

Northern Arizona HCTC Handbook



Northern Arizona Regional Behavioral Health Authority



“Never doubt that a small, group of thoughtful, committed citizens can change the world. Indeed, it is the only thing that ever has.”

-Margaret Mead

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Overview

HCTC (formerly known as TFC (Therapeutic Foster Care) is an innovative team approach provided by experienced, skilled professionals through a family-based treatment environment for children with complex behavioral health care needs as an alternative to institutional care.

Home Care Training for the Home Care Client (HCTC) is a Covered Behavioral Health Service in Arizona available for eligible children with behavioral health issues. It is designed to be intensive, time limited (usually 12-18 months), and focused on addressing the child's behavioral health issues and permanency needs.

ADHS/DBHS Covered Service Guide Definition:

'Home Care Training to Home Care Client (HCTC) services are provided by a behavioral health therapeutic home to a person residing in his/her home in order to implement the in-home portion of the person's behavioral health service plan. HCTC services assist and support a person in achieving his/her service plan goals and objectives and also helps the person remain in the community setting, thereby avoiding residential, inpatient or institutional care. These services include supervision and the provision of behavioral health support services including personal care (especially prescribed behavioral interventions), psychosocial rehabilitation, skills training and development, transportation of the person when necessary to activities such as therapy and visitations and/or the participation in treatment and discharge planning.'

Northern Arizona Regional Behavioral Health Authority (NARBHA) contracts with several HCTC Licensing Agencies through-out the region to recruit, train, license, monitor and support HCTC Families as direct service providers. NARBHA also partners with DES/Child Protective Services to provide joint programming for youth and families involved in both the child welfare and behavioral health systems.

Introduction

As in other areas of the country, Arizona has seen an increasing need for family-based programs capable of offering services to children in need of community based treatment. In 1989, District III DES/CPS clearly recognized this need in rural northern Arizona, and initiated a Professional Family Foster Care (PFFC) program with two foster families. Through a steady process of development and expansion, in 2003, this innovative program joined efforts with Northern Arizona Regional Behavioral Health Authority (NARBHA) and its providers to expand Home Care Training for the Home Care Client (HCTC) services to the whole of northern Arizona. HCTC can be described as:

“A distinct, powerful, and unique model of care that provides children with a combination of the best elements of traditional foster care and residential treatment centers. In [HCTC], the positive aspects of the nurturing and therapeutic family environment are combined with active and structured treatment. ...Programs provide, in a clinically effective and cost-effective way, individualized and intensive treatment for children and adolescents who would otherwise be placed in institutional settings.”

(Foster Family-based Treatment Association (FFTA), March 13, 2001.)

Northern Arizona HCTC Parents share certain core values and principles, which lie at the heart of their services and have shaped its development. These include: a strong belief in normalization as a treatment principle, and in the power of family living as a healing influence; a belief that all children need and have a right to a permanent family; support of family reunification, adoption, kinship care, or other long-term stable family living arrangements to achieve this end; a belief in the value of cultural diversity and in the importance of developing competence in dealing with issues of diversity; and an emphasis upon goal-oriented, individualized treatment, using a comprehensive, team approach.

Children receiving services in Northern Arizona HCTC Homes come from throughout the NARBHA region (Coconino, Mohave, Yavapai, Navajo, and Apache Counties). Before the advent of this program, these children would have frequently been placed out of the region in more restrictive, institutional settings such as Residential Treatment Centers, Therapeutic Group Homes, or Psychiatric Hospitals. The duration of HCTC placement is expected to be 12-18 months or less, with the goal of returning the child home or on to another less restrictive, more permanent setting.

Handbook

The HCTC Handbook provides a description of the HCTC Program for the NARBHA region in addition to the roles, responsibilities and service expectations of service providers involved in the administration of the Program. Revisions to the HCTC Handbook are overseen by members from the HCTC Advisory Committee. It is incorporated by contract to guide program implementation and oversight by providers. It is also a resource for anyone who needs information about the northern Arizona program.

How to Become an HCTC Home

HCTC combines the aspects of nurturing, family environment, and structured treatment to meet the individualized needs of children with serious behavioral health needs, who may have experienced neglect and/or abuse. HCTC Parents must be nurturing, patient, possess strong teamwork skills, and have a concern for youth with specialized needs and their families. Potential HCTC Parents will participate in a Home Study and licensure process that provides the HCTC Provider Agency and the family the opportunity to make an informed decision regarding becoming an HCTC Home. As an HCTC Parent you will become a member of a team that is designed to address the unique emotional and behavioral needs of the children placed in your home. Following are some additional requirements and information regarding the process of becoming an HCTC Home.

Licensing Regulations

DES/OLCR Licensing Regulations (R6-5-5850) requires the following special provisions for HCTC Homes (in licensure, these homes are referred to as Professional Foster Homes).

