation of the consumer’s progress/goal attainment, the effectiveness of the interventions, and satisfaction with services since the last person-centered treatment plan was written. 	<ul style="list-style-type: none"> ▪ Entire Team ▪ psychiatrist ▪ Consumer 	<p>Quarterly and at reauthorization; on going.</p>

Non-attendance exception can be decided and documented by the Team Leader.

Documentation of Meetings

The ACT team must have documentation (e.g., notebook, binder, file, etc.) which contains all staffing interactions (which shall become a document for audit purposes, and by which claims/encounters can be revoked-even though there are no funds attached). In addition to the requirements in Section G.2 in the DBHDD Provider Manual, a log of staff meetings is required to document staff meetings as outlined in Section A.2 of the DBHDD Provider Manual.

The ACT program should develop a *Daily log* which is a notebook or a cardex used by the ACT team which is maintained on a **daily basis** during the first meetings of the day to provide a roster of individuals served and for each individual served there is a brief documentation of any treatment or service contacts that have occurred during the day and the behavioral description of the individuals clinical status. Team members who do not attend the morning meeting can review the daily log. The log is a good source of communication between the morning shift and the evening shift. It is similar to a brief shift report in hospital settings (Allness & Knoedler, 2003).

VI. Client-Centered Assessment and Individualized Recovery Treatment Planning

The consumer and the ACT team work together to formulate and prioritize consumers issues, set goals, research approaches and interventions, and establish the individualized recovery treatment plan (IRP). Because eligible individuals may be difficult to engage, the initial recovery treatment plan for an individual may be more generic at the onset of treatment/support. It is expected that the treatment plan be individualized and recovery-oriented after the team becomes engaged with the individual and comes to know the individual. The allowance for “generic” content of the IRP shall not extend beyond one initial authorization period.

The Individualized Recovery plan are individually tailored so that the treatment/rehabilitation/support approaches and interventions achieve optimum symptom reduction, help fulfill the personal needs and aspirations of the consumer, take into account the cultural beliefs and realities of the individual, and improve all the aspects of psychosocial functioning that are important to the consumer.

Initial Assessment

An initial assessment and treatment plan shall be completed on the day of the consumer’s admission to ACT by the team lead and the psychiatrist. The initial assessment evaluates the consumer’s appropriateness for ACT, documents his or her initial diagnosis, reviews the immediate needs for the consumer, informs the consumer about ACT, and develops a generic individualized recovery plan/service plan.

ACT Comprehensive Assessment

- *ACT Comprehensive Assessment* is the organized process of gathering and analyzing current and past information with each consumer and the family and/or support system and other significant people in the individual's social network. The multidisciplinary team is to gather data pertaining to their specialty on the ACT team. For example, the substance abuse section will be completed by the Certified Addictions Counselor. According to best practices and the DACTS model, the comprehensive assessment is used to establish immediate and longer-term service needs with each consumer and to set goals and develop the first individualized treatment plan. Because of the complexity of the mental illness and the need to build trust with the served individual, the comprehensive mental health, addiction, and functional assessments may take up to 60 days. When a person identifies and allows his/her natural supports to be partners in his or her recovery that the supports will be fully involved in the assessment activities. The ACT team documentation will demonstrate this participation and in accordance with confidentiality. Please review NAMI Start-up Manual by Allness and Knoedler (2003) for copy of a comprehensive assessment.

The ACT Comprehensive Assessment will cover the following areas (Allness & Knoedler, 2003)

- Reasons for admission
- History of present illness
- Treatment goals and individual strengths
- Evaluation of mental and functional status; along with a proper diagnosis
- Prior treatment and rehabilitating services used and the outcomes of these services
- Physical health
- Use of alcohol or drugs and SA treatment
- Education and employment
- Assets, limitations, preferences for future education and employment
- Social development and functioning
- Social skills and legal involvement
- Activities of daily living skills
- Family structure and relationships
- Recommendations for initial plan
- Recommendations for treatment plan goals and individual strengths/weaknesses

Goals of the comprehensive assessment

- To reconstruct and evaluate what the individual has been through in his or her life while living with a mental illness
- To form a therapeutic alliance with each ACT consumer
- Working with the individual on his or her own terms by not rushing to complete the comprehensive assessment but to view the assessment as an ongoing practice
- To help the individual identify personal needs and aspirations and instilling hope for recovery
- To understand the individual on various individual and social levels in order to develop an individualized treatment plan
- For nurse and psychiatrist to have evaluate medical needs and interventions that are to be addressed in treatment

Additional Requirements: A psychiatric and social functioning timeline

- *Psychiatric and Social Functioning TimeLine* is a form which assists the team staff to organize chronological information about significant events in the consumer's life. The timeline can reveal how ones mental illness impacts a person from living productively in the community. The timeline can reveal developmental milestones that weren't reached because of the persons' mental illness. The timeline will also provide a treatment history of possible anniversary dates or triggers that lead to hospitalization. This format allows staff systematically to analyze and evaluate the information with the consumer, to formulate hypotheses for treatment, and to determine appropriate treatment and rehabilitation approaches and interventions with the consumer. One person on the team is responsible for gathering the data and completing the form.. The individual chosen to complete the timeline will be working in the ACT office gathering data. Please review the NAMI Start-up Manual by Allness & Knoedler (2003) for a copy of a timeline.

Individualized Recovery Treatment Planning

The Individualized Treatment Plan shall be developed through a client-centered approach in collaboration with the consumer and the family or substitute decision maker. The consumer's participation in the development of the treatment plan shall be documented. Together the ACT team and the consumer shall assess the consumer's needs, strengths, and preferences, and develop an individualized treatment service plan. The Individual Treatment Team members are responsible to ensure that the consumer is actively involved in the development of treatment recovery goals. With the consent of the consumer, the ACT team shall also involve pertinent agencies and members of the consumer's social network in the formulation of treatment/service plan.

The treatment/service plan shall:

- Identify individual issues/problems
- Set specific measurable short-term and mid-term goals for each issue/problem.
- Establish the specific approaches and interventions necessary for the consumer to meet his or her goals, improve his or her capacity to function as independently as possible in the community, and achieve the maximum level of recovery possible (i.e., a meaningful, satisfying, and productive life).
- Document in the plan who will carry out the approaches and interventions.

Possible components of the treatment/service plan may include:

- Symptom management
- Physical health issues
- Substance abuse (if indicated)
- Education and employment
- Social development and functioning
- Activities of daily living
- Family structure and relationship
- Psychiatric illness or symptom reduction
- Housing
- Daily structure and employment
- Family and social relationships
- Co-occurring illnesses (if indicated)

VII. Required Services

The ACT multidisciplinary team will individually plan and deliver services that are targeted to help consumers address the complex interaction between symptoms and psychosocial functioning in order for the consumer to achieve personal goals.

Best Practices and Full Fidelity for ACT include the following services:

- Service coordination
- Crisis assessment and intervention
- Symptom assessment and management
- Cognitive-Behavioral Therapy, Motivational Interviewing
- Self-management skills
- Medication prescription, administration, monitoring and documentation;
- Substance abuse treatment
- Work/education-related services
- Activities of daily living services and family supports
- Social, interpersonal relationship and leisure-time activity services
- Support services or direct assistance to ensure that consumers obtain the basic necessities of daily life

It is important that members of the ACT team reflect the cultural diversity of the local population that the team serves.

Crisis Assessment and Intervention

A crisis is a period of disequilibrium and decreased functioning. A crisis is not the event but the individual's perception of and response to situation. Consumers' acute responses include helplessness, confusion, anxiety, shock, and anger (Golan, 1978) and crisis supports are considered to be nonlinear interventions. Nonlinear crisis support interventions holds the belief that emotional disorder does not reside within the person; rather, psychological and emotional issues often relate to the disordered environments and relationships in which the consumer lives and engages. ACT is a "hospital without walls" and the ACT team is expected to be available 24 hours a day/7 days a week. One goal of ACT is to prevent hospitalization. Each ACT consumer should have a WRAP to assist him or her in recognizing signs and triggers that might inhibit a crisis episode.

The ACT team should have conversations upon admission and through on going dialogue with the consumer regarding preventive measures for not being hospitalizations/incarcerated before the consumer has de-compensated to the point of needing inpatient care or jail. Examples of preventive measure include medication compliance, teaching skills to consumer that he or she can use when being triggered or is feeling stressed, having a list of names and numbers of contacts consumer may call, and/or exploring items that may be of comfort for the consumer which can provide a sense of safety/security.

The beginning stage of a crisis:

- Engagement with consumer
- Define and assess the crisis situation
- Explore meaning and importance of the upsetting situation
- Identify the emotional and behavioral responses and perceptions of consumer
- Break down the crisis in to smaller manageable parts to help identify steps leading up to consumer feeling helpless
- Review current behavioral reactions
- Review how situation could have been dealt with differently by providing hope, reviewing strengths, and choices

The second phase of crisis intervention consists of an Action Plan:

- Design an action plan
- Review barriers to action plan
- Write down past resilience behaviors
- Identify triggers
- Identify signs leading up to crisis

The last stage of a crisis intervention consists of:

- Review the action taken and evaluate success
- Guidance about handling future crisis situations
- Process feelings around ending the crisis-therapeutic relationship
- If crisis intervention did not deescalate thoughts, feelings, or behaviors then hospitalization may be necessary

Co-Occurring Disorder Services

If a consumer has a co-occurring disorder, the Substance Abuse Specialist will provide at least one weekly session addressing co-occurring issues with the use of stage-wise interventions. Evidence based practices shows positive results for individuals with co-occurring disorders which includes Integrated Dual Diagnosis Treatment, Motivational Interviewing, and Cognitive Behavioral Therapy,

The ACT team shall provide a stage-based integrated treatment model that is non-confrontational, considers interactions of mental illness and substance abuse, and has client-determined goals. When promoting behavior change for a consumer, the change is based on incremental growth. In order for lasting change to occur, an individual must be educated, prepared, motivated, and supported. The stage-wise interventions are suggestions to provide individually adapted health and behavioral changes tailored to the individual's specific interests, preferences, and readiness to change. Evidence Based Practice stage-wise interventions teach participants the behavioral skills needed to incorporate healthier habits into their lifestyle. The interventions provide leverage constructs from established behavioral change models.

Consumers in the early stages of readiness to change (pre-contemplation or engagement stage) receive content that is designed to raise their awareness about the benefits of change. As their state of readiness evolves, the interventions adapt according to the consumers goals and confidence level. The interventions are built around weekly themes that encourage sustainable and incremental changes. The goal is to promote action by providing resources, education, and support. Motivational Interviewing incorporates stages of change that are identifiable by the person's statements and behaviors.

Harm Reduction needs to be addressed with the dually diagnosed consumer. Harm reduction is not a model but a set of practical strategies that reduce negative consequences of substance use by incorporating a spectrum of strategies for safer use and to manage ones use to possible abstinence. Harm reduction strategies meet substance users where they are in his or her life.

Harm reduction is based on four principles

- While absolute abstinence may be preferable for many or most substance abusers, very few will achieve it, and even that small group will take time to do so and may relapse periodically
- Ordinary medical treatment readily accepts and practices ameliorative therapies, which preserve health and well-being even when people fail to observe all recommended health behaviors
- Therapists should present accurate information to clients and may even express their own beliefs, but they cannot make judgments for clients
- There are many shades of improvement in every kind of therapy—this improvement may be all that people are capable of and should be encouraged and nurtured.

(Denning, Little, & Glickman, 2004)

Examples of Harm Reduction Techniques

- Remind consumer not to repeat the previous dosage if he/she has stopped using drugs/alcohol for a while in order to prevent overdose or blackouts through lowered tolerance
- Encourage the consumer to take their first dose later in the day to encourage control and gradual reduction (avoid or reduce the early morning dose)
- Reflect on previous episodes of treatment and relapses as well as why
- Analyze the causes underlying one's previous criminal behavior, triad connection, and its possible consequences
- Explore costs and benefits of crime

Work Related Services

Work related services are integrated in to the ACT model to guide consumers to find and maintain competitive employment. Employment, even if part-time, will create social inclusion for the consumer, enhance self esteem, and provide a structured life style. Every individual with a mental illness diagnosis has the right to access opportunities to have employment.

An ACT consumer can receive services with a Supported Employment agency and ACT simultaneously. A collaborative relationship between the supported employment agency and the ACT vocational specialist will be established. Both professionals will provide different components of treatment and services but both professionals work toward achieving the same goal of assisting the consumer in obtaining competitive employment and building upon skill set. A MOU will need to be developed between the supported employment case manager and the ACT vocational specialist if these are separate agencies providing the services.

A few reasons why working is good for someone's mental health

- Allows one to feel “ I'm doing something useful”
- Allows one to be busy and fulfills the time
- Allows creativity and to make money
- Allows one to do a variety of tasks
- Allows meeting new people
- Allows new experiences
- Allows one to learn about responsibility
- Allows opportunities to make friends
- Allows one to contribute to the community

Activities of Daily Living and Wellness Recovery

Activities of daily living services support consumers with enhancing and maintaining housing which is safe and affordable. The ACT team will teach/assist (but not complete for) consumers in procuring necessities in order to maintain and live independently. The ACT team will teach activities of daily living skills such as performing household activities, cooking, grocery shopping, and laundry, developing healthy eating habits, carrying out personal hygiene and grooming tasks, developing or improving money-management skills; using available transportation, and to effectively use a personal physician or other medical professional. Also, the ACT team will educate consumers on wellness topics such as nutrition, exercise, diabetes and diabetes prevention, heart disease, relaxation and stress management, and smoking cessation.

Social/Interpersonal Relationship and Leisure-Time Skill Training

The ACT team will assist consumers in the improvement of their social/interpersonal relationships and their use of leisure-time as needed. These activities may include improving communication skills, developing assertiveness, developing social skills, increasing social experiences, family reunification, and planning appropriate use of leisure time and relating to landlords, neighbors, and others effectively. When ACT recipients are also receiving a DBHDD Residential Service, the consumer may not receive ACT-provided skills training which is a part of the “residential” service. The ACT provider shall be in close coordination with the Residential provider such that there is no duplication of services supports/efforts. A formal MOU is needed to structure and clearly define what services the ACT team will provide and what services the Residential Provider will provide.

Peer Support Services

DBHDD promotes client-centered practices with the use of Certified Peer Specialists. The peer support specialists serve to validate consumers' experiences and to guide and encourage consumers to take responsibility for and actively participate in their own recovery. In addition, services help consumers identify, understand, and combat stigma and discrimination against mental illness and develop strategies to reduce self-imposed stigma.

Because of life experience with mental illness and mental health services, the certified peer specialist provides expertise that professional training cannot replicate. The Certified Peer Specialists are fully integrated ACT team members who provide highly individualized services in the community and promote consumer self-determination and decision-making. Peer specialists also provide essential expertise and consultation to the entire team to promote a culture in which each consumer's point of view and preferences are recognized, understood, and respected.

Peer Support services include:

- Self-disclosing and sharing of life experience to serve as a mentor and a role model;
- Assisting consumers to recognize the need for and developing a coping mechanisms to deal with symptoms and social stigma;
- Educating staff within the team regarding the consumer perspective on the mental health system and assisting the team to maintain a client centered approach that maximizes consumer participation and empowerment;
- Advocating for development of consumer initiatives within the community and identifying opportunities for consumer empowerment; and
- Introducing and referring consumers to consumer self-help programs and advocacy organizations that promote recovery; and
- Developing a WRAP with consumer

Support Services

To ensure that consumers have access to the basic necessities of daily life, the ACT team will assist consumers in using transportation, making medical and dental appointments, provide benefits counseling (e.g. Income Assistance, assistance in filing Social Security/Disability); assisting with finding affordable housing; and assistance in locating and referring to other community resources.

Family-Centered Services

ACT teams are expected to include consumer's family members or others who the consumer considers to be of significance to participate in the consumer's recovery process. Some services utilize active inclusion of significant others in the consumer's recovery are:

- To discuss strengths and experiences of the consumer
- How the consumers' mental illness impacted his or her support system
- To promote reduction in stress and increase coping skills
- To structure problem solving approach
- To improve communication skills
- To build support systems and plans
- To provide family psychoeducation
- To address family unification

Groups

Research indicates that better outcomes are achieved when group treatment is integrated as a curriculum based treatment for individuals with severe and persistent mental illness. Research suggests that modifications in maladaptive behavior occur most effectively when stages of treatment are taken into account (Kanas, 2000).

- Clarification for groups: (up to 8 units/week) A group may be offered to no more than 10 ACT participants at one time and must be directed by no fewer than 2 staff in order to be billed as a Group. This group contains no less than 3 consumers and no more than 10 consumers. This may be offered for no more than 2 hours in any given week. Only ACT consumers are permitted to attend these group services. The group practitioner levels are 1-5 when a curriculum-based therapeutic group is offered such as Dialectical Behavioral Therapy skills building, Motivational Interviewing, Cognitive Behavioral groups (DBHDD, 2011). Acceptable group practitioners are those on the ACT team who meet the practitioner levels as follows:
 - Practitioner Level 1: Physician/Psychiatrist
 - Practitioner Level 2: Psychologist, CNS-PMH
 - Practitioner Level 3: LCSW, LPC, LMFT, RN
 - Practitioner Level 4: LMSW; LAPC; LAMFT; Psychologist/LCSW/LPC/LMFT's supervisee/trainee with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology, functioning within the scope of the practice acts of the state; MAC, CAC-II, CADC, CCADC, GCADC (II, III); CAC-I or Addiction Counselor Trainees with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, and

counseling, psychology, or criminology (may only perform these functions related to treatment of addictive diseases).

- Practitioner Level 5: CAC-I, RADT (I, II, or III), Addiction Counselor Trainees with high school diploma/equivalent (practitioners at this level may only perform these functions related to treatment of addictive diseases)
- Substance abuse groups are expected to be offered 1 time a month to at least 50% of the total dually diagnosed consumers in ACT (SAMSHA; DBHDD, 2011). This group has to be treatment oriented and curriculum based. An ACT team can refer a consumer to another program that offers a treatment oriented and curriculum based group. Must attend same group (SAMSHA; DBHDD, 2011).

Examples of Self Help Groups that are not billable include

- Double Trouble
- NA/AA Anonymous

Note: If an ACT organization provides these self help groups, the interactions that may occur between a consumer and an ACT team member is not billable.

ACT is a comprehensive team intervention and most additional services are excluded, with the exceptions of

- Peer Supports,
- Residential Supports,
- Community Transition Planning (to be utilized as a person is transitioning to/from an inpatient setting, jail, or CSP)
- Group Training/Counseling (within parameters listed in Section A), and
- Supported Employment

And those services which are identified as a part of the transition plan (see page 13 of this document)

VIII. Client Record

The ACT team shall maintain a treatment record for each consumer. The treatment record is confidential, complete, accurate, and contains up-to-date information relevant to the consumer's care and treatment. The record shall accurately document assessments, treatment plans, and the nature and extent of services provided, such as a person unfamiliar with the ACT team can easily identify the consumer's treatment needs and services received. The team leader and the program assistant shall be responsible for the maintenance and security of the consumer treatment records. The consumer records are located at the ACT team headquarters and, for confidentiality and security, are to be kept in a locked file. For purposes of confidentiality, disclosure of treatment records by the ACT team is subject to all the provisions of applicable state and federal laws. Consumers

shall be informed by staff of their right to review their record and the process involved to request to do so. Each consumer's clinical record shall be available for review and may be copied by authorized personnel (DBHDD, 2011). .

Detailed expectation for documentation are set forth in the Provider Manual for Community Mental Health, Developmental Disabilities, and Addictive Diseases Providers for the Department of BHDD. *Documentation Guidelines for Behavioral Health Providers*.

IX. Client Rights and Complaint Resolution Procedures

ACT teams' policies and procedures ensure the protection of consumer rights and must be consistent with provincial legislation and Provider Manual for Community Mental Health, Developmental Disabilities, and Addictive Diseases Providers for the Department of BHDD, and the Medicaid Part I Program and Policy Manual, which include a mechanism to readdress complaints. All team members must fully understand a consumer's right:

- To have his or her capable decisions about autonomy and self determination
- To be respected; to make decisions that may not be in his or her best interests; and to give or refuse consent to services or treatment, where the consumer is capable with respect to such decisions.
- Where the consumer is not capable, all team members must respect the need to comply with legislation and professional operations that govern consent to treatment and services for incapable persons.
- These principles are intrinsic to the basic tenets of consumer-centered care. The team must facilitate the fair and efficient resolution of complaints.
- Nondiscrimination
- Control of own money
- Voice or file grievances or complaints
- Confidentiality

XI: ACT Fidelity Review: Program Evaluation

- *What is an ACT Fidelity Review* The ACT Fidelity Scale is the Dartmouth Assertive Community Scale (DACTS) developed by Teague, Bond, and Drake (1998). The DACTS contains 28 program specific items to measure the adequacy of implementation of ACT programs. Each item is scored a likert scale from 1-5 with 5 meaning Fully Implemented. The scale items fall in to three categories: human resources (structure and composition); organizational boundaries; and nature of services.
 - ACT Fidelity monitoring ascertains a measurement of the Team's current practice based upon clinical record reviews, staff interviews, and interviews with consumers; along with

administrative documents. The fidelity score and composite report can assist you in practice improvement areas and assist in providing technical assistance to your professional employees.