- A. HCTC Homes shall comply with all foster home requirements except as otherwise provided under the DES and any additional NARBHA and Provider Agency regulations.
- B. An HCTC Parent applicant shall provide to the provider agency and/or the Licensing Authority documentation or demonstration of:
 1. Verified, successful HCTC Parenting experience; or
 2. Verified experience working with or the ability to care for high-need, special care children.
- C. An HCTC Parent shall complete training requirements as outlined in the Training Section of this Handbook. HCTC Provider Agencies are responsible for ensuring all HCTC Parents receive training in accordance with ADHS/DBHS Provider Policy 9.1 – Training Requirements, Section 6.b to comply with training requirements listed in R6-5-5850.
- D. The provider agency will notify NARBHA of HCTC Families and provide specific information on the family home, specialized skills, and number of beds, prior to receiving a contract with NARBHA.
- E. NARBHA maintains the right to refuse a contract with specific agencies or homes, limit beds, or decline referrals, regardless of OLCR licensure.
- F. Notwithstanding any other provisions of this article, an HCTC Home is subject to the licensing limitations in this subsection.
- G. An HCTC Home shall have no more than two special care children. The HCTC Provider Agency may recommend an exception to allow the HCTC Parent to care for additional children when the HCTC Parent has demonstrated the ability to care for more than two special care children. For

more information on this, please reference the section on Criteria for Number of Youth in this Handbook.

Recruitment

The HCTC Provider Agencies evaluate the populations served and have recruitment plans including targeting and marketing to attract prospective HCTC Parents. Potential HCTC families may be recruited from an agency's pool of experienced foster families. Provider Agencies may be asked by NARBHA and/or the HCTC Advisory Committee to recruit in specific geographic areas or for special populations.

The Provider Agency must submit Quarterly Reports to NARBHA which include recruitment activities, progress and barriers.

NARBHA has a regional recruitment brochure available to agencies to assist in home recruitment activities.

Assessment

To assure that HCTC Homes are appropriate for the provision of HCTC services, each prospective professional HCTC care family receives an HCTC Family Assessment of Professional HCTC Parent Capability/Home Study. Elements include:

- Physical Capacity (The physical evaluation establishes that the HCTC Parents are free from any disease or physical conditions that have been determined to be a detriment to the welfare of the child)
- Emotional Capacity (The family demonstrates mental and emotional stability)
- Interpersonal Relationships
- Knowledge of Developmental Needs of Children
- Financial Stability
- Cultural Evaluation
- Linguistic Evaluation
- Capacity and Willingness for Initial and On-going Training
- Appropriate Criminal Background Checks for All Adults in the Household
- Child Abuse Registry Checks
- Appropriate References
- Assessment for the Ability to Provide Care, Nurturing, and Supervision to children
- Assessment is on-going. In addition to initial assessment, it may occur at various times throughout service as an HCTC Parent, such as at the time of license renewal, time of acceptance of a new child, when physical arrangements change in the HCTC Home, or when

background checks are necessary on any new adult that moves into the home. A Home Study must be updated by the HCTC Provider Agency at least annually.

Criteria are followed to determine the number of children that can receive services in each HCTC Home. Items to be taken into consideration include such things as the needs of the children, resources available to the HCTC Family, support services, number of biological and adoptive children residing in the home, DES/CPS and NARBHA regulations and requirements.

HCTC Services Packets identify the individual needs of the child. An HCTC Family Assessment/Home Study is located in the HCTC Provider Agency files, and identifies the individual qualities of the family. Referrals should be accepted based on assessment of the family's strengths and challenges in relation to the individualized needs of the referred child.

Criteria for Number of Youth Receiving Services

It is the responsibility of the HCTC Provider Agency to assess the appropriateness of HCTC Providers who are applying for licensure. This also includes making recommendations on the initial number of beds. For example, even though a family may qualify under OLCR regulations for licensure of (2) beds, the HCTC Provider Agency may determine the family should start with (1) bed due to limited experience or other factors. Additionally, agencies can only approve beds in accordance with NARBHA guidelines. For example, OLCR may qualify a family for (4) HCTC/Professional beds, but NARBHA restricts new providers to (2) beds for the first year.

Research strongly suggests that number of children in an HCTC Home is correlated with disruption rates and overall success of HCTC Programs. Best Practice is considered to be 1-2 placements per home. However, there are circumstances where HCTC Homes demonstrate success serving more than this number of youth, depending on a variety of factors such as experience, training, supports, and overall demonstration of positive outcomes for the children being served in their home.

NARBHA believes there should be criteria met prior to increasing number of youth in an HCTC Home and increases must be approved on an individualized basis. The 'Criteria Checklist for Additional Youth' has been developed to be utilized by the HCTC Provider Agencies as a guideline for additional service provision (refer to Appendix). It is important to note that the HCTC Provider Agencies must also carefully consider other factors such as:

- Number of biological/adoptive children residing in the home
- Employment outside of the home
- The HCTC Parent's motivation for fostering more than two special care children
- Any CPS reports involving the HCTC Parent

- Outcome data aggregated by the HCTC Provider Agency

NARBHA will review the recommendation and give approval for the HCTC Provider Agency to forward the recommendation to OLCR for approval to amend the license.

HCTC Initial Review Panel

All HCTC Provider Agencies will work with the Initial Review Panel to conduct an interview of potential HCTC Families prior to their entrance to the HCTC Program in Northern Arizona. Follows is an outline of the HCTC Initial Review Panel Protocol:

- A. For HCTC Provider Agencies that recruit families licensed as foster parents, the Initial Review Panel would conduct the interview after the family has been identified as a potential HCTC Home and after being trained on the NARBHA HCTC Handbook but prior to submitting the family's license for amendment to OLCR.
- B. For HCTC Provider Agencies that recruit families without a current foster parent license, the Review Panel would conduct the interview after orientation, completion of initial paperwork, background check, Home Study, PS-MAPP and training on the NARBHA HCTC Handbook but prior to the submission for licensure.
- C. Composition of HCTC Review Panel consists of the following:
 1. Prospective HCTC Parent(s)
 2. HCTC Provider Agency Representatives
 3. Responsible Agency (RA) Representative
 4. DES/CPS Representative
 5. NARBHA Representative
 6. Current HCTC Parent(s) if available

* It's important to assure that all stakeholder representatives participating in the panel are familiar with the utilization and principles of HCTC and what their agency's role is in relation.