- The ACT Fidelity Scale has been developed to measure the adequacy of ACT program implementation. A team of 2 to 3 representatives will conduct the Fidelity Reviews and will convene to review results. If the team feels a need for further clarification, you will be asked to submit additional documents to ensure the most accurate results as possible. It is important for the ratings to be made objectively, based on fidelity evidence.
- At the end of the review, a brief summary of findings will be verbally shared with the program, highlighting significant ratings with an emphasis on the strengths of the program.
- You will receive an ACT Fidelity Monitoring Report which includes a fidelity score and explanation. The report will be informative, factual, and constructive.
- The ACT Fidelity Review is conducted at least once a year. The DBHDD Evidence Based Program Specialist will contact the agency to schedule a Fidelity review.
- To review ACT Fidelity Tool Kit, please visit www.samsha.gov.
- *The Description of the 3 Categories of the DACTS*
 - **Human resources section:**
The Human Resources Domain measures the number and mix of Professional's comprising the ACT team and the extent to which the team uses a multi-disciplinary approach to service delivery.
 - **Organization boundaries section :**
The Organizational Boundaries Domain examines the structure and operations of the ACT team and the extent to which the team coordinates with other organizations involved in delivery of services to ACT recipients.
 - **Nature of services :**
The Nature of Services Domain evaluates how the ACT team delivers services to ACT recipients

Note: A fidelity review will not be conducted on an ACT agency if the agency has not been billing for services at least 6 months. Also, if an ACT agency does not have the proper staffing as stated in the Provider Manual for Community Mental Health,

Developmental Disabilities, and Addictive Diseases Providers for the Department of BHDD, which reflects the DACTS full fidelity recommendations, the agency will not receive a fidelity score because the agency is considered not meeting minimal staffing requirements to provide ACT services.

The fidelity assessment is administered by individuals who have experience and training in interviewing, data collection, and auditing. The evaluators have an understanding of the nature of ACT. It is expected that the ACT agency receive a 90% to 100% for the implementation of ACT services in order to be considered meeting full fidelity to the model.

XII. Community Advisory Bodies

Each ACT program is encouraged to establish a local community advisory body that would support and guide the ACT team implementation and operation. This body may support other mental health services as well as ACT teams. This body performs a key role in promoting high quality and recovery-oriented services for ACT clients.

The advisory members are chosen for their specific knowledge about the ACT model, their general knowledge of mental health and addiction services, their links with relevant community resources, and their ability to represent the interests of consumers and the ACT community program. Members selected should include both mental health consumers and the community stakeholders. Membership on the advisory body should be culturally aware and competent, and reflect the diversity of the local population.

Possible Committee Members

- State, county, and local mental health administrators
- Consumers and family members
- Corrections
- Vocational rehabilitation
- Housing and Medicaid representatives
- NAMI

The community advisory body should have written terms of reference for incorporating the requirements outlined in this section. The main responsibilities of the advisory body are to

- Promote fidelity to the ACT Program Operations.
- Problem-solve and advocate to reduce system barriers to ACT implementation.
- Provide the program with advice on timely resolutions to emerging issues.
- Represent the interests of consumers and their families about services received from the ACT team.
- Develop and maintain good communication with the community.

- Promote partnerships, awareness and understanding of the program's target population.
- Review and make recommendations on the ACT agency's annual operating plan and budget, identify any opportunities to increase cost-effectiveness by collaborating with other agencies, and bringing to the Board's attention any significant deviations from the plan and budget during the year.

ACT Coalition

ACT teams are a key community resource to help manage consumers in the community who are most at risk of re-hospitalization. ACT can also serve as a bridge to the community for many of our consumers who have had repeated and prolonged hospitalizations.

In order to improve the utilization of ACT services, DBHDD hosts monthly meetings including ACT providers and key members of the DBHDD as well as other speakers. The meetings include information which is directly relevant to providing treatment for ACT consumers and for maintaining full fidelity to the model.

It is therefore very important that you or a decision maker in your agency attend at least 80% of the meetings. Do not send representatives who are not administratively responsible for management level decisions. We welcome staff from your team but require a key management team member to develop strategies related to ACT services.

Letters will be mailed to agencies that are not meeting the Department of Behavioral Health and Developmental Disabilities expectations for the 80% attendance to the ACT Coalition Meetings. According to the Commissioner's letter dated in July 2010, the expectation is to see you or a key administrative person at the ACT Coalition Meetings the 2nd Thursday of the month at 1pm.

The ACT provider will need to maintain a current ACT team list serve in order to receive emails about ACT related items and invites to the ACT Coalition. Please email the agency's primary contact for ACT and the CEO's email to XXXXXX.

The Benefits of the ACT Coalition Meetings

A collaborative and objective arrangement that allows ACT providers an opportunity to pool resources and combine efforts in order to effect change in serving mentally ill adults.

- Technical assistance trainings to help ACT provider evolve their program
- An opportunity to network with other agencies
- An opportunity to find support from fellow peers
- To share resources
- To learn about changes in policies and procedures
- To learn from guest speakers

XII: Outcomes

Outcomes show the benefits and changes for individuals during or after participating in the ACT program activities. The outcomes can be both positive and negative over time. With the use of outcome data, the patterns of the program and consumers become visible depending on the program's overall organizational structure and consumer characteristics.

The DBHDD expects all ACT providers to bestow quality services with the emphasis of reaching full fidelity to the ACT Model. If the ACT agency is modeling full fidelity, the outcome data will display a decline in recurrent acute episodes of the illness, an increase in the consumer's quality of life, an increase of consumer involvement in social and employment roles and activities, and a decline of homelessness, hospitalizations, and incarcerations.

Outcomes are considered a program evaluation tool that provides the viewer a snap shot of the program implementation to the ACT model. Each ACT program shall evaluate: 1) consumer outcomes; 2) consumer and family satisfaction with the services; and 3) fidelity to the ACT model. Program evaluation will be used by the ACT team, the Regional Offices, an External Review Organization, the state ACT Coordinator of DBHDD, and the community advisory board in order to evaluate program effectiveness and to establish program improvement and performance goals. Each ACT agency is expected to submit outcome data to the state ACT Coordinator once a month. Please review outcome form on pages 43-44.

XIII. Recovery

Recovery is more than the elimination of symptoms from an otherwise unchanged life. It is about regaining wholeness, connection to the community, and a purpose-filled life. Pat Deegan (1987) wrote:

“Recovery does not refer to an end product or result. It does not mean that one is "cured" nor does not mean that one is simply stabilized or maintained in the community. Recovery often involves a transformation of the self wherein one both accepts ones limitation and discovers a new world of possibility. This is the paradox of recovery i.e., that in accepting what we cannot do or be, we begin to discover who we can be and what we can do. Thus, recovery is a process. It is a way of life. It is an attitude and a way of approaching the day's challenges. It is not a perfectly linear process. Like the sea rose, recovery has its seasons, its time of downward growth into the darkness to secure new roots and then the times of breaking out into the sunlight. But most of all recovery is a slow, deliberate process that occurs by poking through one little grain of sand at a time”.

DBHDD expects all ACT agency's to Create a Recovery Supportive Environment where consumers are involved in all aspects of their own treatment, where people define their own recovery, staff acknowledge that consumers are fellow human beings and not a diagnosis, and self-determination, critical thinking, and independence are valued.

ACT Monthly Programmatic Report –ANNEX C

Please Submit the ACT Monthly Programmatic Report by the 10th of each month to the State ACT Coordinator at XXXXXXXX. This report must reflect the *actual* number of consumers benefiting from ACT Services each Monthly.

Provider Name: _____ Geographic Area: _____

Month and Year of Service: _____

A. ACT TEAM CENSUS

Monthly

1. ACT Team Consumer Census End of LAST MONTH. _____
2. Number ACT Team Consumer Enrollments this Month. _____
3. Number ACT Team Consumer Discharges this Month (12.a + b + c + d + e). _____
4. ACT Team Consumer Census End of THIS MONTH (11.a + b + c + d + e + f). _____

B. OUTCOME DATA (For Consumers Receiving ACT Services this Month)

Monthly

5. Number Admissions to Psychiatric Hospitals, CSPs, Inpatient Detox, this Month. _____
6. Number Days Utilized in Psychiatric Hospitals, CSPs, Inpatient Detox, this Month. _____
7. Number of ACT Consumer Contacts with Police/Criminal Justice this Month. _____
8. Number of Days Spent in Jail or Prison this Month. _____
9. Number of ACT Consumers Competitively Employed this Month. _____
10. Number of ACT Consumers w/an Episode of Homelessness this Month. _____
11. ACT Team Consumers by Living Arrangement this Month:

FY2012 Provider Manual Part IV/Section I Assertive Community Treatment (ACT) Teams

- a. Congregate Care (Personal Care Home, Group Home) _____
- b. With Family or Friends (no rental agreement) _____
- c. Supervised Apartment (rental agreement, on-site support) _____
- d. Independent Apartment (rental agreement, no on-site support) _____
- e. Homeless or Shelter _____
- f. Other _____

C. DISCHARGE DATA

Monthly

12. Number ACT Consumer Discharges By Discharge Criteria this Month:

- a. Graduated, Stepped Down to Lesser Intensive Services _____
- b. Graduated, No Need for Further Services _____
- c. Drop Out, Refused Service, Unable to Locate, Unplanned Move _____
- d. Admitted to Institution (Hospital, Prison, Nursing Facility) _____
- e. Deceased _____

Provider Program Manager

DBHDD ACT Coordinator

Date Submitted

Data Received

Evidence Based Practices in ACT- Appendix B

EBP Embedded in ACT:

- Illness Management and Recovery
- Integrative Dual Diagnosis Treatment
- Collaboration with families/Psycho-education
- Motivational Interviewing Techniques
- Supported Employment
- Permanent Supported Housing
- Psycho-educational Multifamily Groups

Specific evidence-based practices that are within the ACT model can be provided by the ACT team :

- Cognitive Behavioral Therapy for Social Skills Training
- Evidence-based pharmacological treatment using practice guidelines (algorithms) and a collaborative approach with ACT consumers;
- Double Trouble to Recovery (non-billable because self help group)
- Pathways to Housing First Model
- Dialectical Behavioral Therapy
- Trauma Affect Regulation: Guide for Education and Therapy
- Seeking Safety
- Program to Encourage Active, Rewarding Lives for Seniors
- IPS
- Trauma Recovery Empowerment Model

Note: Please review www.SAMHSA.gov for descriptions of all these evidence based practices.

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Part IV

**Community Service Standards Specific for
Behavioral Health Services**

SECTION II

***Crisis Stabilization Standards
for Adults***

Fiscal Year 2012



**Georgia Department of Behavioral Health &
Developmental Disabilities**

April 2012

DBHDD

**DEPARTMENT OF BEHAVIORAL HEALTH AND
DEVELOPMENTAL DISABILITIES¹⁰**

**CORE REQUIREMENTS FOR ADULT CRISIS STABILIZATION PROGRAMS
Operated by COMMUNITY SERVICE BOARDS**

Effective July 1, 2001

Crisis Stabilization Program standards for adults are incorporated by reference into those found in the State of Georgia, Department of Behavioral Health and Developmental Disabilities document entitled “Standards for All Providers”.¹⁰

The CSP standards document has been footnoted to indicate modifications and additions to the standards since their inception. Crisis Stabilization Program standards that arose from issues resulting from the Certificate of Need concern addressed in the “Letter of Agreement” between the Department of Community Health and DHR Division of MHDDAD, signed on the 28th day of February, 2001 by George P. A. Newby, representing DCH and by Jerry Lovrien, representing DHR, have not been modified and may be modified only pursuant to agreement between DHR and DCH.

SSr 11.1. DESCRIPTION OF THE PROGRAM

SSr 11.1(a). Crisis Stabilization Program is a medically monitored short-term residential service operated by the Community Service Board⁴ for the purpose of providing psychiatric stabilization and detoxification services. The crisis stabilization program must be designated by the Department as both an emergency receiving facility and an evaluating facility.

Interpretive guideline 1: The department may designate any private facility or such portion of a certified community mental health and substance abuse program which complies with the standards for a CSP within the State of Georgia at the request of or with the consent of the governing officers of such facility. Rules of DHR MHMRSA ERETF 290-4-1-.02(a). Et. Seq.

Interpretive guideline 2: As defined in the Rules of DHR MHMRSA ERETF 290-4-1-.01(b), the term “Crisis Stabilization Program (“CSP”) means a short term residential program operated as a part of a comprehensive community mental health and substance abuse program [operated by a Community Service Board or by a Department of Behavioral Health and Developmental Disabilities (DBHDD) state hospital facility]^{4/10} for the purpose of providing psychiatric stabilization or detoxification services, which complies with applicable Community Service Standards contained within the *Provider Manual for Community Mental Health, Developmental Disabilities and Addictive Diseases for The Department of Behavioral Health and Developmental Disabilities Providers*..

Interpretive guideline 3: Crisis stabilization programs are state supported residential services provided as a part of a Community Service Board⁴ and designed to serve as a first line alternative to

⁴ CSP’s may be state operated effective FY04

¹⁰ Updated FY10

hospitalization in state hospitals, offering psychiatric stabilization and detoxification services on a short term basis.

Interpretive guideline 4: The target population served in the CSP is adults (age 18 or older) with severe and persistent mental illness, persons with substance related disorders and persons with co-occurring mental health and substance use needs.

Interpretive guideline 5: Emancipated minors and juveniles who are age 17 may be served within these programs when their need for stabilization can be met by the CSP, when they do not need specialized child and adolescent services, and when their life circumstances demonstrate they are more appropriately served in an adult environment. Such admissions must be approved by the Medical Director.

Interpretive guideline 6: Residential detoxification services offered within the CSP **shall not exceed** services described in Level III.7 of the *American Society for Addiction Medicine Patient Placement Criteria* (ASAM), Second Edition, April 2001.

Interpretive guideline 7: NOTE: Twenty-four hour residential services offering detoxification **ONLY** shall be licensed by the Healthcare Facility Regulation Division under the “Rules of Department of Human Resources Chapter 290-4-2: Drug Abuse Treatment and Education Programs”. These CSP standards shall not apply.

Interpretive guideline 8: **Psychiatric stabilization services** offered within the CSP **shall not exceed** services described in Level Six of the *Level of Care Utilization System for Psychiatric and Addiction Services, Adult Version 2000* (LOCUS), published by the American Association of Community Psychiatrists, August 2006 (most recent version).¹⁰

Interpretive guideline 9²: The term “emergency receiving facility” means a facility designated by the department to receive patients under emergency conditions as provided in Part 1 of Article 3 of Chapter 3 or of Chapter 7 of Title 37. Rules of DHR MHMRSA ERETF 290-4-1-.01(d).

Interpretive guideline 10²: The term “evaluating facility” means a facility designated by the department to receive patients for evaluation as provided in Part 2 of Article 3 or of Chapter 7 of Title 37. Rules of DHR MHMRSA ERETF 290-4-1-.01(e).

Interpretive guideline 11²: Designation reviews will be conducted for physical plant, safety and food service according to the specifications outlined in the Rules for Drug Abuse Treatment & Education Programs, Chapter 290-4-2, section .11 “Physical Plant and Safety” and section .12 “Food Service”.

¹⁰ Updated citation added FY08

² Added to CSP Standards FY02

¹⁰ Updated FY2010

¹⁰ Added to CSP standards FY10

Interpretive guideline 12⁶: CSP's that are newly constructed or CSP's undergoing physical plant modifications after June 30, 2005 shall address safety issues to minimize the opportunity for self-harm of an individual such as, but not limited to the following:

- Shower fixtures in bathrooms shall be flush-mounted in the wall
- Headers supporting bathroom stalls shall be flush-mounted to the ceiling
- There shall be two avenues of visual access into the seclusion and restraint room, one of which shall be through a shatterproof window in the locked door. The room shall have a minimum fifty (50) square feet in area and the door to the room can be opened from the outside.¹⁰
- Blind spots on the unit and in the seclusion and restraint room shall be addressed through use of convex mirrors allowing for visual access. A room used for seclusion or restraint must:
 - i. Allow staff full view of the resident in all areas of the room;
 - ii. Be free of potentially hazardous conditions such as unprotected light fixtures and electrical outlets
- Video cameras are not a permitted alternative to direct observation of an individual in the seclusion or restraint room.
- Doors to bedrooms shall be hung on hinges that swing both in to the room and out from the room.⁷ Note that if a building is being *modified* and it is not possible for the door to swing both ways, the door should be mounted to open away from the room.
- Facility must have a satisfactory food service permit score, if applicable. Facility may utilize meal preparation services from an affiliated or contracted entity with a current food service permit. A copy of the current food service permit must be on file in the facility. Should the facility elect to have meals prepared off-site, the facility will have a modified kitchen that includes a microwave, a refrigerator, and clean-up facilities.¹⁰
- Facility must maintain a daily temperature log for freezer and refrigerator.¹⁰
- Foods, drinks and condiments shall be dated when opened.¹⁰
- Facility must have a sufficient designated area to accommodate meal service. This area may double as a group or activity area.¹⁰
- Facility maintains a temperature between 65 and 82 degrees F that ensures the comfort and safety of all clients.¹⁰
- Facility is free of offensive odor and noise.¹⁰
- Ramps are built according to specifications of Section 504 of the Rehabilitation Act of 1973.¹⁰
- The facility enforces a nonsmoking policy, but may provide a designated smoking area. If smoking is permitted, the facility designates and confines smoking to the designated smoking area.¹⁰
- Outdoor client area must be secured for safety and privacy.¹⁰
- Pre-admission waiting area, including restroom, must meet all safety requirements applicable to designated client areas.¹⁰
- Multi client bedrooms shall have a minimum of 60 sq ft per client and a private room shall not be less than 100 sq ft.¹⁰

⁶ Added to CSP Standards FY06

⁷ Added to CSP Standards FY07

- Beds must be either weighted or secured to the floor.¹⁰
- Prohibited bed types include but not limited to beds with springs, cranks, rails or wheels. The use of hospital beds is discouraged and rollaway, cots, double deck, stacked; hide-a-bed and studio couches are not to be used in lieu of standard beds.¹⁰
- Facility lighting shall be sufficient enough for reading and other activities.¹⁰
- Gender specific restrooms shall have adequate ventilation and have an adequate number of sinks, toilets and showers to accommodate the population served.¹⁰
- Exposed plumbing pipes shall be covered to prevent client access.¹⁰
- Rods/curtains utilized for privacy shall be designed not to sustain more than 30 pounds.¹⁰
- Water temperature for consumer usage must be maintained between 110-120 degrees. For those facilities providing onsite food service, a separate water heater is designated for usage.¹⁰
- Facility windows and mirrors must be either temper glass, plastic or shatterproof.¹⁰

Interpretive guideline 13: Facilities are accessible to and usable by physically disabled individuals and must meet the minimum requirements of Section 504 of the Rehabilitation Act of 1973. Centers install required alterations or modifications in accordance with the 1984 Law of Georgia regarding Access to and Use of Public Facilities by Physically Handicapped Persons: O.C.G.A. Section 30-3-1 et. Seq.

SSr 11.1(b). The Crisis Stabilization Program shall describe its capacity to serve voluntary and involuntary clients.

Interpretive guideline 1^{6.1}: The program description of the CSP clearly describes their service mission including its capacity to carry out the emergency receiving and evaluating functions of the CSP.

Interpretive guideline 2: The CSP clearly outlines their voluntary and involuntary admission criteria and there is evidence of documented practice of the established admission criteria.¹⁰

SSr 11.1(c). The Crisis Stabilization Program is NOT a designated treatment facility as defined by O.C.G.A. 37-3 and 37-7.

Interpretive guideline 1: The term ‘treatment facility’ means a facility designated by the department to receive patients for treatment as provided in Part 3 of Article 3 of Chapter 3 of Title 37. Rules of DHR MHMRSA ERETF 290-4-1-.01(f).

Interpretive guideline 2: The program description of the CSP clearly states that it is not a designated treatment facility or service.

SSr 11.1(d). The Crisis Stabilization Program shall not use the word “inpatient” anywhere for any purpose to describe the services offered within the CSP.

^{6.1} Modified FY06

Interpretive guideline 1: The program description and all other documents within the CSB and CSP shall describe the services offered within the CSP as *residential* services.

SSr 11.1(e). The Crisis Stabilization Program shall not hold itself out as a hospital or bill as a hospital for inpatient service.

Interpretive guideline 1: There is no evidence that the CSP is holding itself out as a hospital or that it is billing for hospital or inpatient services.

SSr 11.1(f).² The CSP shall not operate in a manner or offer any service that brings them within the purview of Georgia's Certificate of Need (CON) Program as defined by the CON Statute and Rules (O.C.G.A. 31-6-1 et. seq. and O.C.R.R. 272-2-1 et. seq.).

Interpretive guideline 1: There is no evidence that the CSP is operating in a manner or offering any service which brings them within the purview of Georgia's Certificate of Need (CON) Program.

SSr 11.2 CERTIFICATION OF THE CRISIS STABILIZATION PROGRAM

SSr 11.2. The Crisis Stabilization Program shall be surveyed for compliance with State standards.

Interpretive guideline 1: Any Crisis Stabilization Program (CSP), to be eligible for designation, shall be a part of a comprehensive community mental health and substance abuse program and shall be in compliance with: 1) Standards for All Providers found in the *Provider Manual for Community Mental Health, Developmental Disabilities and Addictive Diseases for the Department of Behavioral Health and Developmental Disabilities*¹⁰ and 2) the Department of Human Resources Grants to Counties Policy Manual. Rules of DHR MHMRSA ERETF 290-4-1-.02(d).

Interpretive guideline 2⁶: Any state Crisis Stabilization Program (CSP), to be eligible for designation, shall be operated by an accredited and licensed (if applicable) healthcare authority and shall be in compliance with: 1) Standards for All Providers found in the *Provider Manual for Community Mental Health, Developmental Disabilities and Addictive Diseases for the Department of Behavioral Health and Developmental Disabilities*¹⁰ and 2) the Department of Human Resources Grants to Counties Policy Manual. Rules of DHR MHMRSA ERETF 290-4-1-.02(d).

SSr 11.3. LINKAGES FOR CARE OF COMPLEX CARE NEEDS

SSr 11.3. The Crisis Stabilization Program shall have operating agreements with private and public inpatient hospitals and treatment facilities.

Interpretive guideline 1: Crisis Stabilization Programs shall have documented operating agreements and referral mechanisms for psychiatric, addictive disorder and physical health care needs that are beyond the scope of the Crisis Stabilization Program and that require inpatient treatment.