- D. The HCTC Review Panel will not be responsible for the final decision of whether or not a potential family will enter into the HCTC Program. Rather, they will provide feedback to the HCTC Provider Agency on their observations, assessment, recommendations and concerns gained from the interview process. Specifically, the Review Panel will give their opinion as to whether or not they feel the family is ready for becoming an HCTC Home or if they have assessed that a plan of improvement is recommended prior to entrance into the HCTC Program. It is the HCTC Provider Agency's responsibility to make the final decision for bringing the family into the program. However, it is strongly suggested that the opinions and recommendations of the Panel be valued and considered when making this decision.

NARBHA maintains the right to refuse a contract with specific agencies or homes, limit or reduce placements, or decline referrals regardless of OLCR licensure.

Initial Review Panel: Roles and Expectations

All panel members will possess a fundamental knowledge of the philosophy and utilization of HCTC services as well as being aware of other HCTC Stakeholders' roles.

Responsible Agency (RA): Representing the local behavioral health provider.

- Familiar with RA's role in utilization of HCTC services
- Possesses a clear understanding of the HCTC referral process, service planning, and transition planning
- Able to incorporate former professional experiences with prospective family (when possible) and how this can aid future relationship
- CFT practice
- Familiar with RA's role in facilitating shared parenting
- Coordination of Care

Licensing Agency: Coordinator and facilitator of Initial Review Panel

- Representing the prospective providers' training progress
- Able to speak to licensing, monitoring, and agency specific issues
- Aware of prospective providers' strengths, history, experience, preference, and training needs

Prospective HCTC Provider: Demonstration of experience, preferences, training desires, and principles of HCTC

- Demonstration of their understanding of the CFT process
- Familiar with Arizona's 12 principles
- Understanding of provider role in service planning and transition planning
- Distinction between HCTC and regular foster care
- Understanding of HCTC as a time limited and goal specific treatment

CPS/DES: Representing child welfare's role related to HCTC

- Distinguishing between HCTC and regular foster care
- Offering historical information when providers are transitioning from regular foster care to HCTC
- Shared parenting
- Transition and permanency planning

NARBHA: HCTC network of support and programming representative.

- Program fidelity
- Regional integration
- Network issues
- Coordination of care

Current HCTC Provider (when available): Offering provider perspective to the panel.

- Able to bring first hand provider experiences to panel
- Can relate to prospective family's position
- Possess experience of boundaries and benefits to be expected.

Transitioning from Regular Foster Care/Resource Family to HCTC Provider

NARBHA supports maintaining stability of previously placed foster children who may already reside in newly licensed HCTC homes. NARBHA expects previously placed foster care youth to make a natural transition from the home in-line with their CPS case plan goals. The HCTC Provider can begin accepting HCTC referrals prior to these children discharging. The interest and wellbeing of the existing foster youth must be regarded when considering HCTC referrals. The combined total of HCTC service and regular foster care youth cannot exceed the OLCR License and should be reviewed by the Provider Agency for appropriateness. No new CPS foster placements can be placed in the home after the home converts to HCTC programming. Any exceptions to this (e.g. kinship, teen parent and child placements) must be approved by NARBHA.

CPS may request a review by the RA to consider previously placed foster youth for HCTC level services in newly licensed homes. A change from foster care to HCTC services can be made based on medical necessity and recommendation of the Child and Family Team.

Requests by HCTC Parents to Hold Additional Employment

HCTC Providers are expected to be able to perform the functions of the program, which entails meeting the individualized service and support needs of children in their care. If a provider performs outside work, independent of HCTC services they must have this approved by the Provider Agency. The Provider Agency is expected to review for any conflict of interest and ensure the hours and types of work do not interfere with HCTC programming. Consideration should be given to the number of HCTC parents in the home, the number of children, and the needs of the current children. The Provider Agency must review this periodically as part of regular monitoring activities and recommend changes as necessary.

Tax Information

HCTC providers are responsible for their own consultation on income tax requirements. HCTC services are not the same as traditional foster care services. HCTC services are funded through Medicaid dollars as a covered behavioral health treatment service for eligible youth. Pay rate for HCTC services reflects the different skill level and service expectations.

Orientation, Training and Professional Development

HCTC Families receive orientation, pre-service, annual training and professional development opportunities in order to successfully meet the needs of the children placed in their care. All training should be congruent in philosophy and practice with OLCR, NARBHA and ADHS/DBHS policies and practices, the Arizona Vision and 12 Principles, PS-MAPP/Family to Family, and the ADHS/DBHS Advanced HCTC Curriculum.