² Added to CSP Standards FY02

Operating agreements shall delineate the type and level of service to be provided by the private or public inpatient hospital or treatment facility. Operating agreements must be updated **at a minimum every five years** as evidenced by date and signatures.¹¹

Interpretive guideline 2: The following shall be clearly stated within the body of the operating agreements between the CSP and designated treatment facilities(s):

The purpose of clinical services provided by the CSP is psychiatric stabilization or detoxification. When it becomes evident 48 hours into the ‘evaluation’ legal status that a client is not stabilizing and may not stabilize quickly, arrangements shall be made to transfer the client to a designated treatment facility at that point. The transfer of the client shall take place no later than 72 hours into the ‘evaluation’ legal status, unless there has been a different time limit established in a written agreement with a hospital. The client may be transferred to the treatment facility on the existing 1014 or 2014 legal status. For the purposes of calculating the 48 or 72 hours, Saturdays, Sundays or holidays will not apply.

Interpretive guideline 3: The private facility or the CSP shall utilize available resources in the community to provide psychological tests and social work services if such services are needed for the patients and do not exist within the facility. Rules of DHR MHMRSA ERETF 290-4-1-.04(4).

SSr 11.4. EMERGENCY MEDICAL TREATMENT AND ACTIVE LABOR ACT (EMTALA)

SSr 11.4. The Crisis Stabilization Program will operate within the guidelines of EMTALA with respect to stabilization and transfer of clients.

Interpretive guideline 1: The Crisis Stabilization Programs are not hospitals nor do they receive Medicare monies. However, the CSP’s will operate within the guidelines of EMTALA with respect to the stabilization and transfer of clients to and from hospitals.

SSr 11.5. LENGTH OF STAY

SSr.11.5^{2.1}. The average length of stay shall not exceed five (5) days excluding Saturdays, Sundays and Holidays.

Interpretive guideline 1: For any one episode of care, an individual person may not remain in a CSP beyond 10 days, excluding Saturdays, Sundays and Holidays, with the exception described in Interpretive Guideline 2 below.

Interpretive guideline 2^{4.1}: A CSP must designate transitional beds separate from crisis residential beds. Clients occupying transitional beds may remain in the CSP beyond 10 days excluding Saturdays, Sundays and Holidays **only if they are in services and activities on a daily basis that indicate the individual is actively engaged in transitioning to the community**^{6.1}.

¹¹ Requirement for updated agreements added FY08

^{2.1} Modified FY02

^{10.1} Updated FY10

¹⁰ Added to CSP Standards FY10

Length of stay in a transitional bed may not exceed 30 calendar days including crisis days. Transitioning activities may include, but are not limited to, participation in day services; meetings with the client/family; and/or active participation in services with the intent toward discharge.¹⁰ The CSP must record the date of transfer to the transitional bed(s) and the length of stay in transitional beds for each episode of transitional care. Transitional bed designation should be made using these parameters:

- a) A CSP with up to 29 beds may designate one or two beds as transition beds. The total bed count for crisis beds and transition beds shall not exceed 29.
- b) A CSP with up to 39⁴ beds may designate up to three beds as transition beds. The total bed count shall not exceed 39.
- c) A CSP with 40⁴ or more beds may designate up to four additional beds as transition beds.

Interpretive guideline 4²: CSP's shall report census and length of stay data as required to the Department of Behavioral Health and Developmental Disabilities for both regular and transitional CSP beds.^{10,1}

SSr 11.6. ADVERTISING OF SERVICES

SSr.11.6. The Crisis Stabilization Program shall not advertise services offered within the CSP.

Interpretive guideline 1: The Community Service Board may inform and educate the public about services offered by the CSP, but shall not advertise any of the CSP services or hold itself out in any manner as providing inpatient or hospital service.

SSr 11.7. BILLING AND REVENUE SOURCE

SSr 11.7(a).^{2,1} The primary revenue source shall be public funds.

Interpretive guideline 1: Review of revenue budget for the CSP will show that no less than 95% of the funding is public, including State Grant in aid and Medicaid. Note: Medicaid may be billed only if the program has 16 or fewer beds.

SSr 11.7(b). Clients are billed on a sliding fee scale basis according to their ability to pay.

Interpretive guideline 1: Review of billing practices shall demonstrate that clients have been billed on a sliding fee scale basis.

SSr 11.8. PHYSICIAN OVERSIGHT

SSr 11.8(a). All services offered within the Crisis Stabilization Program shall be provided under the direction of a physician.

^{6,1} Modified FY06

⁴ Added to CSP Standards FY04

^{4,1} Modified FY04

² Added to CSP Standards FY02

^{2,1} Modified FY02

Interpretive guideline 1: “Physician” means any person who is licensed to practice in this State under the provisions of Article 2 of chapter 34 of Title 43, or who is employed as a physician by the United States Veterans Administration or other federal agency. Rules of DHR MHMRSA ERETF 290-4-1-.01(g).

Interpretive guideline 2: The active medical staff of the CSP shall include a physician who has completed at least one year of approved psychiatric residency and consultation by a psychiatrist shall be available. Rules of DHR MHMRSA ERETF 290-4-1-.04(2)

Interpretive guideline 3: In the event that the physician providing coverage is not a psychiatrist, arrangements shall be in place for psychiatric consultation.

Interpretive guideline 4: There is documented evidence of Physician oversight for the dispensing of sample medications.¹⁰

SSr 11.8(b) A physician shall conduct assessments of new clients address client care issues and write orders as required.

Interpretive guideline 1: A physician is NOT required to be on site 24 hours a day, however the physician must report to the Charge Nurse daily. A physician must be available by pager 24 hours a day and must respond to staff calls immediately, not to exceed one hour. The physician must personally report to the CSP within one hour at the request of the charge nurse.

Interpretive guideline 2: CSP’s must have capacity to admit and discharge seven days a week.

Interpretive guideline 3: A physician must assess each new client within 24 hours of admission.

Interpretive guideline 4: Documentation by the physician shall include, at a minimum the initial evaluation of the client, resulting diagnoses and care orders, the response to care and services provided, a rationale for medications ordered or prescribed, and assessment of the client at the time of discharge.

Interpretive guideline 5¹⁰: Searches of individuals shall be ordered by the physician. There is to be no mandatory removal of clothing or standing orders for strip searches. Strip searches are to be performed for cause and the rationale clearly documented in the person’s record.

Interpretive guideline 6^{10.1}: Levels of observation shall be ordered by the physician and will be based on physician assessment. When the levels of observation are changed, there is documented justification to support the ordered level change by the physician.

SSr 11.8(c). The functions performed by physician’s assistants, nurse practitioners and clinical nurse specialists are within the scope allowed by state law and professional practice acts.

¹⁰ Added to the standards FY10

^{10.1} Added to the standards FY10

Interpretive guideline 1: The CSP utilizing physician's assistants, nurse practitioners and clinical nurse specialists can demonstrate verbally and through documentation their implementation of agreements and protocols required by state law and professional practice acts. Renewal of Georgia Board of Nursing authorization as a nurse practitioner will coincide with the renewal of the registered professional nurse license.

SSr 11.9. REGISTERED NURSE OVERSIGHT

SSr 11.9(a). The Crisis Stabilization Program shall have a position classified as a lead nurse or higher that serves as the nursing administrator.

Interpretive guideline 1: The Registered Nurse designated as nursing administrator is a full-time employee of the programs whose job responsibilities include, but are not limited to, the clinical supervision of the nursing staff, implementation of physician's orders and oversight of the clinical functions of the unit.

SSr 11.9(b). The Crisis Stabilization Program shall have a Registered Nurse present within the facility at all times.

Interpretive guideline 1: A Registered Nurse must be in the CSP facility at all times.

Interpretive guideline 2: A Registered Nurse must be the Charge Nurse at all times.

Interpretive guideline 3: There must be one Registered Nurse within the CSP facility for every 30 CSP facility beds.

Interpretive guideline 4: CSPs that employ sanctioned nurses must assure that their assigned duties comply with the requirements stated by the Georgia Board of Nursing/Georgia Board of Examiners of Licensed Practical Nurses in their consent orders.¹⁰

SSr 11.10. STAFF TO CLIENT RATIOS

SSr 11.10. Staff to client ratios shall be established based on the stabilization needs of clients being served.

Interpretive guideline 1: The ratio of direct care staff to clients should not be less than 1:8 (including the Registered Charge Nurse). Assigned levels of observation shall be utilized as guidelines for establishing staffing ratios greater than 1:8.¹⁰

Interpretive guideline 2: There shall always be at least two staff present within the CSP including the Charge Nurse.

Interpretive guideline 3: The utilization of licensed practical nurses shall be considered to provide technical support to the Registered Nurse.

Interpretive guideline 4: The functions performed by registered nurses and licensed practical nurses are within the scope allowed by State Law and professional practice acts.

SSr 11.11. USE OF SECLUSION OR RESTRAINT

SSr 11.11(a). A Crisis Stabilization Program may only use restraint and seclusion as a safety intervention of last resort.

Interpretive guideline 1: In all cases, the law regarding seclusion and restraint found in 42 CFR 482.13 (revised October 1, 2006)¹², O.C.G.A. 37-3 and 37-7 as well as the rules found in Rules of Department of Human Resources, Mental Health, Mental Retardation and Substance Abuse Chapter 290-4-6 Patients' Rights shall apply.

Interpretive guideline 2: All forms of restraint and seclusion shall be used solely for the purposes of providing effective treatment and protecting the safety of the patient and other persons and shall not be used as punishment [or] for the convenience of staff. Restraint in any form or seclusion should only be used when no less restrictive methods of controlling behavior which would reasonably insure the safety of the patient and other persons are feasible. Rules of DHR MHMRSA PR290-4-6-.02 (1)(c)1.

Interpretive guideline 3^{5.1}: Seclusion or restraint may be used when less restrictive interventions have been determined to be ineffective. All interventions utilized prior to the seclusion or restraint episode must be descriptively documented in the sequence used and identified as to the staff member conducting the intervention.

Interpretive guideline 4^{5.1}: CSP's must have a written policy and procedure about the use of seclusion and restraint. Evidence of annual training and competency in the proper and safe use of seclusion and restraint including techniques and alternative methods for handling behavior, symptoms and situations that traditionally have been treated through the use of restraints or seclusion must be available within staff personnel files for all staff who have direct contact with clients.

Interpretive guideline 5: The body of the admission assessment shall contain an assessment of past trauma or abuse. The person shall also be asked how they would prefer to be approached should they become dangerous to themselves or to others. Findings from these queries shall direct the decision making process for determining behavioral interventions.

Interpretive guideline 6: In all cases, the rules regarding *Inpatient Psychiatric Services for Individuals Under Age 21 in Psychiatric Facilities or Programs* found at 42 CFR Part 441 Subpart D and the *Condition of Participation for the Use of Restraint or Seclusion in Psychiatric Residential Treatment Facilities Providing Inpatient Psychiatric Services for Individuals Under Age 21* found in 42 CFR Part 483 Subpart G shall apply.¹⁰

¹² Added to CSP Standards FY08

^{5.1} Modified FY05

^{5.1} Modified FY05

SSr 11.11(b).^{5.1} A physician or other licensed practitioner permitted by the State shall give an order for the seclusion or restraint episode within one hour of the implementation of seclusion or restraint intervention.

Interpretive guideline 1^{5.1}: The physician or Clinical Nurse Specialist (CNS) must be notified immediately of the seclusion or restraint episode. An order must be given that approves the use of the seclusion or restraint intervention, that defines specific time limits for the episode (not to exceed four (4) hours), and that states the behavioral indicators which signal the end of the episode. The restraint or seclusion episode shall be ended at the earliest possible time.

Interpretive guideline 2⁵: The treating physician must be consulted within one hour if the restraint or seclusion is ordered by a licensed practitioner permitted by the State who is not a physician.

SSr 11.11(c).⁸ A physician or other licensed practitioner permitted by the State must see and evaluate the need for restraint or seclusion within one (1) hour after the initiation of this intervention.

Interpretive guideline 1⁸: The physician or CNS must personally examine the client by the end of the first hour of the seclusion or restraint episode. The findings of the examination of the client shall be documented in the client record.

Interpretive guideline 2: If the client is released from seclusion or restraint prior to the end of the first hour *and* prior to the personal examination of the physician or CNS, the rationale for release of the client *and* the fact that the client was not personally seen by a physician or CNS shall be fully documented within the client record.

Interpretive guideline 3^{5.1}: After the order expires, a new determination for continued seclusion or restraint may be made ONLY after the client is PERSONALLY examined by a physician or CNS and may be ordered for an additional specific time episode not to exceed four (4) hours.

Interpretive guideline 4: After any seclusion or restraint episode, there must be a determination by the treating physician or Medical Director as to whether transfer to a treatment facility for a higher level of care is indicated. The treating physician or Medical Director's determination for a higher level of care (ASAM 3.7 or LOCUS 6 or greater) must be documented within the progress notes. Justification for maintaining the client at the CSP for additional care must be documented in the physician progress note.

SSr 11.11(d). During the seclusion or restraint episode, the person must be continuously monitored and a documentation entry to that effect be made every 15 minutes.

⁵ Added to CSP Standards FY05

⁸ Modified FY08

^{5.1} Modified FY05

Interpretive guideline 1: A staff member must be assigned to be present immediately outside the seclusion door when a client is secluded.

Interpretive guideline 2: A staff member must be assigned to be present at all times within the room and the door to the room left open when a client is restrained.

Interpretive guideline 3: A client placed in physical restraints shall be checked at least every 15 minutes by staff members trained in the use of restraints, and a written record of these checks and all other activities shall be made.

Interpretive guideline 4: While in restraints each client should be spoken to, checked for indications of obvious physical distress, be offered liquids and an opportunity to meet his need to urinate and defecate as needed or at least every 2 hours unless the person is asleep or his condition does not permit. The restraints sites should be checked every hour for evidence of swelling or abrasion. Each hour a restraint should be removed from each limb for five minutes and then reapplied if his condition permits. A client in restraints should receive all meals available to other client except as otherwise ordered by a physician based upon the person's health needs and his condition to take meals while in restraints. In all situations, the client must receive nutrition at regular meal intervals unless refused by the client. Restraints are to be discontinued when they are no longer needed to prevent the client from hurting self or others and their medical needs allow removal.

Interpretive guideline 5: During any seclusion/restraint episode, there is documented nursing staff oversight.¹⁰

Interpretive guideline 6: Video monitoring does not meet the requirement of personal monitoring of the client while in seclusion or restraints. Where video monitoring does "co-exist" with 1:1 monitoring, the privacy of the video monitored image is secured from other clients, visitors and non-direct care staff. ¹⁰

SSr 11.11(e). Staff shall conduct a debriefing with the client after release from seclusion or restraint.

Interpretive guideline 1: The client shall have an opportunity to talk to an appropriate staff member authorized by the facility (preferably a staff member who was not involved in the incident), as soon as appropriate after release from seclusion or restraint.

Interpretive guideline 2: The following are potential issues to explore with the client:

- What the client remembers happening prior to their becoming angry, destructive or self injurious?
- Whether the client remembers sensory changes prior to being placed in seclusion or restraints?
- What thoughts the client has about why the client was placed in seclusion or restraint?
- How the client felt while in seclusion or restraint?

- How the client felt after being released from seclusion or restraint?
- Was there something the client did that was helpful in gaining personal control?
- Was there something the staff did that was helpful in the client gaining personal control?
- What changes could be made to assist the client in future instances when the client might lose control?

Interpretive guideline 3: The client responses shall be documented with pertinent intervention information incorporated within the client plan of care.

SSr 11.11(f). The staff members involved in the seclusion or restraint episode shall receive a debriefing after the episode.

Interpretive guideline 1: The staff members involved in the seclusion or restraint episode shall be interviewed immediately after the episode to determine the following information. The identified leader of the episode shall conduct the critique of the seclusion or restraint episode.

- What physical cues were present that indicated escalation of client behaviors?
- What interventions were conducted, by what staff member and in what order as the events unfolded leading up to seclusion or restraint?
- What was the client response to each intervention conducted?
- Could alternate interventions result in a different outcome other than seclusion or restraint?
- What did the staff involved do well?
- What could staff do differently in the future that might avoid reaching the point of a seclusion or restraint?
- What recommendations shall be documented within the client plan of care for use in future situations?

Interpretive guideline 2: Staff must document in the client's record that debriefing took place and must include:

- a. The names of staff who were present for the debriefing;
- b. The names of staff who were excused from the debriefing;
- c. Any changes to the client's treatment plan that resulted from the debriefing.

Interpretive guideline 3: Staff involved in an emergency safety intervention that resulted in an injury to a client or staff must meet with supervisory staff and evaluate the circumstances that caused the injury and develop a plan to prevent future injuries.

SSr 11.12 ORGANIZATIONAL RISK AND COMPLIANCE⁶

SSr 11.12 The CSP has a well-defined approach for assessing its performance, for anticipating, identifying, correcting and solving problems, and for improving quality of care related to use of safety interventions of last resort.

Interpretive guideline 1: The CSP maintains a record of each emergency safety situation, the interventions used, and their outcomes.

Interpretive guideline 2: Staff involved in an emergency safety intervention that results in an injury to a client or staff must meet with supervisory staff and evaluate the circumstances that caused the injury and develop a plan to prevent future injuries.

Interpretive guideline 3: Data regarding the use of safety interventions of last resort will be aggregated and reported quarterly to the CSP management and risk management authority of the managing Community Service Board or State Hospital facility. The report shall include issues that have been addressed pursuant to review of the data, or that no action is required based on aggregate information.

SSr 11.13 PHARMACY SERVICES

SSr 11.13 All pharmacy operations or services within the CSP must be licensed and under the direct supervision of a Registered Pharmacist or provided by contract with a licensed pharmacy operated by a Registered Pharmacist.

Interpretive guideline 1: Pharmacy services must be provided under the license and supervision of a Registered Pharmacist who is operating under a ‘retail’ or ‘hospital’ license.

Interpretive guideline 2: Any request for exemptions for requirements regarding a pharmacy license must be submitted in writing to the Georgia State Board of Pharmacy.

Interpretive guideline 3: CSP must ensure access to Pharmacy services for prescription medications within eight (8) hours of the Physician’s order¹⁰

SSr 11.14. MEDICATION ADMINISTRATION

SSr 11.14 in all cases, the rules regarding medications found in Rules of Department of Human Resources, Mental Health, Mental Retardation and Substance Abuse Chapter 290-4-9 Clients’ Rights shall apply.

Interpretive guideline 1: Medications shall be used solely for the purposes of providing effective treatment and protecting the safety of the client and other persons and shall not be used as punishment or for the convenience of staff.

⁶ Added to CSP Standards FY06

Interpretive guideline 2⁶: The CSP shall follow policies and procedures found in the Division of MHDDAD Policy 2:100, *Informed Consent and Involuntary Administration of Psychotropic Medication*, concerning the use of psychotropic medications and the use of involuntary medications.^{6/10}

Interpretive guideline 3: The CSP shall follow management protocols for controlled substances, floor stock medications, and physician's sample medications. These accountability medication management techniques must include: inventories, counting, signing out each dose or sample to an individual, and witnessed / documented disposal.¹⁰

SSr 11.15. PROVISION OF INDIVIDUALIZED CARE

SSr 11.15. Educational and program offerings within the CSP include services to meet the individual stabilization needs of each client including co-occurring mental health and substance use needs.

Interpretive guideline 1: Educational and program offerings include offerings that address issues both common and distinct to the person in psychiatric distress and to the person requiring detox from substances.

Interpretive guideline 2: The client clinical record will demonstrate individualized interventions based on the care needs of each person served as evidenced within the body of assessments, documentation of the progression of care and documented discharge linkages.

Interpretive guideline 3: Staff training records shall show evidence of annual training and competency in caring for the person with co-occurring mental health and substance use issues.

SSr.11.16 REPORTING OF SERIOUS OCCURRENCES⁶

SSr.11.16. The CSP must report each serious occurrence.

Interpretive guideline 1: Critical incidents shall be reported as specified in DBHDD Policy for *Reporting of Consumer Deaths and Critical Incidents*.¹⁰

SSr. 11.17 REPORTING OF CLIENT DATA TO THE DEPARTMENT OF BHDD^{7/10}

SSr.11.17. The crisis stabilization program shall report data to the Department of BHDD as directed by provider agreement.¹⁰

⁶ Added to CSP Standards FY06

¹⁰ Updated FY10

⁶ Added to CSP Standards FY06

⁷ Added to CSP Standards FY07

¹⁰ Updated FY10

Interpretive guideline 1: Encounter data shall be reported to the Department of BHDD in the format directed by the operational guidelines provided by the Department of BHDD to the parent organization (Community Service Board or State Hospital Facility)¹⁰.

Interpretive guideline 2: Encounter data shall include but may not be limited to:

- a. Client name
- b. Date of admission
- c. Date of discharge
- d. Legal status
- e. Admitting diagnosis
- f. Referred to

SSr. 11.18. DESIGNATION AS A CRISIS STABILIZATION PROGRAM

SSr 11.18. The designation must be approved and may be withdrawn by the department. Designation is not transferable.

Interpretive guideline 1: Designation as a crisis stabilization program must be approved and may be withdrawn by the Department of BHDD. Designation is non-transferable.

Interpretive guideline 2: Each designation or provisional designation shall be returned to the department in the following cases. This includes but may not be limited to:

- Change in location
- Program closure
- Department of BHDD finding of failure to comply with CSP standards¹⁰
- Loss of accreditation.

Part IV

**Community Service Standards Specific for
Behavioral Health Services**

SECTION III

***Crisis Stabilization Standards
For Children and Youth***

Fiscal Year 2012



**Georgia Department of Behavioral Health &
Developmental Disabilities**

April 2012

DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL DISABILITIES

CORE REQUIREMENTS FOR CRISIS STABILIZATION PROGRAMS FOR CHILDREN AND YOUTH

Effective July 1, 2005

The following requirements for Crisis Stabilization Programs for Children and Youth have been built from the Core Requirements for Crisis Stabilization Programs serving adults that were implemented in July of 2001, and have been modified to address issues around children and youth.

The CSP standards document has been footnoted to indicate modifications and additions to the standards since their inception. Crisis Stabilization Program standards that arose from issues resulting from the Certificate of Need concern addressed in the “Letter of Agreement” between the Department of Community Health and DHR Division of MHDDAD, signed on the 28th day of February, 2001 by George P. A. Newby, representing DCH and by Jerry Lovrien, representing DHR, have not been modified and may be modified only pursuant to agreement between DHR and DCH.

Crisis Stabilization Program standards for children and youth are incorporated by reference into those found in the State of Georgia Department of Behavioral Health and Developmental Disabilities document entitled “Standards for All Providers”.¹⁰

SSr 11.1. DESCRIPTION OF THE PROGRAM

SSr 11.1(a). The Crisis Stabilization Program for children and youth is a medically monitored short-term residential service operated by the Community Service Board⁴ for the purpose of providing psychiatric or behavioral stabilization for children and youth who are seriously emotionally disturbed and/or detoxification services for youth. The crisis stabilization program must be designated by the Department as both an emergency receiving facility and an evaluating facility.

Interpretive guideline 1: The department may designate any private facility or such portion of a certified community mental health and substance abuse program which complies with the standards for a CSP within the State of Georgia at the request of or with the consent of the governing officers of such facility. Rules of DHR MHMRSA ERETF 290-4-1-.02(a). Et. Seq.

Interpretive guideline 2: As defined in the Rules of DHR MHMRSA ERETF 290-4-1-.01(b), the term “Crisis Stabilization Program (“CSP”) means a short term residential program operated as a part of a comprehensive community mental health and substance abuse program [operated by a Community Service Board or by a Department Behavioral Health and Developmental Disabilities (DBHDD) state hospital facility]^{4/10} for the purpose of providing psychiatric stabilization or detoxification services, which complies with applicable community service standards contained within the *Provider Manual for Community Mental Health, Developmental Disabilities and Addictive Diseases for the Department of Behavioral Health and Developmental Disabilities*.¹⁰

¹⁰ Updated FY10

⁴ CSP’s may be state operated effective FY04

¹⁰ Updated FY10

Interpretive guideline 3: Crisis stabilization programs are state authorized residential services provided as a part of a Community Service Board⁴ and designed to serve as a first line alternative to hospitalization in state hospitals, offering psychiatric or behavioral stabilization and detoxification services on a short term basis. CSP's for children and youth are not designed to provide 'study and report' services or to be available for court ordered placement for the purpose of temporary placement only.

Interpretive guideline 4: The target population served in the CSP is children and youth ages 5-17 requiring psychiatric or behavioral stabilization and youth ages 13-17 with substance related disorders or with co-occurring mental health and substance use needs.

Interpretive guideline 5: Youth through age 21 may be served at a Crisis Stabilization Program for Children and Youth *provided* it is indicated clinically and is based on the youth's maturational age. The Medical Director must approve such admissions.

Interpretive guideline 6: Residential detoxification services offered within the CSP **shall not exceed** services described in Level III.7 of the Adolescent Criteria section of the *American Society for Addiction Medicine Patient Placement Criteria for the Treatment of Substance-Related Disorders* (ASAM PPC-2R), Second Edition, April 2001.

Interpretive guideline 7: NOTE: Twenty-four hour residential services offering detoxification ONLY shall be licensed by the Healthcare Facility Regulation Division under the "Rules of Department of Human Resources Chapter 290-4-2: Drug Abuse Treatment and Education Programs." These CSP standards shall not apply.

Interpretive guideline 8: **Psychiatric stabilization services** offered within the CSP **shall not exceed** services described in Level Six of the *Child and Adolescent Level of Care Utilization System for Psychiatric and Addiction Services*, Version 1.5 (CALOCUS), published by the American Association of Community Psychiatrists, August 2006 (most recent version).⁷

Interpretive guideline 9²: The term "emergency receiving facility" means a facility designated by the department to receive patients under emergency conditions as provided in Part 1 of Article 3 of Chapter 3 or of Chapter 7 of Title 37. Rules of DHR MHMRSA ERETF 290-4-1-.01(d).

Interpretive guideline 10²: The term "evaluating facility" means a facility designated by the department to receive patients for evaluation as provided in Part 2 of Article 3 or of Chapter 7 of Title 37. Rules of DHR MHMRSA ERETF 290-4-1-.01(e).

Interpretive guideline 11²: Certification reviews will be conducted for physical plant, safety and food service according to the specifications outlined in the Rules for Drug Abuse Treatment &

⁴ CSP's may be state operated effective FY04

⁷ Updated citation added FY08

² Added to CSP Standards FY02

¹⁰ Added to CSP standards FY10

Education Programs, Chapter 290-4-2, section .11 “Physical Plant and Safety” and section .12 “Food Service”.

Interpretive guideline 12⁶: CSP’s that are newly constructed or CSP’s undergoing physical plant modifications after June 30, 2005 shall address safety issues to minimize the opportunity for self-harm of an individual such as, but not limited to the following:

- a. Shower fixtures in bathrooms shall be flush-mounted in the wall
- b. Headers supporting bathroom stalls shall be flush-mounted to the ceiling
- c. There shall be two avenues of visual access into the seclusion and restraint room, one of which shall be through a shatterproof window in the door. The room shall be a minimum fifty (50) square feet in area and the door should be opened from the outside.¹⁰
- d. Blind spots on the unit shall be addressed through use of convex mirrors allowing for visual access. A room used for seclusion or restraint must:
 - i. Allow staff full view of the resident in all areas of the room;
 - ii. Be free of potentially hazardous conditions such as unprotected light fixtures and electrical outlets
- e. Video cameras are not a permitted alternative to direct observation of an individual in the seclusion or restraint room
- f. Doors to bedrooms shall be hung on hinges that swing both in to the room and out from the room. ⁷Note that if a building is being *modified* and it is not possible for the door to swing both ways, the door should be mounted to open away from the room.
- g. Facility must have a satisfactory food service permit score, if applicable. Facility may utilize meal preparation services from an affiliated or contracted entity with a current food service permit. A copy of the current food service permit must be on file in the facility. Should the facility elect to have meals prepared off-site, the facility will have a modified kitchen that includes a microwave, a refrigerator, and clean-up facilities.¹⁰
- h. Facility must maintain a daily temperature log for freezer and refrigerator.¹⁰
- i. Foods, drinks and condiments shall be dated when opened.¹⁰
- j. Facility must have a sufficient designated area to accommodate meal service. This area may double as a group or activity area.¹⁰
- k. Facility maintains a temperature between 65 and 82 degrees F that ensures the comfort and safety of all clients.¹⁰
- l. Facility is free of offensive odor and noise.¹⁰
- m. Ramps are built according to specifications of Section 504 of the Rehabilitation Act of 1973.¹⁰
- n. Outdoor client area must be secured for safety and privacy.¹⁰
- o. Preadmission waiting area, including restroom where exist, must meet all safety requirements applicable to designated client areas.¹⁰
- p. Multi client bedrooms shall have a minimum of 60sq ft per client and a private room shall not be less than 100 sq ft.¹⁰
- q. Beds must be either weighted or secured to the floor.¹⁰

⁶ Added to CSP Standards FY06

⁷ Added to CSP Standards FY07

- r. Prohibited bed types include but not limited to beds with springs, cranks, rails and wheels. The use of hospital beds is discouraged and rollaway, cots, double deck, stacked; hide-a-bed and studio couches are not to be used in lieu of standard beds.¹⁰
- s. Furniture should be appropriately sized to fit population served and preferably weighted.¹⁰
- t. Electronics and/or game equipment needs to be locked/secured when not in use.¹⁰
- u. Facility lighting shall be sufficient enough for reading and other activities.¹⁰
- v. Gender specific restrooms shall have adequate ventilation and have an adequate number of sinks, toilets and showers to accommodate the population served.¹⁰
- w. Exposed plumbing pipes shall be covered to prevent client access.¹⁰
- x. Rods/curtains utilized for privacy shall be designed not to sustain more than 30 pounds.¹⁰
- y. Water temperature for consumer usage must be maintained between 110 – 120 degrees F. For those facilities providing onsite food service, a separate water heater is designated for usage.¹⁰
- z. Facility windows and mirrors must be either temper glass, plastic or shatterproof.¹⁰

Interpretive guideline 13: Facilities are accessible to and usable by physically disabled individuals and must meet the minimum requirements of Section 504 of the Rehabilitation Act of 1973. Centers install required alterations or modifications in accordance with the 1984 Law of Georgia regarding Access to and Use of Public Facilities by Physically Handicapped Persons: O.C.G.A. Section 30-3-1 et. Seq.

SSr 11.1(b). The Crisis Stabilization Program shall describe its capacity to serve voluntary and involuntary residents.

Interpretive guideline 1: The term ‘treatment facility’ means a facility designated by the department to receive patients for treatment as provided in Part 3 of Article 3 of Chapter 3 of Title 37. Rules of DHR MHMRSA ERETF 290-4-1-.01(f).

Interpretive guideline 2: The CSP clearly outlines their voluntary and involuntary admission criteria and there is evidence of documented usage of the established admission criteria. ¹⁰

SSr 11.1(c). The Crisis Stabilization Program is NOT a designated treatment facility as defined by O.C.G.A. 37-3 and 37-7.

Interpretive guideline 1: The term ‘treatment facility’ means a facility designated by the department to receive patients for treatment as provided in Part 3 of Article 3 of Chapter 3 of Title 37. Rules of DHR MHMRSA ERETF 290-4-1-.01(f).

Interpretive guideline 2: The program description of the CSP clearly states that it is not a designated treatment facility as provided in Part 3 of Article 3 of Chapter 3 of Title 37.

SSr 11.1(d). The Crisis Stabilization Program shall not use the word “inpatient” anywhere for any purpose to describe the services offered within the CSP.

Interpretive guideline 1: The program description and all other documents within the CSB and CSP shall describe the services offered within the CSP as *residential* services.

SSr 11.1(e). The Crisis Stabilization Program shall not hold itself out as a hospital or bill as a hospital for inpatient services.

Interpretive guideline 1: There is no evidence that the CSP is holding itself out as a hospital or that it is billing for hospital or inpatient services.

SSr 11.1(f).² The CSP shall not operate in a manner or offer any service that brings it within the purview of Georgia's Certificate of Need (CON) Program as defined by the CON Statute and Rules (O.C.G.A. 31-6-1 et. seq. and O.C.R.R. 272-2-1 et. seq.).

Interpretive guideline 1: There is no evidence that the CSP is operating in a manner or offering any service that brings them within the purview of Georgia's Certificate of Need (CON) Program.

SSr 11.2 CERTIFICATION OF THE CRISIS STABILIZATION PROGRAM

SSr 11.2. The Crisis Stabilization Program shall be surveyed for compliance with State standards.

Interpretive guideline 1: Any Crisis Stabilization Program (CSP), to be eligible for designation, shall be a part of a comprehensive community mental health and substance abuse program and shall be in compliance with: 1) Standards for All Providers found in the *Provider Manual for Community Mental Health, Developmental Disabilities and Addictive Diseases for the Department of Behavioral Health and Developmental Disabilities*² and 2) the Department of Human Resources Grants to Counties Policy Manual. Rules of DHR MHMRSA ERETF 290-4-1-.02(d).

Interpretive guideline 2⁶: Any state operated Crisis Stabilization Program (CSP), to be eligible for designation, shall be operated by an accredited and licensed (if applicable) healthcare authority and shall be in compliance with: 1) Standards for All Providers found in the *Provider Manual for Community Mental Health, Developmental Disabilities and Addictive Diseases for the Department of Behavioral Health and Developmental Disabilities*²

SSr 11.3. LINKAGES FOR COMPLEX CARE NEEDS

SSr 11.3. The Crisis Stabilization Program shall have operating agreements with private and public inpatient hospitals and treatment facilities.

Interpretive guideline 1: Crisis Stabilization Programs shall have documented operating agreements and referral mechanisms for psychiatric, addictive disorder and physical health care needs that are beyond the scope of the Crisis Stabilization Program and that require inpatient treatment. Operating agreements shall delineate the type and level of service to be provided by the private or public inpatient hospital or treatment facility.

² Added to CSP Standards FY02

⁶ Added to CSP Standards FY06

Interpretive guideline 2: The following shall be clearly stated within the body of the operating agreements between the CSP and designated treatment facilities(s):

“The purpose of clinical services provided by the CSP is psychiatric or behavioral stabilization for children and youth who are severely emotionally disturbed and detoxification for youth ages 13-17 with substance related disorders or co-occurring mental health and substance use needs.” When it becomes evident 48 hours into the “evaluation” legal status that a client is not stabilizing and may not stabilize quickly, arrangements shall be made to transfer the client to a designated treatment facility at that point. The transfer of the client shall take place no later than 72 hours into the “evaluation” legal status, unless there has been a different time limit established in a written agreement with a hospital. The client may be transferred to the treatment facility on the existing 1014 or 2014 legal status. For the purposes of calculating the 48 or 72 hours, Saturdays, Sundays, or holidays will not apply.

Interpretive guideline 3: The CSP shall have an agreement that makes available medical pediatric services for children and youth.

Interpretive guideline 4: The private facility or the CSP shall utilize available resources in the community to provide psychological tests and social work services if such services are needed for the patients and do not exist within the facility. Rules of DHR MHMRSA ERETF 290-4-1-.04(4).

SSr 11.4. EMERGENCY MEDICAL TREATMENT AND ACTIVE LABOR ACT (EMTALA)

SSr 11.4. The Crisis Stabilization Program will operate within the guidelines of EMTALA with respect to stabilization and transfer of residents.

Interpretive guideline 1: The Crisis Stabilization Programs are not hospitals nor do they receive Medicare monies. However, the CSP’s will operate within the guidelines of EMTALA with respect to the stabilization and transfer of residents to and from hospitals.

SSr 11.5. LENGTH OF STAY

SSr.11.5^{2.1}. The average length of stay shall not exceed nine (9) days excluding Saturdays, Sundays and Holidays.

Interpretive guideline 1: For any one episode of care, an individual child or youth may not remain in a CSP beyond 14 days, excluding Saturdays, Sundays and Holidays, with the exception described in Interpretive Guideline 2 below.

Interpretive guideline 2^{4.1}: A CSP must designate transitional beds separate from crisis residential beds. Residents occupying transitional beds may remain in the CSP beyond 14 days excluding Saturdays, Sundays and Holidays **only if they are in services and activities on a daily basis that indicate the resident is actively engaged in transitioning to the community.** Length of stay in a transitional bed including crisis days may not exceed 29 calendar days. Transitioning

^{2.1} Modified FY02

^{4.1} Modified FY04

activities may include, but are not limited to, participation in day services, meetings with client/family, continuing school classes, and/or active participation in services with the intent toward discharge.¹⁰ The CSP must record the date of transfer to the transitional bed(s) and the length of stay in transitional beds for each episode of transitional care. Transitional bed designation should be made using these parameters:

- a. A CSP with up to 29 beds may designate one or two beds as transition beds. The total bed count for crisis beds and transition beds shall not exceed 29.
- b. A CSP with up to 39⁴ beds may designate up to three beds as transition beds. The total bed count shall not exceed 39.
- c. A CSP with 40⁴ or more beds may designate up to four additional beds as transition beds.

Interpretive guideline 3: It is the intent of the Department of BHDD that children or youth shall return to their natural environment as quickly as possible.^{10.1} Therefore the TOTAL LENGTH OF STAY in a CSP for any one episode of care that includes a stay in both a crisis residential bed and a transitional bed **shall not exceed 29 calendar days.**

Interpretive guideline 4²: CSP's shall report census and length of stay data as required to the Department of BHDD for both regular and transitional CSP beds.^{10.1}

SSr 11.6. ADVERTISING OF SERVICES

SSr.11.6. The Crisis Stabilization Program shall not advertise services offered within the CSP.

Interpretive guideline 1: The Community Service Board may inform and educate the public about services offered by the CSP, but shall not advertise any of the CSP services or hold itself out in any manner as providing inpatient or hospital service.

SSr 11.7. BILLING AND REVENUE SOURCE

SSr 11.7(a).^{2.1} The primary revenue source shall be public funds.

Interpretive guideline 1: Review of revenue budget for the CSP will show that no less than 95% of the funding is public, including State Grant in Aid and Medicaid. Note: Medicaid may be billed only if the program has 16 or fewer beds.

SSr 11.7(b). Legal guardians are billed on a sliding fee scale basis according to their ability to pay. Fees for children and youth served under the Department of Family and Children's Services or under the Department of Juvenile Justice shall be set by mutual agreement by the Departments.

¹⁰ Added to CSP Standards FY10

⁴ Added to CSP Standards FY04

^{10.1} Updated FY10

² Added to CSP Standards FY02

^{2.1} Modified FY02

Interpretive guideline 1: Review of billing practices shall demonstrate that residents' legal guardians have been billed on a sliding fee scale basis.

Interpretive guideline 2: Review of billing practices shall demonstrate that fees billed for children and youth served under the Department of Family and Children's Services or under the Department of Juvenile Justice are billed according to agreements set by the Departments.

SSr 11.8. PHYSICIAN OVERSIGHT

SSr 11.8(a). All services offered within the Crisis Stabilization Program shall be provided under the direction of a physician.

Interpretive guidelines 1: "Physician" means any person who is licensed to practice in this State under the provisions of Article 2 of chapter 34 of Title 43, or who is employed as a physician by the United States Veterans Administration or other federal agency. Rules of DHR MHMRSA ERETF 290-4-1-.01(g).

Interpretive guideline 2: The active medical staff of the CSP shall include a physician who has completed at least one year of approved psychiatric residency and consultation by a psychiatrist shall be available. Rules of DHR MHMRSA ERETF 290-4-1-.04(2)

Interpretive guideline 3: It is preferred that the CSP is under the direction of a psychiatrist with training or experience in working with children and youth.

Interpretive guideline 4: In the event that the physician providing coverage is not a psychiatrist, arrangements shall be in place for psychiatric consultation.

Interpretive guideline 5: There is documented evidence of Physician oversight for the dispensing of sample medications.

SSr 11.8(b) A physician shall conduct assessments of new residents, address resident care issues and write orders as required.

Interpretive guideline 1: A physician is NOT required to be on site 24 hours a day, however the physician must report to the Charge Nurse daily. A physician must be available by pager 24 hours a day and must respond to staff calls immediately, not to exceed one hour. The physician must personally report to the CSP within one hour at the request of the charge nurse.

Interpretive guideline 2: CSP's must have capacity to admit and discharge seven days a week, 24 hours per day.

Interpretive guideline 3: A physician must assess each new resident within 24 hours of admission.

Interpretive guideline 4: Documentation by the physician shall include, at a minimum, the initial evaluation of the resident, resulting diagnoses and care orders, the response to care and services provided, a rationale for medications ordered or prescribed, and assessment of the resident at the time of discharge.

*Interpretive guideline 5*¹⁰: Searches of individuals shall be ordered by the physician. There is to be no mandatory removal of clothing or standing orders for strip searches. Strip searches are to be performed for cause and the rationale clearly documented in the person's record.

Interpretive guideline 6^{10.1}: Levels of observation shall be ordered by the physician and based on physician assessment. When the levels of observation are changed, there is documented justification to support the ordered level change by the physician.

SSr 11.8(c). The functions performed by physician's assistants, nurse practitioners and clinical nurse specialists are within the scope allowed by state law and professional practice acts.

Interpretive guideline 1: The CSP utilizing physician's assistants, nurse practitioners and clinical nurse specialists can demonstrate verbally and through documentation their implementation of agreements and protocols required by state law and professional practice acts. Renewal of Georgia Board of Nursing authorization as a nurse practitioner will coincide with the renewal of the registered professional nurse license.

SSr 11.9. REGISTERED NURSE OVERSIGHT

SSr 11.9(a). The Crisis Stabilization Program shall have a position classified as a lead nurse or higher that serves as the nursing administrator.

Interpretive guideline 1: The Registered Nurse designated as nursing administrator is a full-time employee of the programs whose job responsibilities include, but are not limited to, the clinical supervision of the nursing staff, implementation of physician's orders and oversight of the clinical functions of the unit.

Interpretive guideline 2: It is preferred that the designated Registered Nurse administrator has training or experience with children and youth.

SSr 11.9(b). The Crisis Stabilization Program shall have a Registered Nurse present within the facility at all times.

Interpretive guideline 1: A Registered Nurse must be in the CSP facility at all times.

Interpretive guideline 2: A Registered Nurse must be the Charge Nurse at all times.

¹⁰ Added to the standards FY10

^{10.1} Added to the standards FY10

Interpretive guideline 3: There must be one Registered Nurse within the CSP facility for every 30 CSP facility beds.

Interpretive guideline 4: CSPs that employ sanctioned nurses must assure that their assigned duties comply with the requirements stated by the Georgia Board of Nursing/Georgia Board of Examiners of Licensed Practical Nurses in their consent orders.¹²

SSr 11.10. STAFF TO CLIENTS RATIOS

SSr 11.10. Staff to clients' ratios shall be established based on the stabilization needs of residents being served.

Interpretive guideline 1: The ratio of direct care staff to clients should not be less than one to four (1:4), including the Registered Charge Nurse. Assigned levels of observation shall be utilized as guidelines for establishing staffing ratios greater than 1:4.

Interpretive guideline 2: There shall always be at least three staff present within the CSP including the Charge Nurse.

Interpretive guideline 3: The utilization of licensed practical nurses shall be considered to provide technical support to the Registered Nurse.

Interpretive guideline 4: The functions performed by registered nurses and licensed practical nurses are within the scope allowed by State Law and professional practice acts.

SSr 11.11 USE OF TIME OUT

SSr 11.11(a) If “time out” or “time away” is used as a less restrictive intervention prior to using an emergency safety intervention, the “time out” or “time away” shall be used according to these guidelines.

Interpretive guideline 1: Time out may be utilized in these ways:

- a. Away from the area of activity or from other clients', such as in the client's room (exclusionary)
- b. In the area of activity or other clients' (inclusionary)
- c. Only private rooms can be utilized as a “time-out” or “time away” area.¹⁰

Interpretive guideline 2: A client in time out must never be physically prevented from leaving the time out area.

Interpretive guideline 3: A designated seclusion or restraint room shall not be used for time out.