Orientation*

- Types of children in need of this service
- Information on the philosophy and practices of the Provider Agency
- Information on the Arizona Vision and 12 Principles
- The roles and responsibilities of the HCTC Family
- Policies and procedures (including discipline)
- The role of the HCTC Provider Agency in assisting the HCTC Family in serving children

Pre-service Training*

HCTC Provider Agencies are responsible for ensuring all HCTC Parents receive training in accordance with ADHS/DBHS Provider Policy 9.1 – Training Requirements, Section 6.b to comply with training requirements listed in R6-5-5850. All agencies that recruit and license Professional Foster Home providers must provide and credibly document the following training to each provider:

- CPR and First Aid Training;
- 30 hours of pre-service training* utilizing Partnering for Safety and Permanence: the Model Approach to Partnerships in Parenting (PS-MAPP); and
- 18 hours of pre-service training utilizing the Arizona Home Care Training to Client (formerly Therapeutic Foster Home) Service Curriculum. *[Effective January 1, 2009, all providers delivering HCTC services must have completed this Curriculum.]*
- Behavioral health management of crisis situations including:
 - Prevention of violent behaviors, (including de-escalation, identification of triggers, crisis and safety planning)
 - Behavior management skills,
 - De-escalation techniques, and
 - Physical restraint practices/ESR Guidelines

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- Medical/health care issues, procedures, and techniques, including the purpose/use/administration of medications, medication interactions, and potential medication reactions.
- Northern Arizona HCTC Handbook; Provider agencies are required to train on the HCTC Handbook and provide prospective families with a copy. The HCTC Handbook is incorporated by contract to Provider Agency and HCTC Provider expectations.

***Note: Orientation and Pre-service training must include the following specific content:**

- Characteristics and needs of children who receive services in the HCTC Home
- The role of the Professional HCTC Parent as a member of the care and treatment team
- The importance of birth parent and family involvement in a child's life
- Methods for appropriately addressing the cultural, ethnic, and religious needs of a child in care
- Attachment, separation, and loss issues for children and families
- Behavior management policies/practices and skills; including:
 - A HCTC Parent shall set limits and rules for children in care. The HCTC Parent shall tell the children about the HCTC Parent's expectations regarding child behavior, including inappropriate conduct, and the HCTC Parent's methods for disciplining children who violate expectations, limits, and rules
 - A HCTC Parent shall use discipline which is reasonable, developmentally appropriate, related to the infraction, and consistent with any guidelines in the child's case plan
 - A HCTC Parent shall use disciplinary methods which help a HCTC Child to build self-control, self-reliance, and self-esteem
 - An HCTC Parent shall communicate rules, consequences, and disciplinary methods to an HCTC Child in a manner appropriate to the child's age, developmental capacity, and ability to understand
 - An HCTC Parent shall explain the HCTC Parent's limits, rules, and expectations to any placing agency or person that places a child with the HCTC Parent
 - An HCTC Parent shall not delegate the responsibility for imposing discipline on an HCTC child to any person other than an adult assigned responsibility for the HCTC Child and made known to the child and as approved and documented by the CFT. It is the responsibility of the HCTC Parent to relay any necessary information regarding HCTC Program policies and individualized needs of the child to alternative, approved caregivers
 - An HCTC Parent shall not punish or maltreat an HCTC Child, and shall not allow any other person to do so. As used in this section, "punishment or maltreatment" include, but are not limited to, the following actions: any type or threat of physical hitting or striking inflicted in any manner upon the body; verbal abuse, including arbitrary threats of removal from the HCTC Home; disparaging remarks about an HCTC Child or an HCTC Child's natural family members or significant persons; deprivation of meals, clothing, bedding, shelter or sleep;

denial of visitation or communication with an HCTC Child's natural family members and significant persons when such denial is inconsistent with the HCTC Child's case plan; cruel, severe, depraved or humiliating actions; locking an HCTC Child in a room or confined area inside or outside of the HCTC Home; and requiring an HCTC Child to remain silent or be isolated for time periods that are developmentally inappropriate

- An HCTC Parent shall not use physical or mechanical restraints; and
- An HCTC Parent shall implement an Emergency Safety Response only in accordance with the guidelines outlined in this Handbook
- Confidentiality, including HIPAA guidelines and Protected Health Information (PHI)
- Emergency procedures
- Resources and supportive services available to children and HCTC Parents
- HCTC billing and payment procedures
- HCTC Provider Agency contact persons and procedures
- The impact of providing HCTC services on the HCTC Parent and their own family and ways to address and cope with this impact
- Specialized topics related to child welfare, health, growth and development
- The Indian Child Welfare Act of 1978 (PL 95-608).

Annual Training

In addition, the provider delivering HCTC services for children must complete and credibly document a minimum of six hours annual training as outlined in R6-5-5850, Special Provisions for a Professional Foster Home.

Professional Development

On-going professional development is an important part of support for HCTC Parents to maintain effective treatment milieus for children with serious emotional and behavioral issues. HCTC Parents, with the support of their Provider Agencies, are expected to:

- Seek out, attend and document specialized training in relevant topics, which develop skills specific to caring for children in need of HCTC Services
- Engage in regular, ongoing, open communication with the HCTC Provider Agency and HCTC In-Home Consultant/Family Therapist
- Participate in review activities with the HCTC Provider Agency, In-home Consultant/Family Therapist, and peers at least annually to identify strengths, successes, challenges, and areas for improvement

Professional Development Meetings

All HCTC Agencies are required to conduct Professional Development Meetings on a minimum of a quarterly basis with the HCTC Parents. The purpose of these meetings is to provide the HCTC Parents opportunity to grow and develop as a professional by receiving support and feedback from their peers in a supportive atmosphere. The unique nature of the HCTC profession, barriers, and successes are discussed in a manner that creates a team approach to development. All HCTC Parents are required to attend and participate in these on-going meetings as a member of the HCTC Program.

Specialized Trainings

Based on the recommendations of the HCTC Advisory Committee, HCTC Provider Agencies, Responsible Agencies and NARBHA will collaborate to arrange and facilitate advanced trainings, as funding is available, targeting areas of development specific to the efficacy of the HCTC Program or the needs of HCTC Parents.

HCTC Advisory Committee

The HCTC Advisory Committee meets on a minimum of a quarterly basis for the purpose of collaborating with other agencies on regional HCTC Program development. Changes related to the HCTC Program are discussed in this forum in order to ensure that decisions are made in partnership with regional stakeholders in HCTC programming. The Committee also reviews, clarifies, and discusses issues related to program standards, philosophy, and practice.

Core members of the Committee consist of:

- HCTC Provider Agencies
- HCTC Parents
- DES/CPS
- Responsible Agencies (RAs)
- NARBHA

Any other agencies or individuals that hold stake in the success of the HCTC Program are also welcome to attend. NARBHA is responsible for hosting and coordinating the meetings at least quarterly. These meetings create a platform and collaborative atmosphere for identifying system strengths which enhance and resolving barriers which threaten the efficacy of the program.

Participants can recommend agenda items by contacting the assigned NARBHA HCTC Meeting Coordinator.

HCTC Referral Procedure

In order to maintain the therapeutic integrity and service capacity of the HCTC Programs in Northern Arizona it is vital that HCTC referrals originate from the Responsible Agencies (RAs) and are for behavioral health purposes only. While many youth are dually involved in the behavioral health and CPS systems, HCTC services are not available solely for CPS placement purposes. When a child is dually enrolled and in need of HCTC services the referral must be CFT driven and originate from the RA.

While HCTC provider homes are licensed through DES, they are not available for emergency or long-term placement by CPS. Although an HCTC Home provides a supportive and nurturing family environment, its function of addressing significant behavioral health needs is not appropriate for youth placed for regular foster care services.

The following procedure describes how a child is referred for HCTC Services:

- A. Any involved party identifies the possible need for HCTC Services.
- B. A Child and Family Team (CFT) meeting is requested and held to consider the appropriateness of HCTC Services for the child.
 1. Children experiencing the following are among those who may be considered appropriate for HCTC Services:
 - a. Moving from a more restrictive setting such as a Hospital, Sub-acute, Level I Residential Treatment Center, Level II Behavioral Health Facility (Therapeutic Group Home), or other Group Home
 - b. Multiple disruptions related to the child's behavioral health issues
 - c. High-risk behaviors (e.g. substance abuse, self harm/mutilation, sexually reactive, gang membership)
 - d. High probability of child disrupting in a regular foster home or kinship placement
 - e. Intensive Out-patient Services have been provided but not successful (e.g. intensive in-home, support and rehabilitation services, therapy, respite, behavior coach, personal assistance, day programs)
 2. HCTC Services may not be appropriate for all children. Discussion should happen at the CFT to consider any immediate needs that focus on safety and stability of the child and of other children in the home that includes consideration of HCTC Provider experience, specific treatment needs, and any other individualized needs such as contact with natural families and other natural supports.

- C. The CFT utilizes the Arizona 12 Principles as a guideline for assessing placement. If the CFT determines that the child would benefit from HCTC Services, the need must be documented on the Behavioral Health Service Plan and approved by team members, including the RA Representative. All parties must sign the signature sheet indicating agreement. The RA completes the initial referral form and sends to the Provider Agency contacts.
- D. If the RA does not agree with the request for HCTC Services, they must provide a written notification form (5.1.1) to the guardian. As part of CFT practice, Teams are asked to brainstorm all available and appropriate options that could potentially be accessed to provide services in the least restrictive manner.
- E. The HCTC Provider Agency sends the HCTC Services Packet to HCTC Homes for review by the HCTC Parent and In-home Consultant/Therapist. If time permits, as part of best-practice planning, the HCTC Parents meet with the CFT to discuss and plan the possible transition.
- F. Following placement identification, the RA Behavioral Health Representative completes an 'Intent to Pay' (ITP) so that TXIX payment is made. The DES/CPS Case Worker assures that DES is notified so that the Room and Board payment is made. (For kids not in CPS care, the Room and Board rate is paid through behavioral health.)
- G. Once a referral is accepted, the CFT should formulate a service transition plan that should include a pre-service visit if possible, a crisis and safety plan specific to the home, any specialized training or support needs for the family, and initiate discharge planning.

Initial Referral and HCTC Service Packets

Initial Referral

Once a CFT determines HCTC services are necessary, the RA Representative completes the 'Referral for NARBHA-Region HCTC Services' Form and sends it to the HCTC Provider Agency contacts. The form must be filled out as completely as possible so the Provider Agency has accurate information to determine potential matches with their HCTC homes.

The HCTC Provider Agency then completes the 'HCTC Provider Agency Response' Form and sends it back to the RA contact within five days of referral. If the HCTC Provider Agency has a potential match or an anticipated opening, they will request a complete HCTC Service Packet from the RA.