Interpretive guideline 4: Staff must monitor the client while he or she is in time out.

SSr 11.12. USE OF SECLUSION OR RESTRAINT

SSr 11.12(a). A Crisis Stabilization Program for children and youth may only use restraint and seclusion as an emergency safety intervention of last resort.

Interpretive guideline 1: In all cases, the law regarding seclusion and restraint found in O.C.G.A. 37-3 and 37-7 as well as the rules and definitions found in Rules of Department of Human Resources, Mental Health, Mental Retardation and Substance Abuse Chapter 290-4-6 Patients' Rights shall apply.

Interpretive guideline 2: In all cases, the rules regarding *Inpatient Psychiatric Services for Individuals Under Age 21 in Psychiatric Facilities or Programs* found at 42 CFR Part 441 Subpart D and the *Condition of Participation for the Use of Restraint or Seclusion in Psychiatric Residential Treatment Facilities Providing Inpatient Psychiatric Services for Individuals Under Age 21* found in 42 CFR Part 483 Subpart G shall apply.

Interpretive guideline 3: Restraint and seclusion may not be used simultaneously.

Interpretive guideline 4: All physical restraints and seclusion shall be used solely for the purpose of providing an immediate response to an emergency safety situation

- a. Restraint or seclusion must not result in harm or injury to the resident.
- b. Restraint or seclusion must be used only to ensure the safety of the resident or others during an emergency safety situation.
- c. Restraint or seclusion must be used only until the emergency safety situation has ceased and the resident's safety and the safety of others can be ensured, even if the restraint or seclusion order has not expired.
- d. Restraint or seclusion shall not be used as punishment, coercion, discipline, retaliation or for the convenience of staff.

Interpretive guideline 5: Seclusion or restraint may only be used when less restrictive interventions have been determined to be ineffective.

Interpretive guideline 6: All documentation related to the safety intervention of last resort must be completed by the end of the shift in which the intervention occurs. If the intervention does not end during the shift in which it began, documentation must be completed during the shift in which it ends. Documentation must include all of the following:

- a. Each order for restraint or seclusion.
- b. The time the emergency safety intervention actually began and ended.
- c. The time and results of the 1-hour assessment conducted by the physician or clinically qualified registered nurse.
- d. The emergency safety situation that required the client to be restrained or put in seclusion.
- e. The names of staff involved in the emergency safety intervention.

- f. All interventions utilized prior to the seclusion or restraint episode must be descriptively documented in the sequence used and identified as to the staff member conducting the intervention.

Interpretive guideline 7: CSP's must have a written policy and procedure about the use of seclusion and restraint. Evidence of annual training and competency in the proper and safe use of seclusion and restraint including techniques and alternative methods for handling behavior, symptoms and situations that traditionally have been treated through the use of restraints or seclusion must be available within staff personnel files for all staff who have direct contact with clients. Policy, procedures and training documentation evidence must include:

- a. Techniques to identify staff and client's behaviors, events and environmental factors that may trigger emergency safety situations.
- b. The use of nonphysical intervention skills, such as de-escalation, mediation, conflict resolution, active listening, and verbal and observational methods, to prevent emergency safety situations.
- c. The safe use of restraint and the safe use of seclusion, including the ability to recognize and respond to signs of physical distress in clients who are restrained or who are in seclusion.
- d. Evidence of exercises in which staff members successfully demonstrate in practice the techniques they have learned for managing emergency safety situations.
- e. Evidence that staff is trained and demonstrate competency before participating in an emergency safety intervention.
- f. Evidence that staff have demonstrated their competencies related to seclusion and restraint on a semiannual basis.
- g. Evidence of current certification in the use of cardiopulmonary resuscitation.
- h. Evidence that staff have demonstrated their competency in cardiopulmonary resuscitation on an annual basis.

Interpretive guideline 8: The CSP must document in the staff personnel records that the training and demonstration of competency were successfully completed.

- a. Documentation must include the date training was completed and the name of persons certifying the completion of training

SSr11.12. (b). Notification of the CSP policy on seclusion or restraint must be given.

Interpretive guideline 1: The CSP must inform both the incoming client and the client's parent(s) or legal guardian(s) of the CSP's policy regarding the use of restraint or seclusion during an emergency safety situation of last resort.

Interpretive guideline 2: The CSP must communicate its restraint and seclusion policy in a language that the client or his or her parent(s) or legal guardian(s) understands (including American Sign Language) and when necessary, the CSP must provide interpreters or translators.

Interpretive guideline 3: The CSP must obtain an acknowledgment, in writing, from the client, the parent(s) or legal guardian(s) that he or she has been informed of the CSP's policy on the use of restraint or seclusion during an emergency safety situation. This acknowledgment must be filed in the client's record.

Interpretive guideline 4: The CSP must provide a copy of the facility policy to the client and to the client's parent(s) or legal guardian(s).

SSr.11.12(c). Each resident shall be assessed for a history of past trauma or abuse.

Interpretive guideline 1: The body of the admission assessment shall contain an assessment of past trauma or abuse. The client and his or her parent or legal guardian shall also be asked how he or she would prefer to be approached should he or she become dangerous to themselves or to others. Findings from these queries shall inform the decision making process about the plan of care.

Interpretive guideline 2: Emergency safety interventions must be performed in a manner that is safe, proportionate and appropriate to the severity of the behavior, and the client's chronological and developmental age, size, gender, physical, medical and psychiatric condition and personal history (including any history of physical or sexual abuse).

SSr 11.12(d).^{5.1} A physician or other licensed practitioner permitted by the State shall give an order for the seclusion or restraint episode as soon as possible within the first fifteen minutes of the implementation of seclusion or restraint intervention.

Interpretive guideline 1: Orders for restraint or seclusion must be by a physician or other licensed practitioner permitted by the State and CSP.

Interpretive guideline 2^{5.1}: The physician or Clinical Nurse Specialist (CNS) must be notified immediately of the seclusion or restraint episode. The physician or CNS must order the least restrictive emergency safety intervention that is most likely to be effective in resolving the emergency safety situation based on consultation with staff.

Interpretive guideline 3: If the order for restraint or seclusion is verbal, the verbal order must be received by a registered nurse or other staff licensed to receive orders, while the emergency safety intervention is being initiated by staff or immediately after the emergency safety situation ends.

- a. If the treating physician is not available to order the use of restraint or seclusion, the physician's verbal order must be obtained.
- b. The physician ordering the restraint or seclusion must verify the verbal order in a signed written form in the client's record as soon as possible.
 - i. If the physician or CNS giving the order is not the client's treating physician, the physician or CNS must consult with the treating physician as soon as possible and inform the treating physician of the emergency safety situation;

^{5.1} Modified FY05

^{5.1} Modified FY05

- ii. Staff must document in the client's record the date and time the treating physician was consulted.

Interpretive guideline 4: Each order for restraint or seclusion must:

- a. Be limited to no longer than the duration of the emergency safety situation.
- b. Specify the time limits for the restraint or seclusion episode. Under no circumstances shall an order exceed:
 - i. Four (4) hours for clients ages 17 and above;
 - ii. Two (2) hours for clients ages 9 to 17;
 - iii. One (1) hour for clients under age 9.
- c. Specify the behavioral indicators that signal the end of the episode.
- d. State that the restraint or seclusion episode shall be ended at the earliest possible time.

Interpretive guideline 5: If the emergency safety situation continues beyond the time limit of the physician's order for the use of restraint or seclusion, a registered nurse must immediately contact the ordering physician in order to receive further instructions.

Interpretive guideline 6: After any seclusion or restraint episode, there must be a determination by the treating physician or Medical Director as to whether transfer to a treatment facility for a higher level of care is indicated. The treating physician or Medical Director's determination for a higher level of care (ASAM 3.7 or CALOCUS 6 or greater) must be documented within the progress notes. Justification for maintaining the client at the CSP for additional care must be documented in the physician progress note.

Interpretive guideline 7: Each order for restraint or seclusion must include:

- a. The name of the ordering physician or CNS;
- b. The date and time the order was obtained;
- c. The emergency safety intervention ordered;
- d. The length of time for which the physician authorized its use;
- e. The behavioral indicators that signal the end of the episode.

The restraint or seclusion episode shall be ended at the earliest possible time.

Interpretive guideline 8: Orders for restraint or seclusion may not be written as a standing order or as an as-needed basis.

SSr 11.12(e).^{6.1} A physician or clinically qualified registered nurse must personally examine the client within one (1) hour of the initiation of the emergency safety intervention and immediately upon the end of the seclusion or restraint episode.

Interpretive guideline 1^{5.1}: The physician or clinically qualified registered nurse must personally examine the client within one hour of the initiation of the emergency safety intervention and immediately upon the end of the seclusion or restraint episode. The findings of the examination

^{6.1} Modified FY06

of the resident shall be documented in the resident record and must include the resident's physical and psychological well being, including but not limited to:

- a. The client's physical and psychological status.
- b. The client's behavior.
- c. The appropriateness of the intervention measures.
- d. Any complications resulting from the intervention.

Interpretive guideline 2: If the client is released from seclusion or restraint prior to the end of the first hour *and* prior to the personal examination of the physician or clinically qualified registered nurse, the rationale for release of the client and the fact that the client was not personally seen by a physician shall be fully documented within the client record.

Interpretive guideline 3^{5.1}: After the order expires, a new determination for continued seclusion or restraint may be made ONLY after the client is PERSONALLY examined by a physician or a clinically qualified registered nurse and may be ordered by a physician or CNS for an additional specific time episode not to exceed:

- a. Four (4) hours for clients ages 17 and above;
- b. Two (2) hours for clients ages 9 to 17;
- c. One (1) hour for clients under age 9.

SSr 11.12(f). During the seclusion or restraint episode, clinical staff trained in the use of emergency safety interventions must be physically present, continuously monitoring the physical and psychological well-being of the client and the safe use of restraint or seclusion, and shall document findings and care given every 15 minutes.

Interpretive guideline 1: A staff member must be assigned to be present immediately outside the seclusion door and must continuously visually monitoring the client when seclusion is utilized.

Interpretive guideline 2: A staff member must be assigned to be present at all times within the room and the door to the room left open when a client is restrained.

Interpretive guideline 3: A client placed in physical restraints must be checked at least every 15 minutes by staff members trained in the use of restraints, and a written record of these checks and all other activities shall be made.

Interpretive guideline 4: While in restraints each client should be spoken to, checked for indications of obvious physical and psychological distress, be offered liquids and an opportunity to meet his need to urinate and defecate as needed or at least every 2 hours unless the client is asleep or their condition does not permit. The restraints sites should be checked every hour for evidence of swelling or abrasion. Each hour a restraint should be removed from each limb for five minutes and then reapplied if their condition permits. A client in restraints should receive all meals available to other clients except as otherwise ordered by a physician based upon the client's health needs and as their condition to take meals while in restraints. In all situations, the client must receive nutrition at

regular meal intervals unless refused by the client. Restraints are to be discontinued when they are no longer needed to prevent a client from hurting their self or others and their medical needs allow removal.

Interpretive guideline 5: Video monitoring does not meet the requirement of personal monitoring of the resident while in seclusion or restraints. Where video monitoring does “co-exist” with 1:1 monitoring, the privacy of the video monitored image is secured from other clients, visitors and non-direct care staff.¹⁰

Interpretive guideline 6: During any seclusion/restraint episode, there is documented nursing staff oversight.¹⁰

Interpretive guideline 7: The physician must be available to staff for consultation at least by telephone throughout the period of the emergency safety intervention.

SS 11.12(g). Notification of the use of seclusion or restraint shall be given to the parent(s) or legal guardian(s).

Interpretive guideline 1: The CSP must secure the privacy and notify the parent(s) or legal guardian(s) of the client who has been restrained or placed in seclusion within one hour after the initiation of each emergency safety intervention. There must be documentation of notification or the attempt to notify parent(s) or legal guardian(s) of the client who has been restrained or placed in seclusion within one hour.

Interpretive guideline 2: The CSP must document in the resident’s record that the parent(s) or legal guardian(s) has been notified of the emergency safety intervention including the date and time of notification and the name of the staff person providing the notification.

SSr 11.12(h). Staff shall conduct a debriefing with the resident within 24 hours after release from seclusion or restraint.

Interpretive guideline 1: The client shall have an opportunity to talk to staff members within 24 hours after release from seclusion or restraint. This discussion must include staff involved in the intervention except when the presence of a particular staff person may jeopardize the well being of the resident. The discussion may include supervisory and administrative staff if appropriate.

Interpretive guideline 2: The following are potential issues to explore with the resident:

- a. Circumstances resulting in the use of seclusion or restraint, including:
 - i. What the client remembers happening prior to becoming angry, destructive or self injurious.
 - ii. Whether the client remembers sensory changes prior to being placed in seclusion or restraints.
 - iii. What thoughts the client has about why the resident was placed in seclusion or restraint.

- iv. How the client felt while in seclusion or restraint.
- v. How the client felt after being released from seclusion or restraint.
- b. The outcome of the interventions used, including any injuries that may have resulted from the use of seclusion or restraint.
- c. Strategies to be used by the staff, the client or others that could prevent the future use of restraint and seclusion.
 - i. Alternative techniques might have prevented the use of seclusion or restraint.
- d. Procedures, if any, that staff should implement to prevent any recurrence of the use of restraint or seclusion.
- e. Strategies that were helpful to the client in gaining personal control:
 - i. Was there something the client did that was helpful in gaining personal control?
 - ii. Was there something the staff did that was helpful in the client gaining personal control?

Interpretive guideline 3: Staff must document in the client's record that debriefing took place and must include:

- a. The names of staff that was present for the debriefing.
- b. The names of staff that were excused from the debriefing.
- c. Any changes to the client's treatment plan that result from the debriefing.

SSr 11.12(i). The staff members involved in the seclusion or restraint episode shall receive a debriefing after the episode.

Interpretive guideline 1: Within 24 hours after the use of restraint or seclusion, all staff involved in the emergency safety intervention and appropriate supervisory and administrative staff must conduct a debriefing session that includes, at a minimum, a review and discussion of:

- a. The emergency safety situation that required the intervention, including a discussion of the precipitating factors that led up to the intervention, such as:
 - i. What physical cues were present that indicated escalation of client's behaviors?
- b. Review of techniques used and alternative techniques that might have prevented the use of the restraint or seclusion:
 - i. What interventions were conducted, by what staff member and in what order as the events unfolded leading up to seclusion or restraint?
 - ii. What was the client response to each intervention conducted?
 - iii. Could alternate interventions result in a different outcome other than seclusion or restraint?
- c. What did the staff involved do well?
- d. What could staff do differently in the future that might avoid reaching the point of a seclusion or restraint?
- e. What recommendations shall be documented within the client plan of care for use in future situations?

Interpretive guideline 2: Staff must document in the client's record that debriefing took place and must include:

- a. The names of staff who were present for the debriefing;
- b. The names of staff who were excused from the debriefing; client's
- c. Any changes to the treatment plan as a result from the debriefing.

Interpretive guideline 3: Staff involved in an emergency safety intervention that resulted in an injury to a client or staff must meet with supervisory staff and evaluate the circumstances that caused the injury and develop a plan to prevent future injuries.

SSr 11.13 MEDICAL TREATMENT FOR INJURIES RESULTING FROM A SAFETY INTERVENTION

SSr 11.13 The CSP shall insure that medical treatment is immediately obtained from qualified medical personnel for a resident injured as a result of an emergency safety intervention.

Interpretive guideline 1: Staff must immediately obtain medical treatment from qualified medical personnel for a client injured as a result of an emergency safety intervention.

Interpretive guideline 2: Staff must document in the client's record, all injuries that occur as a result of an emergency safety intervention, including injuries to staff from that intervention.

SSr 11.14 ORGANIZATIONAL RISK AND COMPLIANCE

SSr 11.14 The CSP has a well-defined approach for assessing its performance, for anticipating, identifying, correcting and solving problems, and for improving quality of care related to use of safety interventions of last resort.

Interpretive guideline 1: The CSP maintains a record of each emergency safety situation, the interventions used, and their outcomes.

Interpretive guideline 2: Staff involved in an emergency safety intervention that results in an injury to a client or staff must meet with supervisory staff and evaluate the circumstances that caused the injury and develop a plan to prevent future injuries.

Interpretive guideline 3: Data regarding the use of safety interventions of last resort will be aggregated and reported quarterly to the CSP management and risk management authority of the managing Community Service Board or State Hospital facility. The report shall include issues that have been addressed pursuant to review of the data, or that no action is required based on aggregate information.

Interpretive guideline 4: Each CSP with a current Medicaid provider agreement must provide to the State Medicaid agency, at the time it executes a provider agreement with the Medicaid agency, in writing, that the CSP is in compliance with CMS's standards governing the use of restraint and seclusion. The CSP director must sign this attestation.

SSr 11.15 PHARMACY SERVICES

SSr 11.15 All pharmacy operations or services within the CSP must be licensed and under the direct supervision of a Registered Pharmacist or provided by contract with a licensed pharmacy operated by a Registered Pharmacist.

Interpretive guideline 1: Pharmacy services must be provided under the license and supervision of a Registered Pharmacist who is operating under a ‘retail’ or ‘hospital’ license.

Interpretive guideline 2: Any request for exemptions for requirements regarding a pharmacy license must be submitted in writing to the Georgia State Board of Pharmacy.

Interpretive guideline 3: CSP must ensure access to Pharmacy services for prescription medications within eight (8) hours of the Physician’s order.¹⁰

SSr 11.16. MEDICATION ADMINISTRATION

SSr 11.16 In all cases, the rules regarding medications found in Rules of Department of Human Resources, Mental Health, Mental Retardation and Substance Abuse Chapter 290-4-9 Residents’ Rights shall apply.

Interpretive guideline 1: Medications shall be used solely for the purposes of providing effective treatment and protecting the safety of the client and other persons and shall not be used as punishment, coercion, discipline, retaliation or for the convenience of staff.

Interpretive guideline 2⁶: The CSP shall follow policies and procedures found in the Division of MHDDAD Policy 2:100, *Informed Consent and Involuntary Administration of Psychotropic Medication*, concerning the use of psychotropic medications and the use of involuntary medications.^{6/10}

Interpretive guideline 3: The CSP shall follow management protocols for controlled substances, floor stock medications, and physician’s sample medications. These accountability medication management techniques must include: inventories, counting, signing out each dose or sample to an individual, and witnessed / documented disposal.¹⁰

SSr 11.17 INDIVIDUALIZED CARE

SSr 11.17. Educational and program offerings within the CSP include services to meet the individual stabilization needs of each resident including psychiatric or behavioral stabilization for children and youth who are seriously emotionally disturbed and detoxification services for youth. Educational and program offerings shall also include attention to the child or youth’s academic development.

⁶ Added FY06

¹⁰ Updated FY10

Interpretive guideline 1: Educational and program offerings include offerings that address issues both common and distinct to the child or youth needing psychiatric or behavioral stabilization and for the youth needing detoxification services.

Interpretive guideline 2: Each child or adolescent shall be assessed to determine his or her academic development. The CSP shall utilize educational integration services has a mechanism to support and enhance the child or adolescent's academic development.

- a. Educational specialists or teachers will be available to provide instruction and support services such as tutoring;
- b. Individualized planning and linkage shall occur with child or youth's community school.

Interpretive guideline 3: Educational, program and academic offerings are age appropriate and presented in a way easily understood by the resident.

Interpretive guideline 4: The client's clinical record will demonstrate individualized interventions based on the care needs of each person served as evidenced within the body of assessments, documentation of the progression of care and documented discharge linkages.

Interpretive guideline 5: A record of academic assessment, offerings and the child or youth's response to those offerings shall be maintained in a separate record that shall be filed with the clinical record at discharge.

Interpretive guideline 6: Staff training records shall show evidence of annual training and competency in caring for children or youth needing psychiatric or behavioral stabilization and for the youth needing detoxification services.

SSr.11.18 REPORTING OF SERIOUS OCCURRENCES

SSr.11.18. The CSP must report each serious occurrence.

Interpretive guideline 1: Serious occurrences shall be reported as specified in DBHDD Policy for *Reporting of Consumer Deaths and Critical Incidents*.¹⁰

Interpretive guideline 2: The CSP must report any serious occurrence to the State Medicaid agency. Serious occurrences that must be reported include:

- a. Client's death
- b. Client's suicide attempt
- c. Serious injury to a client manifesting itself as any serious impairment of the physical condition of the resident as determined by qualified medical personnel including, but not limited to:
 - i. Burns
 - ii. Lacerations
 - iii. Bone fractures

¹⁰ Updated FY10

- iv. Substantial hematoma
- v. Injuries to internal organs, whether self-inflicted or by someone else

Interpretive guideline 3: The CSP shall notify the parent(s) or legal guardian(s) as soon as possible and in no case later than 24 hours after a serious occurrence.

Interpretive guideline 4: A description of the serious occurrence must be recorded in the client's record, including:

- a. Medical treatment sought, outcome of treatment, and follow-up required;
- b. That the serious occurrence was reported, including
 - i. The names of the parent(s) legal guardian(s) to whom it was reported
 - ii. The name of the agencies to which it was reported, including the name of the person at the agency who received the report.
 - 1. The State Medicaid Agency (if the CSP is enrolled as a Medicaid provider)
 - 2. The Department of BHDD¹⁰

Interpretive guideline 5: In addition to the agencies listed above, if the CSP is enrolled as a Medicaid provider, ALL DEATHS of any client must be reported to the Regional Office for the Centers for Medicare and Medicaid (CMS) by no later than the close of the next business day after the resident's death.

- a. The method of reporting and corresponding documentation noted within this standard shall apply.
- b. Staff must document in the client's record that the death was reported to the CMS regional office.

Interpretive guideline 6: A copy of the incident and accident report shall be kept by the CSP.