HCTC Service Packet

An HCTC Service packet is required when placement for a child is requested in an HCTC Home.

Service Packets must include:

Cover memo requesting HCTC Services. Cover memo includes:

- Reasons for need of HCTC Services

- Behavioral/emotional problems child currently exhibits
- Diagnosis
- Medications (include next refill due date and next medication review date – RA must ensure appropriate supply of meds through the service transition)
- Custody status
- Educational/other special needs
- Recent case developments

Other Required documents:

- Listing of child's placement history
- Copies of recent and any prior psychiatric, psychological and/or psycho-educational or other useful evaluations. It may be necessary to obtain a current evaluation if not available
- Copy of most recent Behavioral Health Assessment
- Copy of CFT Behavioral Health Service Plan (documenting need for HCTC services), and signature page
- Crisis Prevention Plan
- Strengths, Needs, and Culture Discovery (SNCD)
- Reports/summaries completed by therapists treating the child/family.
- Relevant school information, including copies of IEPs and immunization records
- Copy of birth certificate, social security number, CMDP and/or AHCCCS number
- Any other case documentation pertinent to understanding the child's needs

Additional Recommended Documents which should be requested to be sent by CPS (if applicable):

- CPS Case Plan (if involved with CPS)
- Pertinent court reports, including Initial Report, most recent court report, and any other reports containing important case information. (Required unless voluntary placement)
- Social History of the child's family
- CASA reports
- JPO reports/dispositions
- Any other case documentation pertinent to understanding the child's needs

General and Informed Consent to Treatment

Reference Provider Policy 3.11 'General and Informed Consent to Treatment' for the full policy text [www.narbha.org].

Section 3.11.7-D: Special requirements for children: Non-emergency Situations

Northern Arizona HCTC Handbook – Revised 2008

In cases where the parent is unavailable to provide general or informed consent and the child is being supervised by a caregiver who is not the child's legal guardian and does not have power of attorney, general and informed consent must be obtained from one of the following:

- Lawfully authorized legal guardian;
- Foster parent, group home staff or other person with whom the Department of Economic Security/Child Protective Services (DES/CPS) has placed the child; or
- Government agency authorized by the court.

If someone other than the child's parent intends to provide general and, when applicable, informed consent to treatment, the following documentation must be obtained and filed in the child's comprehensive clinical record:

Individual/Entity	Documentation
Legal guardian	Copy of court order assigning custody
Relatives	Copy of power of attorney document
<i>HCTC Provider/non-CPS Youth*</i>	<i>Copy of power of attorney document or Copy of court order assigning physical custody</i>
Other person/agency	Copy of court order assigning custody
DES/CPS Placements (for children removed from the home by DES/CPS), such as: <ul style="list-style-type: none"> ▪ Foster parents ▪ Group home staff ▪ Foster home staff ▪ Relatives ▪ Other person/agency in whose care DES/CPS has placed the child 	None required

For any child who has been removed from the home by Child Protective Services (CPS), the foster parent, group home staff, foster home staff, relative or other person or agency in whose care the child is currently placed may give consent for the following behavioral health services:

- Evaluation and treatment for emergency conditions that are not life threatening; and
- Routine medical and dental treatment and procedures, including early periodic screening, diagnosis and treatment services, and services by health care providers to relieve pain or treat symptoms of common childhood illnesses or conditions (including behavioral health services and psychotropic medications).

Any minor who has entered into a lawful contract of marriage, whether or not that marriage has been dissolved subsequently, or any homeless minor may provide general and, when applicable, informed consent to treatment without parental consent.

**For any child who is placed in HCTC care but not under custody of CPS, the parent or legal guardian must provide a copy of a Power of Attorney document allowing the provider to sign for medical, dental and educational consents and must update the POA every six months. Teams may additionally choose to use the HCTC Provider-Parent Participation Agreement Form. (See Appendix).*

Emergency Situations

In emergency situations involving a child in need of immediate hospitalization or medical attention, general and, when applicable, informed consent to treatment is not required.

Any child, 12 years of age or older, who is determined upon diagnosis of a licensed physician, to be under the influence of a dangerous drug or narcotic, not including alcohol, may be considered an emergency situation and can receive behavioral health care as needed for the treatment of the condition without general and, when applicable, informed consent to treatment.

If behavioral health providers doubt whether the individual bringing the child in for services is a person/agency representative in whose care DES/CPS has placed the child, the provider may ask to review verification, such as documentation given to the individual by DES indicating that the individual is an authorized DES/CPS placement. If the individual does not have this documentation, the provider may also contact the child's DES/CPS caseworker to verify the individual's identity.

HCTC Referral List

In the circumstance where a child has been referred for HCTC Services by their Child and Family Team and an appropriate provider is not available at the time, the child will be placed on the HCTC Referral List. Each HCTC Provider Agency maintains an HCTC Referral List. A regional HCTC Referral List is maintained by the HCTC Program Coordinator at NARBHA for the purpose of monitoring and tracking the needs of children who have been referred for out of home care. Youth will remain on the referral list for up to 60 days. If they still require HCTC placement after 60 days, the RA must initiate a new referral.

If an RA refers a child for HCTC services and there are no current beds or appropriate matches available, the RA must review and offer alternative services and supports through the CFT that can meet the immediate behavioral health needs of the child.

RAs must notify NARBHA and HCTC Provider Agencies when a child no longer needs placement so the child can be removed from the referral list.

The Child and Family Team (CFT)

The success of the HCTC Program requires a collaborative effort between multiple systems. To be effective, all must cooperate and partner as a true team, in support of the child. In the words of a child in an HCTC Home:

My Team By YD

I'm scared and I'm lost.

There's nothing for me to see.

I'm hurting inside from all the lies.

I try and I try, but all I do is cry. My pain just won't go away.

I can't go on another day.

But wait, what's that I see?

A shining light at the end of the sky.

There's hope for me now, I can finally smile and be proud.

I have a team and they showed me that I can finally be me.

They help me every day.

They're there when I need them.

They always listen when I'm sad.

They always make me laugh even when I'm mad.

What are CFTs?

The Child and Family Team (CFT) is a group of people that includes, at a minimum, the child and his/her family, the HCTC Parent, a behavioral health representative, and any individuals important in the child's life and who are identified and invited to participate by the child and family. This may include, for example, teachers, extended family members, friends and other natural supports, family support partners, healthcare providers, coaches, community resource providers, representatives from churches, synagogues or mosques, agents from other service systems like Child Protective Services or the Division of Developmental Disabilities, etc. The size, scope and intensity of involvement of the team members are determined by the objectives established for the child, and by which individuals are needed to develop and coordinate an effective service plan, and can therefore expand and contract as necessary to be successful on behalf of the child.

The Child and Family Team is responsible for collaboratively planning and delivering services to the child and family in the most appropriate setting, in a timely fashion, and in accordance with best practices, while respecting the child's and family's cultural heritage. Every child in HCTC services must have an active Child and Family Team. It is mandatory that the HCTC Parents and the child participate in the Team process.

Team Members

The members of this team should include:

- Natural Family and Natural Supports. (This may include any person significantly involved in the child's life including family and/or extended family and their network of associates, friends and neighbors, and community and faith-based organizations)
- The Child
- The HCTC Parents
- The DES/CPS Case Manager (if applicable)
- The Responsible Agency Behavioral Health Representative
- Outpatient therapist, psychiatrist, psychologist, Primary Care Physician or other professionals involved in the child's treatment
- Teachers
- Court Appointed Special Advocate (CASA)
- The HCTC Services In-Home Consultant/Family Therapist
- The HCTC Services Provider Agency Representative
- Other involved State Agency Representative (JPO, DDD, ADJC)
- Directly involved attorneys, advocates, paraprofessionals

The Role of the HCTC Parent in the CFT Process

The HCTC Parent plays an important role in the CFT process by bringing first-hand, direct information to the Team on changes in the child's behaviors which may indicate a need for adjustments to treatment, medication, or crisis planning. They also help inform the Team of strengths that can assist in identifying functional and symptomatic improvements. The HCTC Parent should also bring concerns or observations to the Team on the need for more supports or structure on shared parenting or other issues that the RA or CPS may need to address in structuring family contact. The HCTC Provider additionally contributes input on any strengths or needs which support discharge and permanency planning.

The Role of the Responsible Agency (RA) in the CFT Process

The RA has a number of roles in the CFT process including, facilitating the CFT process (or ensuring the process is facilitated according to practice guidelines), ensuring the Arizona Vision and 12 Principles are followed and the family's voice and choice are respected, identifying the child's behavioral health needs and facilitating discussion of appropriate treatment services, and adjusting service planning to match current needs. The team process utilizes a strengths-based approach identifying what currently works for the family and how to build on this. To do this they must honor the families' culture and value system. Children and families are more likely to succeed when they have ownership of their goals and the plan to get there. The RAs assist with this by facilitating the CFT process and partnering with other agencies in the family's life to create continuity in the support the family is receiving.

The Role of Child Protective Service (CPS) in the CFT Process (for CPS Involved Children)

CFTs are consistent with Team Decision Making and Family Group Decision Making in supporting family-driven, strengths-based planning. It is also consistent with Shared Parenting practices in supporting dialogue and decision-making between the natural family and the alternative caregiver.

The CPS Case Manager should ensure that safety and permanency planning are incorporated in CFT decision-making. CPS Case Managers will endeavor to participate in all CFTs of their assigned children. If the CPS Case Manager cannot attend, they will assure another CPS representative will attend in their place. The CPS Mental Health Specialist may also attend the CFTs when possible. Any CPS Representative can participate in the role as guardian at the CFT.

If a CPS representative is not in attendance, the CFT facilitator will notify the CPS Supervisor, MHS, and/or APM. While the CFT can meet without the CPS Case Manager present if the MHS or other designee is in attendance, there can be no meeting without the participation of a CPS representative for children in the care and custody of the State.

The Role of NARBHA in the CFT Process

NARBHA is committed to practice improvement across Northern Arizona. NARBHA is responsible for monitoring RA capacity and fidelity for the provision of CFT services for children enrolled in the NARBHA network.

NARBHA attends meetings or consults with Team Members to assist with barrier resolution or other issues as needed. NARBHA offers regular CFT training and coaching opportunities for RAs and other

stakeholders as needs are identified. As per ADHS/DBHS requirements, NARBHA also conducts case reviews and family interviews to assess the quality of CFT practice.

Any CFT that is interested in coaching/consultation with a NARBHA CFT Coach can request this through NARBHA Children’s Services, NARBHA Customer Services, or through the RA.