SSr. 11.19 REPORTING OF CLIENT DATA TO THE DEPARTMENT OF BHDD^{7/10}

SSr.11.19. The crisis stabilization program shall report data to the Department of BHDD as directed by provider agreement.¹⁰

Interpretive guideline 1: Encounter data shall be reported to the Department of BHDD in the format directed by the operational guidelines provided by the Department of BHDD to the parent organization (Community Service Board or State Hospital Facility).¹⁰

Interpretive guideline 2: Encounter data shall include but may not be limited to:

- a. Client name
- b. Date of admission

¹⁰ Updated FY10

⁷ Added to CSP Standards FY07

FY08 State Protection & Advocacy program references are removed from text

- c. Date of discharge
- d. Legal status
- e. Admitting diagnosis
- f. Referred to

SSr. 11.20 DESIGNATION AS A CRISIS STABILIZATION PROGRAM

SSr 11.20. The designation must be approved and may be withdrawn by the department. Designation is not transferable.

Interpretive guideline 1: Designation as a crisis stabilization program must be approved and may be withdrawn by the Department of BHDD. Designation is non-transferable.

Interpretive guideline 2: Each designation or provisional designation shall be returned to the department in the following cases. This includes but may not be limited to:

- Change in location
- Program closure
- DBHDD finding of failure to comply with CSP standards
- Loss of accreditation

Part IV

**Community Service Standards Specific for
Behavioral Health Services**

SECTION IV

***Documentation Guidelines for
Behavioral Health Providers***

Fiscal Year 2012



**Georgia Department of Behavioral Health &
Developmental Disabilities**

April 2012

Introduction

The purpose of documentation of consumer services is to provide a written, legal record of the course of treatment and the delivery of services. Ideally, documentation provides the following:

- Evidence that the consumer's needs have been assessed, eligibility established and needs prioritized;
- Medical necessity of the service is supported;
- Appropriate outcomes are identified and discharge criteria established;
- Appropriate treatment is planned;
- Appropriate interventions and services are selected;
- Evidence of consumer participation, consent and response to treatment are present;
- Evidence of monitoring of service provision and progress towards desired outcomes are monitored;
- Evidence of reassessment(s) occurring on an ongoing and as needed basis;
- Evidence that services and treatment plans are amended and changes are implemented to facilitate progress when needed; and
- Clear evidence that the services billed are the services provided.

Core Components of Documentation

There are three core components of consumer related documentation. These include **assessment and reassessment**; **treatment and care planning** (individualized service/recovery plan); and **progress notes**. These core components are independent and yet must be inter-related in order to create a sound medical record. The required elements for all Behavioral Health services are detailed below. The documentation guidelines outlined herein do not supersede service-specific requirements. This Provider Manual may list additional requirements and standards which are service-specific; when there is a conflict, providers should defer to those requirements which are most stringent.

Assessment

Comprehensive assessment and reassessment documentation includes all components of the current ERO authorization, a biopsychosocial assessment, a medical screening, an integrated/interpretive summary, and a verified diagnosis. A verified diagnosis is defined as a behavioral health diagnosis provided by a licensed psychologist, a physician, or a Physician Assistant or APRN¹ working in conjunction with a physician with an approved job description or protocol. At a minimum, all diagnoses must be verified annually by a licensed psychologist, medical doctor, APRN, or Physician Assistant following a face-to-face evaluation of the consumer (internal or external to the agency).² For any diagnoses

¹ APRNs include Clinical Nurse Specialists (CNS) and Nurse Practitioners (NP).

² This will be monitored by the ERO audit tool effective January 1, 2010.

that are valid for less than one year, an assessment must be completed more often as indicated in the current DSM. If this requirement is not met due to consumer refusal or choice, documentation in the record should reflect this.

For all verified diagnoses assigned or annually verified following **August 1, 2010**: Documentation of diagnosis/diagnoses must clearly indicate the diagnosis or diagnoses and include a summary of findings to include any supporting documentation. The documentation must clearly indicate the diagnosing practitioner, his/her credential/s, date of diagnosis, and be signed by the practitioner. On all medical record documentation, the practitioner's printed name must be the name listed on his or her practitioner's license³. This requirement is applicable to diagnoses provided both internal and external to the agency.

As defined in Part I, Section I of this Provider Manual, "Eligibility, Service Definitions and Requirements", a diagnostic impression is sufficient for brief or stabilization services. Diagnostic impressions may be provided by those professionals or paraprofessionals who are permitted to provide the Behavioral Health Assessment service.

A comprehensive assessment must include:

- Justification of elements which support diagnosis;
- Summary of central themes of presenting symptoms/needs and precipitating factors;
- Consumer strengths;
- Prior treatment and rehabilitation services used and outcomes of these services;
- Interrelationship of history and assessments;
- Preferences for treatment, consumer choice and hopes for recovery;
- An assessment for co-occurring disorders;
- Barriers impacting prospects for stabilization and recovery;
- Current issues placing the client most at risk;
- How needs are to be prioritized and addressed;
- What interventions are needed, when, how quickly, in what services and settings, length of stay, and with what provider(s); and
- The step-down services.

Treatment and Care Planning

Treatment and care planning documentation is included in the consumer's Individualized Recovery/Resiliency Plan (IRP). The IRP should be reviewed frequently and evolve to best meet the consumer's needs. This plan sets forth the course of care by integrating the information gathered from the current assessment, status, functioning, and past treatment history into a clinically sound plan of care. The following components are required:

³ It is acceptable that the initials can be used for first and middle names. The last name must be spelled out and each of these must correlate with the names on the license. This is an effort to ensure that a connection can be made between the printed/stamped name on the chart entry and a license.

Order/Recommendation for Course of Treatment⁴

All services must be recommended (“ordered”) by a physician or other appropriately licensed practitioner. The recommendation/order for a course of treatment must specify each service (**by official Group Name**) to be provided and shall be reviewed and signed by the appropriately licensed practitioner(s) on or before the initial date of service **AND** on or before the effective date of each reauthorization of service(s). If the provider utilizes service packages (i.e. Intensive Outpatient) to order services, each service included in the service package must be individually named (**by official Group Name**) in the recommendation/order. All recommendations/orders expire at the time of the expiration of the current authorization.

- There are two formats that may be used for writing a recommendation/order:
 1. An individualized recovery/resiliency plan (IRP) which fulfills the required components **A-E** listed below, can be used as a recommendation/order for the applicable authorization period for services indicated within the plan.
 2. A stand-alone recommendation/order in the client record which fulfills required components **A-E** listed below.
- **Required Components** of the recommendation/order include:
 - A. Consumer name,
 - B. All services recommended as a course of treatment/ordered as indicated by Group Name as listed in the current DBHDD Provider Manual,
 - C. Signature and credentials⁵ of appropriately licensed practitioner(s),
 - D. Printed or stamped name and credentials of appropriately licensed practitioner(s), and
 - E. Date of signature(s).
- The appropriately licensed practitioner(s) authorized to recommend/order specific services may be found within each service definition.
- Should the recommendation for course of treatment (order) cross multiple pages in a paper record, the provider is responsible for ensuring that it is clear that the additional pages are a continuation of the order. For example, in a 2 page order, page 2 must contain the name of the consumer, a page number, and indication that the signature of the practitioner indicates authorization for services as noted on page 1.
- Recommendation for course of treatment (“orders”) may be made verbally. This Provider Manual may list additional requirements and standards which are service-specific; *when there is a conflict, providers should defer to the more stringent requirements and standards*. Required components of the verbal recommendation/order include:

⁴ Note that the following requirements apply only to recommendation/orders for **services** as defined in the MH and AD Service Definitions and Guidelines (FY 09 Provider Manual, Part I, Section I). Standards regarding orders for medication and procedures can be found in the Standards for All Providers (FY 09 Provider Manual, Part II, Section II).

⁵ See Appendix 1 for additional information regarding credentials.

- The organization must have policies and procedures which govern procedures for verbal orders;
- Recommendations/Orders must be documented in the medical record and include:
 - A. Consumer name,
 - B. All services recommended as a course of treatment/ordered as indicated by official Group Name as listed in the current DBHDD Provider Manual,
 - C. Printed or stamped name and credentials of appropriately licensed practitioner(s) recommending service, and
 - D. Date of verbal order(s); and
 - E. Printed or stamped name, credentials, original signature, and date signed by the staff member receiving the verbal order. Organization's policy must specify which staff can accept verbal orders for services.
- Verbal orders must be authenticated by the ordering practitioner's signature within seven (7) calendar days of the issuance of orders. This may be an original signature or faxed signed order.
- Faxed orders signed by the ordering practitioner are acceptable and a preferred alternative to verbal orders. The fax must be dated upon receipt, contain Required Components A-E.

Individualized Treatment (Recovery/Resiliency) Planning must:

- Identify and prioritize the needs of the consumer;
- Document by consumer signature and/or, when applicable, guardian signature that the consumer is an active participant in the planning and process of care (to the degree to which that is possible). Subsequent changes to the plan must also document consumer or guardian signature via dated initials.
- State goals which will honor achievement of stated hopes, choice, preferences, and desired outcomes of the consumer and/or family;
- Assure goals/objectives are:
 - related to assessment/reassessment;
 - designed to ameliorate, rectify, correct, reduce or make symptoms manageable; and
 - indicative of desired changes in levels of functioning and quality of life to objectively measure progress.
- Define goals/objectives that are individualized, specific and measurable with achievable timeframes;
- Detail interventions which will assist in achieving the outcomes noted in the goals/objectives;
- Identify and select services and interventions of the right duration, intensity and frequency to best accomplish these objectives;
- Assure there is a goal/objective that is consistent with the service intent;
- Identify frequency and duration of services which are set to achieve optimal results with resource sensitive expenditures.

Discharge/Transition Plan which:

- Documents transition planning at onset of service delivery;
- Defines discharge criteria which objectively measures progress by aligning with documented goals/objectives, desired changes in levels of functioning, and quality of life;
- Defines specific step-down service/activity/supports to meet individualized needs; and
- Is measurable and includes anticipated step-down/transition date.

Within 30 days from the date of discharge, the Discharge Summary must:

- Document the reason for ending services;
- Indicate the outcome of the goals and objectives made during the service provision period;
- Strengths, needs, abilities, and preferences of the individual;
- Define specific to step-down service/activity/supports where consumer was referred; and
- Living situation at discharge.

Progress Note

Progress Note documentation includes the actual implementation and outcome(s) of the designated services in a consumer's IRP. The progress note is an integral part of the consumer's written legal record. The purpose of the progress note documentation is to accurately describe the delivery of services and the impact of the services to the consumer.

Progress note documentation requires prospective and current providers to develop and implement protocols by which they design, execute and monitor the documentation in a consistent, systematic, agency wide manner on an ongoing basis. While the Department of BHDD has not prescribed a specific format for progress notes, there are clear standards related to the **content, components, required characteristics, and format of progress note documentation.**

The Department of BHDD has provided the information in this section to communicate **requirements** for progress note documentation and to offer guidance for implementation of the standards related to the purpose, components, characteristics, content, context and quality of progress note documentation.

It is the recommendation of Department of BHDD that current and prospective providers of Medicaid Community Mental Health Services and State Funded Services utilize the information in structuring their internal standards, protocols, practices, performance, monitoring and training activities.

The **content in progress note documentation** must provide all the necessary supporting evidence to justify the need for the services based on medical necessity criteria and support

all requirements for billing and adjudication of the service claims. For this reason, progress notes for all billed services (e.g. face-to-face, telemedicine, collateral, etc) should include observations of the consumer's symptoms, behaviors, affect, level of functioning and reassessment for risk when indicated as well as information regarding the exact nature, duration, frequency and purpose of the service, intervention and/or modality. Review of sequential progress notes should provide a snapshot of the consumer over a specified time frame.

Required components of progress note documentation:

- **Linkage** - Clear link between assessment and/or reassessment, Individualized Recovery/Resiliency Plan and intervention(s) provided.
- **Consumer profile** – Description of the current status of the consumer to include consumer statements, shared information and quotes; observations and description of consumer affect; behaviors; symptoms; and level of functioning.
- **Justification** – Documentation of the need for services based on admission criteria and measurable criteria for medical necessity. This documentation should also reflect justification for payment of services provided and utilization of resources as it relates to the service definition and the needs/desires of the consumer.
- **Specific services/intervention/modality provided** – Specific detail of all provided activity(ies) or modality(ies) including date, time, frequency, duration, location and when appropriate, methodology.
- **Purpose or goal of the services/intervention/modality**- Clarification of the reasons the consumer is participating in the above services, activities, and modalities and the demonstrated value of services.
- **Consumer response to intervention(s)** – Identification of how and in what manner the service, activity, and modality have impacted the consumer; what was the effect; and how was this evidenced.
- **Monitoring** - Evidence that selected interventions and modalities are occurring and monitored for expected and desired outcomes.
- **Consumer's progress** – Identification of the consumer's progress (or lack of progress) toward specific goals/objectives as well as the overall progress towards wellness.
- **Next steps** – Targeted next steps in services and activities to support stability
- **Reassessment and Adjustment to plan** – Review and acknowledgement as to whether there is a need to modify, amend or update the individualized service/recovery plan and if so, how.

Required characteristics of progress note documentation⁶:

- **Presence of note** – For any claim or encounter submitted to DBHDD (including Medicaid Rehabilitation Option), a note must be present justifying that specific intervention. In addition, other ancillary or non-billable services which are related to the

⁶ Any electronic records process shall meet all requirements set forth in this document.

well-being of the individual served must be included in the consumer's official medical record.

- **Service billed** – All progress notes must contain the corresponding HIPAA code which must include any designated modifier. When documenting practitioner modifiers, the modifier must indicate the reimbursement level, which may differ from the practitioner level in certain cases. For example, if a RN provides CSI, the RN would include the modifier U4 to indicate the practitioner level even though an RN is generally a level 2 Practitioner.
- **Timeliness** – All activities/services provided are documented (written and filed) within the current consumer record within a pre-established time frame set by agency policy not to exceed 7 calendar days. Best practice standards require progress notes to be written within 24 hours of the clinical or therapeutic activity.
- **Legibility** – All documentation that is handwritten must be readable, decipherable and easily discernable to the all readers.
- **Conciseness and clarity** – Clear language, grammar, syntax, and sentence structure is used to describe the activity and related information.
- **Security and confidentiality** – All documentation is managed in such a manner to ensure consumer confidentiality and security while providing access and availability as appropriate.
- **Activities dated** - Documentation specifies the date/time of service.
- **Dated entries** – All progress note entries are dated to reflect the date of signature of the individual providing the service (this date may differ from the actual date of service). Dates written to indicate the date of a signature should only be dated by the signer. In electronic records, the date of entry should reflect the date that the secure electronic signature was entered. Back-dating and post-dating are not permitted.
- **Duration of activities** – Documentation of the duration must be noted for all services to include the number of units, times, and dates. For those services in which the unit/rate is based on time (not per contact/encounter), documentation must include time-in and time-out for all services. This requirement applies for both face-to-face and collateral contacts. Residential services are excluded from the daily notation of time-in/time-out and must follow the specific guidelines outlined in each specific residential code. Further instruction related to Psychosocial Rehabilitation and Peer Supports services can be found in the respective Service Guidelines.
- **Rounding of Units** – Rounding of units is permitted when a service meeting the service definition is provided in less time than the unit increment requirement. Each provider must have an internal policy regarding rounding of units. **Effective January 1, 2011:** Regarding “rounding” of units, a unit may be billed for a service when an activity meets the service definition of the service billed but does not meet the full time/unit requirement. In order to bill a unit of service, at least 50% of the time required per unit must be provided and documented by the “time-in, time-out” documentation. For example, a provider may bill a single 15 minute unit for a service greater or equal to 8 minutes and less than 23 minutes. If the duration of the service is greater than or equal to 23 minutes and less than 38 minutes, then 2 units may be billed. Providers must document rounding practices in internal policy.
- **Location of intervention** – For those services which may be billed as either in or out-of clinic, progress notes shall reflect the location as either in-clinic or out-of-clinic (unless

otherwise noted in Service Guideline). If the intervention is in-clinic, no further specificity is required. If an intervention is “out-of-clinic”, the note must reflect the specific location of the intervention; this indication should be specific enough that it can be generally understood where the service occurred (for example: “...at the individual’s home,” “...at the grocery store”, etc.). Documenting that the service occurred “in the community” is not sufficient to describe the location.

- **Participation in intervention** – Progress notes shall reflect all the participants in the treatment and/or support intervention (consumer, family, other natural supports, multi-disciplinary team members, etc.)
- **Signature, Printed staff name, qualifications and/or title⁷** – The writer of the documentation is designated by name and credentials/qualifications and when required, degree and title. If an individual is a licensed practitioner, the printed name must be the name listed on his or her practitioner’s license on all medical record documentation⁸. An original signature is required. The printed name and qualifications and/or title may be recorded using a stamp or typed onto the document. Automated or electronic documentation must include a secure electronic signature⁹.
- **Black or Blue ink** – Currently, the State of Georgia requires that any handwritten documentation must be in black or blue ink.
- **Recorded changes** – Any corrections or alternations made to existing documentation must be clearly visible. **No “white-out” or unreadable cross-outs** are allowed. A single line is used to strike an entry and that strike must be initialed and dated. Any changes to the electronic record must include visible “edits” to include the date and the author of the edit. Additionally, if a document contains a Secure Electronic Signature, it must be linked to data in such a manner that if the data is changed the electronic signature is invalidated.
- **Consistency** – Documentation should follow a consistent, uniform format. Should the progress note cross multiple pages in a paper record, the provider is responsible for ensuring that it is clear that the additional pages are a continuation of the progress note. For example, in a 2 page note, page 2 must contain the name of the consumer, date of service, a page number, and indication that the signature of the practitioner or paraprofessional is related to the progress note on page 1.
- **Diversionary and non-billable activities** –
 - Providers may not bill for multiple services which are direct interventions with the consumer during the same time period. If multiple services are determined to have been billed at the same or overlapping time period, billing for those services are subject to recoupment. Allowable exceptions include a consumer receiving a service during the same time period or overlapping time period as:

⁷ See Appendix 1 for additional information regarding credentials.

⁸ It is acceptable that the initials can be used for first and middle names. The last name must be spelled out and each of these must correlate with the names on the license. This is an effort to ensure that a connection can be made between the printed/stamped name on the chart entry and a license.

⁹ As defined in PART I POLICIES AND PROCEDURES FOR MEDICAID/PEACHCARE FOR KIDS, a Secure Electronic Signature means an electronic or digital signature, symbol, or process associated with a document which is created, transmitted, received, or stored by electronic means which (1) requires the application of a security procedure; (2) capable of verification/authentication; (3) adopted by a party with the intent to be bound or to authenticate a record; (4) signed under penalty of perjury; (5) unique to the person using it; (6) under the sole control of the person using it; and (7) linked to data in such a manner that if the data is changed the electronic signature is invalidated.

- A service provided without client present as indicated with the modifier "HS", or
- A collateral contact service as indicated by the modifier "UK".

For example, a provider may bill Individual Counseling with the consumer while, simultaneously, CSI is being billed for a collateral contact. This is only allowable when at least one of the services do not require that the consumer be present and the progress note documents such.

- Non-billable activities are those activities or administrative work that does not fall within the Service Definition. For example, confirming appointments, observation/monitoring, tutoring, transportation, completing paperwork, and other administrative duties not explicitly allowed within the Service Guidelines are non-billable activities. Billing for non-billable activities is subject to recoupment.
- Billing for services that do not fall within the respective Service Definition is subject to recoupment.
- Diversionary activities are activities/time during which a therapeutic intervention tied to a goal on the individual's treatment plan is not occurring. Diversionary activities which are billed are subject to recoupment. An exception to this includes activities billed as Structured Activity Supports which fall within the service definition.

Formats for progress note documentation:

The Department of BHDD does not require providers to utilize a specific format for progress notes. However, providers are expected to follow best practices and select a format or create a prescribed narrative that can be used consistently throughout their agency. Information regarding best practices for progress note documentation including expanded acronym definition, specific content and examples are available through accrediting bodies, professional organizations, and other resources.

Specific details regarding actual practice should be described in provider's policies, procedures, training manuals and/or documentation instruction sheets.

There are numerous acceptable formats for best practice of progress note documentation. Among many others, these formats may include the *SOAP, PIR, GIO, GIRP, BIRP, OSRP, DAP and TREATS*. The acronyms definitions of these formats stand for:

- *S-O-A-P: Subjective, Objective, Assessment and Plan*
- *P-I-R: Problem(s)-Intervention(s)-Response(s)*
- *G-I-O: Goal(s), Intervention(s), Objective(s)*
- *G-I-R-P: Goal(s), Intervention(s), Response(s), Plan*
- *B-I-R-P: Behavior(s), Intervention(s), Response(s), Plan*
- *O-S-R-P: Objective(s), Strategy(ies), Response(s), Plan*
- *D-A-P: Data, Assessment, Plan*
- *T-R-E-A-T-S: Traits, Response, Events, Assessment, Treatment Strategies*

While these formats differ slightly in identifying acronyms or “labels,” they share similar structure, common data elements and required content. All formats require a clear match or link between the progress note, assessment and service and planning data. In addition, formats lay out specific standards for capturing detailed information related to the consumer’s current status, specific service, intervention, activity and/or modality provided; the consumer response and progress; and what should be the next steps in the planning process.

For more information on progress note development, see BHDD’s “Progress Note Development Checklist” online at www.apsero.com

Documentation of Standard Training Requirement for Paraprofessionals

Providers must comply with the Standard Training Requirement for Paraprofessionals. Documentation of compliance must be available for each paraprofessional. For the Essential Learning (online) component, demonstration of fulfilling this requirement includes printing the certificates and/or the Learners’ transcripts and keeping them in personnel files. Providers must also have documentation available to demonstrate completion of the training provided by the organization. In addition, **effective January 1, 2011**, an orientation agenda/checklist/spreadsheet with the name of the employee, date, topic of training, and number of hours must be available for audit purposes. The date of hire must also be available for review. For additional details regarding the Standard Training Requirement, refer to the Standards for All Providers within this Provider Manual.

Documentation of Supervision for Individuals Working Towards Licensure

Psychologist/LCSW/LPC/LMFT’s supervisee/trainee is defined as:

An individual with a minimum of a Bachelor’s degree and one or more of the following:

1. Registered toward attaining an associate or full licensure;
2. In pursuit of a Master’s degree that would qualify the student to ultimately qualify as a licensed practitioner (Psychologist, LCSW, LMFT, LPC, LMSW, LAMFT, LAPC);
3. Not registered, but is acquiring documented supervision toward full licensure in accordance with O.C.G.A. 43-10A-3

See Service Guideline for information regarding practitioners authorized to provide specific services.

These individuals must be under supervision of a licensed Psychologist/LCSW, LPC, or LMFT in accordance with the GA Composite Board of Professional Counselors, Social Workers, and Marriage and Family Therapists or enrolled in a practicum with an accredited educational Master’s degree program which provides supervision as a part of a curriculum which is the foundation toward licensure.

Effective for all services provided on or after August 1, 2009, students and individuals who meet the definition of a Supervisee/Trainee above will not require a co-signature on

progress notes unless required by the rules of the Georgia Composite Board of Professional Counselors, Social Workers and Marriage and Family Therapists.

In accordance with the Georgia Composite Board of Professional Counselors, Social Workers and Marriage and Family Therapists, interns and trainees must work under direction and documented clinical supervision of a licensed professional. Effective for all services provided on or after August 1, 2009, agencies will be required to present documentation of supervision of Supervisee/Trainees upon request by DBHDD or the DBHDD's ERO. Supervision must be completed monthly; documentation of supervision for previous month must be in employee file by the 10th day of the following month. For example, January supervision must be recorded by February 10th.

As of the print date of this Provider Manual, documentation of supervision is described by O.C.G.A. 43-10A-3 as, "a contemporaneous record of the date, duration, type (individual, paired, or group), and a brief summary of the pertinent activity for each supervision session". More information can be found online at <http://sos.georgia.gov/plb/counselors/>. Documentation of supervision as defined by O.C.G.A. 43-10A-3 must be present and current in personnel record.

In addition, for Supervisee/Trainees who are either:

1. In pursuit of a Master's degree that would qualify the student to ultimately qualify as a licensed practitioner (Psychologist, LCSW, LMFT, LPC, LMSW, LAMFT, LAPC), or
2. Not registered toward attaining licensure, but is acquiring documented supervision toward full licensure in accordance with O.C.G.A. 43-10A-3,

The agency will be required to present an attestation signed by both the supervisor and supervisee/trainee which either:

1. Confirms enrollment in a practicum with an accredited educational Master's degree program which provides supervision as a part of a curriculum which is the foundation toward licensure, or
2. Confirms that supervision is being provided towards licensure in accordance with O.C.G.A. 43-10A-3.

Documentation of Supervisee/Trainees who are receiving on-site supervision in addition to the supervision that they are receiving off-site towards their licensure must include:

1. A copy of the documentation showing supervision towards licensure, and
2. Documentation in compliance with the above-stated requirements.

For example, if a Supervisee/Trainee is working at Agency "A" as a supervisee-trainee and receiving supervision towards their licensure outside of Agency "A", the a copy of the documentation showing supervision towards licensure must be held at Agency "A".

This Provider Manual may list additional requirements and standards which are service-specific; when there is a conflict, providers should defer to those requirements which are most stringent.

Documentation of Supervision of Addiction Counselor Trainees

Addiction Counselor Trainees may provide certain services under Practitioner Level 5. See Service Guideline for information regarding practitioners authorized to provide specific services. The definition of Addiction Counselor Trainee is “an individual who is actively seeking certification¹⁰ as a CADC, CCADC, CAC II or MAC and is receiving appropriate Clinical Supervision”. The Addiction Counselor Trainee Supervision Form (Appendix 2) and supporting documentation indicating compliance with the below requirements must be provided for all services provided by an Addiction Counselor Trainee on or after August 1, 2009. The following outlines the definition of supervision and requirements of clinical supervision:

- Supervision means the direct clinical review, for the purpose of training or teaching, by a supervisor of a specialty practitioner's interaction with a client. It may include, without being limited to, the review of case presentations, audio tapes, video tapes, and direct observation in order to promote the development of the practitioner's clinical skills.
- Monthly Staff Supervision form must be present and current in personnel record. Supervision must be completed monthly; supervision form for previous month must be in employee file by the 10th day of the following month. For example, January supervision must be recorded by February 10th.
- Evidence must be available to show that supervising staff meet qualifications:
 - The following credentials are acceptable for Clinical Supervision: CCS; CADC; CCADC; CAC II; MAC **or** LPC/ LCSW/LMFT who have a minimum of 5 hours of Co-Occurring or Addiction specific Continuing Education hours per year; certification of attendance/completion must be on file.
- The Addiction Counselor Trainee must have a certification test date that is within 3 years of hire as an Addiction Counselor Trainee, and;
- The Addiction Counselor Trainee may not have more than 3 years of cumulative experience practicing under supervision for the purpose of addiction certification, per GA Rule 43-10A, and;
- Addiction Counselor Trainees must have a minimum of 4 hours of documented supervision monthly – this will consist of individual and group supervision.

This Provider Manual may list additional requirements and standards which are service-specific; when there is a conflict, providers should defer to those requirements which are most stringent.

The DBHDD has added specificity regarding the supervision of these practitioners due to the volume of practice provided by LCSW/LPC/LMFT’s supervisee/trainees and Addiction Counselor Trainees. Psychologists in training should adhere to the supervision requirements outlined in the Official Code of Georgia.

¹⁰ Persons actively seeking certification are defined as: Persons who are training to be addiction counselors but only when such persons are: employed by an agency or facility that is licensed to provide addiction counseling; supervised and directed by a supervisor who meets the qualifications established by the certifying body; actively seeking certification, i.e. receiving supervision & direction, receiving required educational experience, completion of required work experience. (Georgia Rule 43-10A)

Appendix 1

The below chart provides abbreviations for credentials recognized in the Practitioner Level system. These approved abbreviations must be on the signature lines in documentation where credentials are required (i.e. orders for services, progress notes, etc). For those staff members (PP, CPS, S/T, etc) whose practitioner level is affected by a degree, the degree initials should also be included. For example, if a Paraprofessional is working with a Bachelor of Arts degree, he or she would include “PP, BA” as his or her credentials.

Professional Title	ABBREVIATION FOR SIGNATURE LINE
Physician	M.D., D.O., etc.
Psychiatrist	M.D., etc.
Physician Assistant	PA
Advanced Practice Registered Nurse, Clinical Nurse Specialist/Psychiatric-Mental Health and Nurse Practitioner	APRN or CNS-PMH or NP
Licensed Pharmacist	LPh
Registered Nurse	RN
Licensed Practical Nurse	LPN
Licensed Dietician	LD
Qualified Medication Aide	QMA
Psychologist	PhD or PsyD
Licensed Clinical Social Worker	LCSW
Licensed Professional Counselor	LPC
Licensed Marriage and Family Therapist	LMFT
Licensed Master’s Social Worker	LMSW
Licensed Associate Professional Counselor	LAPC
Licensed Associate Marriage and Family Therapist	LAMFT
Psychologist/LCSW/LPC/LMFT’s supervisee/trainee	S/T
Certified Clinical Alcohol and Drug Counselor	CCADC
Georgia Certified Alcohol and Drug Counselor, Level III	GCADCIII
Master Addiction Counselor (MAC), National Board of Certified Counselors	MAC-NBCC
Master Addiction Counselor (MAC), National Association of Alcohol and Drug Counselors,	MAC-NAADC
Certified Alcohol and Drug Counselor	CADC
Georgia Certified Alcohol and Drug Counselor II	GCADC-II
Certified Addiction Counselor, Level II	CAC-II
Certified Addiction Counselor, Level I (CAC-I)	CAC-I
Registered Alcohol and Drug Technician I, II, III	RADT-I, RADT-II, RADT-III
Addiction Counselor Trainees	ACT
Certified Psychiatric Rehabilitation Practitioner (CPRP)	CPRP
Certified Peer Specialist (CPS)	CPS
Paraprofessional (PP)	PP
Vocational Rehabilitation Specialist	PP/VS

ADDICTION COUNSELOR TRAINEE SUPERVISION FORM

Individual

Group

SECTION A. EMPLOYEE INFORMATION

Name:	Month of Supervision:
Hire Date as an Addiction Counselor Trainee:	Projected Certification Test Date: (Eligible to test w/in 2 years of hire date)

SECTION B.

Check Domain discussed during Supervision and briefly describe (see TAP 21 description):

- Clinical Evaluation (total monthly hours completed: ____) (accumulative hours completed: ____)
- Treatment Planning (total monthly hours completed: ____) (accumulative hours completed: ____)
- Referral (total monthly hours completed: ____) (accumulative hours completed: ____)
- Service Coordination (total monthly hours completed: ____) (accumulative hours completed: ____)
- Counseling (total monthly hours completed: ____) (accumulative hours completed: ____)
- Client, Family and Community Education (total monthly hours completed: ____) (accumulative hours completed: ____)
- Documentation (total monthly hours completed: ____) (accumulative hours completed: ____)
- Professional and Ethical Responsibilities (total monthly hours completed: ____) (accumulative hours completed: ____)

Short Term Goals/Action Required: (define expectations – timelines – areas needing improvement)

Training Needs: (progress toward certification, licensure and/or other areas of professional growth)

Training Hours Completed: _____

Next Scheduled Supervision: _____

SECTION C. SIGNATURES

Supervisor’s Signature and credentials ¹¹ :	Date:
Employee Signature:	Date:

¹¹ The following credentials are acceptable for Clinical Supervision and are required to provide proof of credential: CCS; CADC; CCADC; CAC II; MAC or LPC/ LCSW/LMFT who have a minimum of 5 hours of Co-Occurring or Addiction specific Continuing Education hours per year, certification of attendance/completion must be on file.

PART V

Block Grant Funding Requirements

**Provider Manual for
Community Mental Health,
Developmental Disabilities and
Addictive Diseases
Providers**

Fiscal Year 2012



**Georgia Department of Behavioral Health &
Developmental Disabilities**

April 2012

Part V

BLOCK GRANT FUNDING REQUIREMENTS

- **Mental Health Block Grant**
- **Substance Abuse, Prevention and Treatment Block Grant**
- **Safe and Drug Free Schools and Communities Block Grant**
- **Special Requirements for Programs serving Children and Adolescents**
- **PATH Summary**
- **Title XX Social Services Block Grant for DD Services**
 - **Reporting Form**



**Georgia Department of Behavioral Health &
Developmental Disabilities**

April 2012

MENTAL HEALTH BLOCK GRANT

(Note: The information contained here is for emphasis and is not inclusive of all requirements for which the Contractor has to comply. For a complete list of all requirements please obtain a full copy of Public Law 102-321, Section 1912 and following applicable code sections at www.mentalhealth.samhsa.gov)

The Contractor in accepting and expending Block Grant funds recognizes the following services for Adult and Child Adolescent Mental Health are the only services eligible to be funded with Mental Health Block Grant dollars for 2010. The Contractor recognizes the services specified below will be provided in accordance with the applicable standards as specified in this Provider Manual.

A. Adult

1. Outpatient services (screening and assessment to determine appropriateness of services or state hospital admissions; physician or nursing assessment; individual, group and/or family counseling, and training; medication administration, monitoring and training; service coordination).
2. 24-hour-a-day emergency care services (crisis intervention services).
3. Intensive community intervention and support or psychosocial rehabilitation services.
4. Consumer directed programs (consumer peer supports).
5. Residential services
6. Supported Employment.
7. Assertive Community Treatment (ACT).

B. Child and Adolescent

1. Outpatient services (screening and assessment, counseling and training, medication administration, medication monitoring).
2. Wraparound/Family support/Respite.
3. Crisis intervention services including Crisis Stabilization Programs and mobile crisis.
4. Intensive In-home Therapy services.

C. Exclusions: Mental Health Block Grant funds may not be expended for:

1. Provision of inpatient services.
2. Cash payments to recipients of services.
3. The purchase or improvement of land; purchase, construction or permanent improvement (other than minor remodeling) of any building or other facility or the purchase of major medical equipment.
4. To satisfy any requirement for the expenditure of non-Federal funds as a condition for the receipt of Federal funds.
5. Provision of financial assistance to any entity other than a public or nonprofit private entity.**

****Federal block grant funds may be expended in procurement or acquisition relationships with for-profit entities. Contracts must be developed that identify specific deliverables to be purchased with the funds.**

SUBSTANCE ABUSE, PREVENTION AND TREATMENT BLOCK GRANT

Federal Substance Abuse Prevention and Treatment Block Grant Funds provide for allotments each year to States for the purpose of planning, carrying out, and evaluating activities to prevent and treat substance abuse. The Block Grant funds may be expended to provide for a wide range of activities to prevent and treat substance abuse and may be expended to deal with the abuse of alcohol, the use or abuse of illicit drugs, and the abuse of licit drugs. The requirements for the expenditure of these funds are summarized below. The complete description of these requirements known as 45 CFR 96 – Rules and Regulations, may be found on the Substance Abuse Mental Health Services Administration (SAMHSA) web site at www.samhsa.gov/centers/csat/csat.html. Click on the index listing for 45 CFR 96 – Rules and Regulations. The document is 57 pages in length.

I. GENERAL PROVIDER ASSURANCES

- A. That an assessment of each consumer's need be conducted and documented;
- B. That a policy and procedure be implemented to prevent inappropriate disclosure of patient records covered by Federal confidentiality regulations for substance abuse.
- C. That prevention activities and treatment services be coordinated with the provision of other appropriate services;
- D. That continuing education of employees providing prevention activities or SA treatment services is required;
- E. That grant dollars not be used to supplant State and local funding of alcohol and other drug prevention and treatment programs;
- F. That grant dollars not be used to cover expenses that are eligible for payment or reimbursement through other sources.
- G. Compliance with restrictions on the expenditure of grant funds, including:
 - 1. Inpatient hospital services, except as provided under specific exceptions;
 - 2. Cash payments to intended recipients services;
 - 3. The purchase or improvement of land, a building or other facility, or the purchase of major medical equipment, except under specific circumstances
 - 4. The satisfaction of any requirement for the expenditure of non-Federal funds as a condition for the receipt of Federal funds;
 - 5. Financial assistance to any entity other than a public or nonprofit private entity*; or
 - 6. To provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs, except under certain circumstances.
- H. That independent peer review in accordance with the Regional Office's requirements be carried out to assess the quality, appropriateness, and efficacy of treatment services;

- I. Compliance with all applicable Federal laws and regulations, including those relating to audits, lobbying, drug-free workplace, non-discrimination, and disclosure of certain information and events.

*Federal block grant funds may be expended in procurement or acquisition relationships with for-profit entities. Contracts must be developed that identify specific deliverables to be purchased with the funds.

II. PROVIDER ASSURANCES WITH REGARD TO PRIMARY PREVENTION PROGRAMS

- A. Use of SAPTBG prevention funds is limited to primary substance abuse prevention activities that are:
 1. Provided in a variety of settings;
 2. Provided to individuals not in need of substance abuse treatment;
 3. Targeted to the general population or sub-populations who are at high risk for substance abuse;
 4. Provided directly or through one or more public or nonprofit private entities.
- B. Activities funded with grant funds must be part of a comprehensive plan that includes services and programs under six CSAP strategies:
 1. **Information dissemination** to promote awareness of the nature and extent of alcohol, tobacco and drug use, abuse and addiction; its effects on individuals, families and communities, and 1.dissemination is characterized by one-way communication from the source to the audience, with limited interaction between the two.
 2. **Education** to affect critical life and social skills, including decision-making, refusal skills, critical analysis (e.g. of media messages) and systematic judgment abilities. Education is characterized by two-way communication, involving interaction between the educator/facilitator and the participant.
 3. **Alternatives** to activities involving alcohol, tobacco and other substance use for at risk populations and sub-populations.
 4. **Identification and Referral** of adults, children and adolescents engaged in the illegal/age inappropriate use of tobacco or alcohol, and/or first use of illicit drugs, in order to assess if their behavior can be reversed through education.
(Note: Activities intended to assess treatment needs are not included within this strategy.)
 5. **A Community-Based Process** to build prevention and treatment capacity at the local level, including, interagency collaboration, coalition building and networking.
 6. **Environmental Strategies** to affect community standards that will result in a reduction of the incidence of the use of alcohol, tobacco and other substances. Strategies include legal and regulatory initiatives, as well as service and action oriented initiatives.
- C. In order to meet the requirements of both the Substance Abuse Prevention and Treatment Block Grant, providers are required to enter service/program data into the Georgia electronic Prevention Minimum Dataset System (MDS) on a consistent basis. The deadline

for data entry is 45 days from the service date. The MDS will also limit data entry on a quarterly basis. The MDS Users Manual, New User Request forms, and entry into the system can be found at [www. georgiamds.uga.edu](http://www.georgiamds.uga.edu)

III. PROVIDER ASSURANCES WITH REGARD TO PROGRAMS FOR WOMEN

- A. Providers shall give preference to admission to services as follows:
 - 1. Pregnant injecting drug users;
 - 2. Pregnant substance abusers;
 - 3. Injecting drug users; and
 - 4. All others

- B. The provider shall publicize the availability of services and the preference extended to pregnant women through its outreach programs, ongoing public service announcements (radio/television), regular advertisements in local/regional print media, posters placed in targeted areas, and frequent notification of availability of such treatment distributed to the network of community based organizations, health care providers, and social service agencies.

- C. Programs will treat the family as a unit and admit both women and their children into treatment services, if appropriate. Programs must provide, or arrange for the provision of, the following services to pregnant women and women with dependent children, including women who are attempting to regain custody of their children:
 - 1. Primary medical care for women, including referral for prenatal care and, while the women are receiving services, childcare;
 - 2. Primary pediatric care, including immunization, for their children;
 - 3. Gender specific substance abuse treatment and other therapeutic interventions for women, which may address issues of relationships, sexual and physical abuse, parenting, and child care;
 - 4. Therapeutic interventions for children in custody of women in treatment which may address developmental needs, sexual and physical abuse and neglect; and
 - 5. Sufficient case management and transportation to ensure access to services.

- D. In the event that the provider has insufficient capacity to serve any pregnant woman seeking treatment, the provider will refer the woman to the Regional Office.

IV. PROVIDER ASSURANCES WITH REGARD TO PROGRAMS FOR INTRAVENOUS DRUG USERS

- A. Providers receiving grant dollars for treatment services for intravenous drug abusers must encourage the participation of such individuals through outreach models prescribed by the Regional Office, or if no such models are prescribed, through a strategy that reasonably can be expected to be an effective. Outreach efforts shall include:
 - 1. Selecting, training and supervising outreach workers;
 - 2. Contacting, communicating and following-up with substance abusers, their associates, and neighborhood residents, within the constraints of Federal and State confidentiality requirements, including 42 C.F.R. Part 2;

3. Promoting awareness among substance abusers about the relationship between intravenous drug abuse and communicable diseases such as HIV, and recommending steps to prevent disease transmission; and
 4. Encouraging entry into treatment
- B. Each individual who requests and is eligible for service must be admitted to a treatment program not later than:
1. Fourteen days after making the request for admission to a program; or
 2. One hundred and twenty days after the date of such request, if:
 - a. No such program has the capacity to admit the individual on the date of such request, and
 - b. Interim services, including referral for prenatal care, are made available to the individual not later than 48 hours after such request.
- C. The provider shall establish a system for reporting unmet demand for treatment services to the Regional Office. This waiting list shall use a unique patient identifier for each injecting drug abuser seeking treatment, including those receiving interim services while awaiting admission to such treatment. The reporting system shall ensure that individuals who cannot be placed in comprehensive treatment within 14 days receive ongoing contact and appropriate interim services while awaiting admission.
- D. Providers receiving grant funding for the treatment of intravenous substance abusers must, upon reaching 90 percent of service capacity, notify the Regional Office within seven days.

V. PROVIDER ASSURANCES WITH REGARD TO TUBERCULOSIS

- A. The provider will implement infection control procedures that are designed to prevent the transmission of tuberculosis.
- B. The provider shall routinely make available tuberculosis services to each individual receiving or seeking treatment services, either directly or through arrangements with other public or nonprofit private entities, including:
 1. Counseling
 2. Diagnostic Testing
 3. Therapy
- C. All individuals identified with active tuberculosis shall be reported to the appropriate State official as required by law.

VI. PROVIDER ASSURANCES WITH REGARD TO HIV (Human Immunodeficiency Virus)

- A. Providers shall participate in any HIV project as required by the Regional Office.
- B. The provider shall routinely make available Early Intervention Services to each individual receiving or seeking treatment services, either directly or through arrangements with other public or nonprofit private entities, provided that such services are not required as a condition of receiving treatment services for substance abuse, and are undertaken

voluntarily and with the informed consent of the individual. Early Intervention Services must include:

1. Counseling for HIV/AIDS
2. Diagnostic testing
3. Therapy

SAFE AND DRUG-FREE SCHOOLS AND COMMUNITIES BLOCK GRANT

The Safe and Drug Free Schools and Communities Block Grant (SDFSC) is authorized by the Title IV of the Federal *Improving America's School Act of 1994* and is administered by the U.S. Department of Education.

The Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD) administers that portion of the State's total SDFSC grant allocated directly to the Governor for drug and violence prevention programs.

Applicants eligible for funding through the Governor's SDFSC allocation include parent groups, community action and job training agencies, and community-based organizations and consortia.

I. GENERAL PROVIDER ASSURANCES

A. Providers of prevention programs shall give priority to activities for:

1. children and youth who are not normally served by state or local educational agencies; or
2. populations that need special services or additional resources (youth in juvenile facilities, runaway or homeless children and youth, pregnant and parenting teenagers, and school dropouts.)

B. Compliance with the Department of Education's *Principles of Effectiveness* ;

1. Be based on an assessment of objective data regarding the incidence of violence and illegal drug use in the elementary schools and secondary schools and communities to be served, including an objective analysis of the current conditions and consequences regarding violence and illegal drug use, including delinquency and serious discipline problems, among students who attend such schools (including private school students who participate in the drug and violence prevention program) that is based on ongoing local assessment or evaluation activities.
2. Be based on an established set of performance measures aimed at ensuring that the elementary schools and secondary schools and communities to be served by the program have a safe, orderly, and drug-free learning environment.
3. Be based on scientifically based research that provides evidence that the program to be used will reduce violence and illegal drug use.
4. Be based on an analysis of the data reasonably available at the time, of the prevalence of risk factors, including high or increasing rates of reported cases of child abuse and domestic violence; protective factors, buffers, assets; or other variables in schools and communities in the State identified through scientifically based research.
5. Include meaningful and ongoing consultation with and input from parents in the development of the application and administration of the program or activity.

- C. Providers are required to enter service/program data into the Georgia electronic Prevention Minimum Dataset System (MDS) on a consistent basis. The deadline for data entry is 45 days from the service date. The MDS will also limit data entry on a quarterly basis. The MDS Users Manual, New User Request forms, and entry into the system can be found at www.georgiamds.uga.edu
- D. Compliance with other guidelines and requirements of the Office of Prevention Services and Programs.

II. AUTHORIZED ACTIVITIES AND SERVICES

- A. Disseminating information about drug and violence prevention;
- B. Training parents, law enforcement officials, judicial officials, social service and health providers, and community leaders and drug and violence prevention, health education, early intervention, pupil services, or rehabilitation referral;
- C. Developing and implementing comprehensive, community-based drug and violence prevention programs that link community resources with schools and integrate services involving education, vocational and job skills training and placement, law enforcement, health, mental health, community service, mentoring, and other appropriate services;
- D. Planning and implementing drug and violence prevention activities that coordinate the efforts of State agencies with efforts of the State educational agency and its local educational agencies;
- E. Activities to protect students traveling to and from school;
- F. Before-and-after school recreational, instructional, cultural, and artistic programs that encourage drug-and violence-free lifestyles;
- G. Activities that promote the awareness of and sensitivity to alternatives to violence through courses of study that include related issues of intolerance and hatred in society;
- H. Developing and implementing activities to prevent and reduce violence associated with prejudice and intolerance;
- I. Developing and implementing activities to prevent illegal gang activity;
- J. Coordinating and conducting community-wide violence and safety assessments and surveys;
- K. Service-learning projects that encourage drug-and violence-free lifestyles; and
- L. Evaluating programs and activities assisted under this section.

SPECIAL REQUIREMENTS FOR PROGRAMS SERVING CHILDREN AND ADOLESCENTS

The Contractor agrees to comply with Public Law 103-227, also known as the Pro-Children Act of 1994, which requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by the Contractor and used routinely or regularly for the provision of health care, day care, early childhood development services, education or library services to children under the age of 18. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the Contractor.

It is expected that all services provided to children and adolescents will be delivered within the state of Georgia unless approved by the Regional Director/Regional Coordinator.

**SUBJECT: Projects for Assistance in Transition from Homelessness
PATH**

REFERENCES: 45CFR 92.22 and Sections 521-535 of the Public Health Service Act

I. PURPOSE

The Projects for Assistance in Transition from Homelessness (PATH) program provides funds to each State to support services to individuals with serious mental illness, as well as individuals with serious mental illness and substance use disorders, *who are homeless or at risk of becoming homeless*.

II. ELIGIBILITY

An adult 18 years of age or older who is-

- homeless or imminent risk of becoming homeless; and
- unwilling or unable to seek services on their own and services must go to them; and
- suspected of having a serious mental illness; and
- not in the custody/guardianship of the State of Georgia; and
- not enrolled in DMHDDAD MICP system as receiving similar or duplicate services.

III. DEFINITIONS

- A. Homelessness- An individual who lacks fixed, regular, and adequate nighttime residence; or whose primary nighttime residence is a shelter designed to provide temporary living accommodations; or an institution that provides temporary residences for persons intended to be institutionalized; or a place not designed for human beings to live.
- B. Imminent Risk of Becoming Homeless-Persons who are about to be evicted from or lose a housing arrangement and have no resources or supports, or are about to be discharged from a psychiatric or substance abuse treatment facility without any resources or supports for housing.

IV. SERVICE SPECIFICATIONS

Those service specifications eligible for PATH funding include the following:

- 1) **Outreach Services:** Face-to-face interaction with literally homeless people in streets, shelters, under bridges, and other non-traditional settings, offering support while assisting with immediate and basic needs, and referral to appropriate resources.
- 2) **Screening, Diagnostic and Treatment Services:** A continuum of physician assessment services ranging from brief eligibility screening to comprehensive clinical assessment and treatment.
- 3) **Case Management Services:** Assist in accessing needed services, coordinate the delivery of services, and follow-up and monitor progress.

- 4) **Supportive and Supervisory Services in Residential Settings:** Within a residential setting, provide support to restore and develop skills in functional areas that interfere with the ability to maintain housing, participate in educational activities, regain or maintain employment, develop or maintain social relationships, and manage resources.
- 5) **Housing Services:** Specialized services designed to increase access to and maintenance of stable housing.
- 6) **Staff Training:** Training of individuals who work in shelters, mental health clinics, substance abuse programs, and other sites where homeless individuals require service;

V. RESTRICTION ON USE OF FUNDS

A Provider receiving PATH funds must agree to the following:

- 1) Not more than 4% of the payments will be expended for administrative expenses regarding payments;
- 2) Not more than 20% of the payments will be expended for housing services;
- 3) Payments will not be expended-
 - a. To support emergency shelters or construction of housing facilities;
 - b. For inpatient psychiatric treatment costs or inpatient substance abuse treatment costs;
 - c. To make cash payments to intended recipients of mental health or substance abuse services.

VI. PROVIDER REPORTING REQUIREMENTS

A Provider receiving PATH funds must:

- 1) Submit a description of the intended use and proposed budget prior to receiving PATH funds. Such description provides information relating to the programs and activities to be supported and services to be provided, including information relating to coordinating such programs and activities with any similar programs and activities of public and private entities; and such description will be revised throughout the year as may be necessary to reflect substantial changes in the programs and activities assisted by the State.
- 2) Submit a completed annual report per CMHS guidelines which includes the following items-
 - a. The types of services being offered by PATH provider;
 - b. The number of characteristics of the persons receiving services from PATH provider; and
 - c. The contribution of PATH funds toward the support of services provided to persons who are homeless and have serious mental illnesses.
- 3) Submit a monthly performance report describing the actual monthly service provision performance and housing coordination expenditures.

VII. PROGRAM EVALUATIONS

- 1) The Georgia PATH Contact will conduct a one-day site visit for all PATH sites annually. A site visit consists of the following:
 - a. Interview with PATH funded staff and administrator

- b. Accompany PATH staff on outreach to at least one homeless service site;
 - c. Review a minimum of three (3) PATH case records
- 2) The Administrator of the Substance Abuse and Mental Health Services Administration (SAMHSA) shall evaluate at least once every 3 years the expenditures of grants by eligible entities in order to ensure that expenditures are consistent with the provisions of the Public Health Service Act, and shall include in such evaluation recommendations regarding changes needed in program design or operations.

VIII. ADDITIONAL INFORMATION SOURCES

Secure a copy of the Public Health Service Act on the PATH website at www.pathprogram.samhsa.gov under Program Information.

TITLE XX SOCIAL SERVICES BLOCK GRANT

Congress passed Public Law 93-647, or Title XX of the Social Security Act (SSA), in 1974 to make federal funds available for states to provide social services which address the needs of each individual state. Social Services Block Grant (SSBG) funds are used to provide a variety of services to Georgia's citizens, including vulnerable children and adults who need protection, persons with mental retardation, and the elderly.

The Department of Human Resources prepares an annual report to inform the Secretary of the U.S. Department of Health and Human Services and the people of Georgia of the intended use of the funds the State is to receive under provision of the Act. This annual report is called the Report on the Intended Use of Title XX Social Services Block Grant Funds. The following description of services to persons with mental retardation (I) and the statements on limitations/assurances on the use of the grants (II) are taken from the Report on Intended Use.

I. SERVICES FOR PERSONS WITH DEVELOPMENTAL DISABILITIES

Services for persons with developmental disabilities are services or activities to maximize the potential of persons with disabilities, help alleviate the effects of disabilities, and to enable persons served to live in the least restrictive environment possible. Component services or activities may include personal and family counseling, respite care, family support, recreation, transportation aid to assist with independent functioning in the community and training in mobility, communication skills, the use of special aides and appliances and self-sufficiency skills. Residential and medical services are not included in the array of SSBG services for persons with developmental disabilities in Georgia.

II. LIMITATION/ASSURANCES ON USE OF GRANTS

The Georgia Department of Human Resources gives assurance that Title XX Social Services Block Grant funds will **NOT** be used:

- 1) for the purchase or improvement of land, or the purchase, construction, or permanent improvement (other than minor remodeling) of any building or other facility, or
- 2) to provide cash payments for costs of subsistence or to provide room and board (other than cost of subsistence during rehabilitation, room and board provided for a short term as an integral but subordinate part of a social service, or temporary emergency shelter provided as a protective service); or
- 3) for payment of the wages of any individual as a social service (other than payment of wages of welfare recipients employed in the provision of day care services); or
- 4) for the provision of medical care; or
- 5) for social services provided in and by employees of any hospital, skilled nursing facility, or prison, or to any individual living in such institution. The only exceptions to this limitation are services to an alcoholic or drug dependent individual or rehabilitation services; or
- 6) for the provision of any educational service which the state makes generally available to its residents without cost and without regard to their income; or

- 7) to provide child care services unless such services meet applicable standards of State and local law; or
- 8) for the provision of cash payments as a service.

III. APPLICATION FOR SERVICE

Each individual or family unit shall have the right to apply for Social Services Block Grant Services without delays in the application process. Application for services may be made by the applicant or by a relative, friend, neighbor or legal guardian acting responsibly on behalf of the person needing the service. The application should be made to Regional Office's designated point of entry.

IV. ELIGIBILITY

All recipients of Social Services Block Grant (SSBG) funded services must be physically located in the State of Georgia.

- **Non-School Aged Adults** - SSBG funded services may be provided to non-school aged adults with a documented programmatic need and a current diagnosis of mental retardation/developmental disability.
- **School Aged Individuals** - School-aged individuals may be provided non-education-related services with a documented programmatic need and a current diagnosis of mental retardation/developmental disability.
- **Pre School Aged Individuals** - SSBG funded services may be provided to pre-school aged individuals with a documented programmatic need and a current diagnosis of mental retardation/developmental disability.

V. BEGINNING THE SERVICES

Once eligibility is determined, the service must be provided with reasonable promptness. Reasonable promptness is defined as within fifteen (15) calendar days. If the service is temporarily unavailable, the individual should be placed on a Planning List.

VI. PLANNING LIST (Waiting Lists)

Planning Lists will be maintained in accordance with Division Policy.

VII. SERVICES TO PERSONS RESIDING IN INSTITUTIONS

In most instances, services to persons residing in institutions are the responsibility of staff of the facility. Accordingly, Social Services Block Grant funds may not be used for the provision of social services that are the inherent responsibility of the institution. Those facilities which are Intermediate Care Facilities or Skilled Nursing Facilities and which receive funding under Title XVIII (Medicare) and/or Title XIX (Medicaid) are required either to provide social services or arrange for them with qualified outside resources. In these facilities and in any other where an investigation indicates that social services are an inherent responsibility of the institution, Social Service Block Grant Services to eligible persons are limited to assisting an

individual and/or family to seek admission to the institution, and/or supporting or augmenting the discharge plan of the facility for the individual. If social services are not an inherent responsibility of the institution, Social Services Block Grant services may be delivered to eligible persons.

IX. DOCUMENTATION OF SERVICE PROVISION

- Contractors are responsible for the documentation of service delivery in compliance with the terms of the provider contract.
- Reporting of Services - Services delivered must be reported in compliance with the terms of the provider contract.

X. NOTIFICATION OF THE CONSUMER OF SERVICE TERMINATION

- A.** Notification to the consumer must follow a decision by the agency to terminate services. Form 5536, included below, shall be used.

(Note: Even though space is available on this Form, the Form should not be used to notify a consumer of eligibility for service. Form 5536 should only be used to notify a client of termination of service.)

In cases of termination of service, services must continue through the ten- (10) day notice period and the notification process must be (1) adequate and (2) timely.

1. **Adequate notice** is defined as a written communication (Form 5536) that includes a statement of the specific action the agency intends to take, the reason for the intended action, explanation of the individual's right to request a fair hearing and the circumstances under which services are continued if a hearing is requested.
2. **Timely notice** is defined as the notice being mailed or hand delivered to the consumer at least ten (10) calendar days before the date the action is to become effective. No action shall be taken to terminate services during the ten- (10) day notice period. If the consumer does not request a hearing before the expiration of the tenth (10th) day, the services shall be terminated after the tenth day has passed.

- B. Waiver of Timely Notice** - The following are situations in which timely notice (10 calendar days) is not required but adequate (written) notice shall be given not later than the effective date of action:

1. The agency received a clearly written statement signed by consumer that he/she no longer wishes to receive services.
2. The whereabouts of the consumer are unknown and mail to him/her has been returned by the Post Office indicating no forwarding address. Returned mail should be filed in the service record.

3. The consumer moves to another State and the move is documented by the agency.
4. The consumer was informed in writing, at the time the services began, that the service would automatically terminate at the end of a specified period.
5. A change in either Federal/State law or policy requires automatic service adjustments for categories of service recipients.

XI. CONSUMER GRIEVANCES

Providers shall make a grievance and appeal process available to aggrieved consumers in compliance with Federal regulations governing the Social Service Block Grant, and policy and procedure promulgated by the Division and the State of Georgia.

**Georgia Department of Human Resources
NOTIFICATION FORM FOR TITLE XX SOCIAL SERVICES**

Agency Name: _____
DATE: _____
CASE ID: _____

Your application for social services has been given careful consideration. The following determination has been made

- I. A. INITIAL DETERMINATION: You have been determined eligible/ ineligible for the following Title xxx Social Services:

Reason (if ineligible)

- B. REDETERMINATION: You have been determined eligible/ineligible for the following Title xx Social Services effective _____.
The following Title xx Social Services have been/will be terminated:

Reason if (ineligible)

- I. You are still eligible for these Title xx Social Services:

However, if the following services will be:

- A. Reduced effective:
Reason:

- B. Terminated effective:
Reason: _____

III. LIMITED ELIGIBILITY

You have been determined eligible for the following Title xx services _____
You have been determined ineligible for the following Title xx services _____

If for any reason you disagree with this decision you may request a hearing. You may request a hearing orally or in contacting this agency within 10 days of the date given at the top of this form. This agency will be glad to furnish the form (s); help you in filing your appeal and in any way possible to prepare for the hearing.

The hearing will be held in your county by a hearing officer. You may be represented at the hearing by legal counsel or other spokesperson. If you would like an attorney, contact this agency which can provide information about legal services that may be available in your community at no cost to you.

Form 5536 (Rev. 05-00)

Signature of Agency Representative

**Georgia Department of Human Resources
Title XX Administration**

PART VI

Policies and Procedures

Provider Manual for Community Mental Health, Developmental Disabilities and Addictive Diseases Providers

Fiscal Year 2012
(Updated for April 1, 2012 Implementation)



**Georgia Department of Behavioral Health &
Developmental Disabilities**

April 2012

**ALL POLICIES ARE NOW POSTED IN [DBHDD POLICYSTAT](http://dbhdd.georgia.gov/policies) LOCATED AT
<http://dbhdd.georgia.gov/policies>**

Details are provided in Policy titled “[Access to DBHDD Policies for Community Providers, 04-100](#)”
The [DBHDD PolicyStat INDEX](#) helps to identify policies applicable for Community Providers

GREEN	Denotes change in policy number
RED	Denotes new or updated policy
POLICY #	NAME
04-100	Access to DBHDD Policies for Community Providers
01-103	Accreditation and Standards Compliance Requirements for Providers of Behavioral Health Services
02-703	Accreditation and Standards Compliance Requirements for Providers of Developmental Disabilities Services
02-802	Bowel Management for Individuals Diagnosed with Developmental Disabilities
02-601	Community Integration in Residential Service Options and Supervised Apartment Living Arrangements for Individuals with Developmental Disabilities
19-101	Complaints and Grievances Regarding Community Services
04-104	Criminal History Records Checks for Contractors
03-502	Criteria for Mental Health Admissions of Adults to DBHDD Hospitals
01-105	Denial and Appeal Process for Psychiatric Residential Treatment Facility (PRTF) Level of Care for Children and Adolescents with a Mental Health Diagnosis
04-102	Emergency Preparedness and Disaster Response – Basic Requirements for DBHDD Hospitals and Community Providers
02-704	Process for Enrolling, Matching and Monitoring Host Homes/Life-Sharing Sites for DBHDD Developmental Disabilities Community Service Providers
16-101	External Entities Audit Standards
24-101	Georgia Open Meetings Act and Open Records Act
04-109	Guiding Principles Regarding Co-Occurring Disorders (Mental Health and Addictive Diseases)
04-110	Guiding Principles Regarding Serving those with Co-Occurring Behavioral Health Disorders and Developmental Disabilities
02-803	Health Risk Screening Tool (HRST)
02-1101	Human Rights Council for Developmental Disabilities Services
02-1102	Behavior Program Review Committee for Developmental Disabilities
01-102	Independent Peer Review for Addictive Diseases Providers
01-104	Informed Consent for Psychotropic Medication Treatment of Child and Adolescent Populations
15-101	Responsibilities of Language Access Coordinators
15-102	Notification of Rights regarding Limited English Proficiency/Sensory Impairment
01-108	Management of Personal Needs Spending Accounts for Individuals Receiving Behavioral Health Services
01-110	Form 1013 – Certificate Authorizing Transport to Emergency Receiving Facility and Report of Transportation (MH)
02-702	Management/Supervision/Safeguarding of Possessions, Valuables, Personal Funds and Day-To- Day Living Expenses in Developmental Disabilities Residential Services

03-520	Medical Evaluation Guidelines & Exclusion Criteria for Admission to State Hospitals and Crisis Stabilization Units
01-107	Payment by Individuals for Community Behavioral Health Services
02-101	Planning List for Developmental Disabilities Services for Individuals Living in the Community
02-801	Prevention of Choking for Individuals with Developmental Disabilities
04-101	Professional Licensing Requirements and the Reporting of Practice Act Violations
25-101	Protection of Human Subjects and Institutional Review Board
23-100	Confidentiality and HIPAA
23-101	Notice of Privacy Practices
23-102	Reporting and Notification of Breaches
23-103	Confidentiality and HIPAA Privacy Complaints
23-104	Sanctions Related to Confidentiality and HIPAA
23-105	Individual Rights Regarding Confidential and Protected Health Information
23-106	Disclosure of Confidential and Protected Health Information
23-107	Business Associates Requirements regarding Confidentiality and Protected Health Information
02-701	Recruitment and Application to become a Provider of Developmental Disabilities Services
04-105	Region of Responsibility Determination
04-106	Reporting and Investigating Deaths and Critical Incidents in Community Services
01-106	Requirements to Ensure that Families Complete the Application Process for Medicaid and PeachCare for Kids
04-107	Requests for Waivers of the Standards for DBHDD Services
02-102	State Funded Respite for Individuals with Developmental Disabilities
04-103	Verification of Lawful Presence in United States for Individuals Seeking MHDDAD Services
21-101	Financial and Reporting Requirements for Community Providers

The following Policy Numbers have been changed in PolicyStat:

NEW POLICY NUMBERS	OLD POLICY NUMBERS
➤ 01-108	6001-601
➤ 03-502	6805-201
➤ 04-103	6001-501
➤ 04-109	6203-101
➤ 04-110	6203-102
➤ 15-101, 15-102	1701
➤ 16-101	1244
➤ 23-104	3.200-06
➤ 23-105	3.200-01
➤ 23-106	3.200-10
➤ 23-107	3.200-08
➤ 24-101	Legal Summary
➤ 25-101	7901

PART VII

Consumer Data: Collection, Reporting and Management

Provider Manual for Community Mental Health, Developmental Disabilities and Addictive Diseases Providers

Fiscal Year 2012



**Georgia Department of Behavioral
Health & Developmental Disabilities**

April 2012

Consumer Data: Collection, Reporting and Management

The Division of MHDDAD is implementing a new comprehensive data collection and utilization management system titled the Multi-Purpose Information Consumer Profile (MICP). The MICP will be used to capture data regarding basic consumer demographics and service detail on all consumers served by the Division. This new form is being implemented in order to streamline and consolidate multiple data collection processes for registration, authorization, and reporting of publicly funded services. For individuals receiving behavioral health services through the Division, as of July 1, 2006 the MICP registration, assessment, and discharge forms will become active and replace the MHMRIS registration, PERMES data reports, TRIGRS authorizations, and the Mental Health and Addictive Disease Core Customer reporting forms. APS Healthcare is the Division's agent for managing this data collection. Please refer to their website at www.apsero.com for additional reporting details and updates as they occur.

The Division sponsors consumer satisfaction and perception of care surveys for all adult populations. These surveys generally require no direct action from service providers. However, providers are expected to make their facilities and consumers available to teams who gather the survey responses.

NOTE: This is meant to cover access to consumers and facilities by the Georgia Mental Health Consumer Network when conducting the PERMES AMH and AAD surveys as well as the NCI Consumer Surveys (currently completed by the Support Coordination Agencies).

Providers of developmental disability services who serve ten or more waiver or state funded adults in residential, day or employment services (including subcontractors) are expected to complete – on an annual basis -- the National Core Indicators Provider Staff Turnover and Board Membership Survey. The survey instrument and instructions for completion will be sent directly to providers.

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PART VIII

Financial Policies, Reporting Requirements and Forms

Provider Manual for Community Mental Health, Developmental Disabilities and Addictive Diseases Providers

Fiscal Year 2012

**Georgia Department of Behavioral Health &
Developmental Disabilities**

April 2012

All Financial Policies, Reporting Requirements and Forms are now posted in [DBHDD POLICYSTAT](#) under a policy entitled: [“Financial and Reporting Requirements for Community Providers, 21-101”](#)

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