Treatment/Service Planning

Many children that enter out of home care do not express their grief, loss, and disrupted attachments in words, but in adverse behaviors. Children in CPS care can have the potential of being misdiagnosed with mental health disorders due to symptoms that are a function of their response to their environment. It is important for Teams to communicate about behavioral patterns of children so that adjustments can be continuously made to the child's treatment plan. Other children present as asymptomatic. This may be misinterpreted as the child being "fine" and opportunities may be missed to intervene and offer support. Those in contact with the child must find ways to help the child find appropriate expression for their hopes, fears, anger, and guilt. Often this means exploring the child's thoughts about why they are in treatment and helping to dispel any false beliefs.

Behavioral Health Service Planning

Service planning is an on-going, individualized process. Before a child is admitted to an HCTC Home, a single Behavioral Health Service Plan for the child is created by the CFT based upon the strengths and needs of the child and family. This plan includes strengths, short term and long-term objectives and goals, needs, options to meet the needs, and a specific plan (including a crisis prevention plan).

A CFT meeting is scheduled at a minimum within one month after placement has occurred, and at least monthly thereafter; to review the effectiveness of the plan and make any needed changes. Additional CFT meetings may be needed to address crisis or changes needed to the Behavioral Health Service Plan. Newly identified progress, strengths and resources, specific strategies for intervention, responses to any arising adjustment issues and crisis prevention strategies are also reviewed based upon the child's progress and Child and Family Team input.

Crisis Prevention and Safety Planning

In order to address and plan for barriers to implementing the Behavioral Health Service Plan, the CFT meets to develop a Crisis Prevention Plan. The primary reason for developing this plan is to prevent unnecessary disruptions in the child's providers and to promote the most successful outcome for the child and family. The child and family/guardian must be present when conducting crisis prevention and safety planning. As noted in the CFT Practice Protocol, Crisis Planning follows a four-step model:

- A. Prediction: At this point in the CFT process, the team responds to the question, "What is the worst thing likely to go wrong?"
- B. Functional Assessment: The CFT facilitator guides the CFT in deconstructing the predicted crisis to gain an understanding of the unique elements and characteristics of the crisis process. What

events, behaviors, or behavior sequences are associated with the initial, middle and ending phases of the crisis?

- C. Prevention: Based on learning during the functional assessment, what options, drawn primarily from the child/family strengths and community supports, can help to prevent those events, behaviors, or patterns of behavior associated with the crisis process? Prevention strategies are described in the ensuing Crisis Plan.
- D. Crisis Planning: The CFT facilitator leads the CFT in developing steps for managing the crisis in the event it occurs despite the prevention strategies. Crisis Plan steps specifically describe who will do what, when, and where. Crisis Plans often include names and phone numbers, as well as contingencies.

All children in HCTC Homes must have a Crisis Prevention Plan. However, Safety Plans are constructed when high-risk conditions, such as run-away behavior, self-harm, sexual acting out or suicidal ideations, are present. When a Safety Plan is required, there will be significant overlap with the Crisis Plan.

It is important to note that Crisis Prevention Planning begins during the HCTC Services Packet review by the HCTC Parents and the In-Home Consultant/Family Therapist. Considering the “match” with HCTC Family and the overall composition of children already residing in the home is a critical initial phase of preventing crises. This includes assessing the appropriateness of referrals in relation to other Crisis and Safety Plans being implemented in the HCTC Home. The In-Home Consultant/Family Therapist continues to play a crucial role in implementing the Crisis and Safety Plans that the Child and Family Team has developed based on the individual needs of the child placed. Because the role and responsibility of this in-home support person includes being on call for the HCTC Family 24/7, conflict resolution, family mediation, and support for the implementation of the Crisis and Safety Plan is accessible for the HCTC Parents when needed.

Although the In-Home Consultant/Family Therapist is frequently the initial contact the HCTC Parents make, there will be occasions where the team will need to conduct an emergency meeting to identify any additional steps required for ensuring safety of the child and other family members or any modifications to the current Crisis Prevention and Safety Plan. This Team may consist of an identified “subgroup” of the Child and Family Team or the entire Child and Family Team itself. The time frame that the team should meet will be dependant on the assessment, outcome, and status of the crisis.

Discharge Planning

HCTC is a treatment-focused, time-limited service designed to meet the child's behavioral health needs in a family-based setting. Discharge Planning (planning for where the child will go when treatment goals have been reached) must start when HCTC services are first initiated.

NARBHA defines discharge as the successful achievement of a planned transition to a less restrictive environment. This differs from a disruption which includes any other move including moves between HCTC Providers and moves to higher levels of care.

Planning for a child's successful discharge is an important component to service planning. It helps guide the CFT in assessing needs and establishing appropriate services and interventions. This process also helps the team maintain a focus on permanency for the child.

Covered behavioral health services (including HCTC) can only be provided when determined 'medically necessary'. Medically necessary covered services refer to those covered services provided by qualified service providers within the scope of their practice to prevent disease, disability and other adverse health conditions or their progression or to prolong life. Medically necessary services are aimed at achieving the following: the prevention, diagnosis, and treatment of behavioral health impairments; the ability to achieve age-appropriate growth and development; and the ability to attain, maintain, or regain functional capacity.

This means there must be an identified behavioral health need and the child can be reasonably expected to benefit/improve from the treatment. CFTs are also expected to explore less restrictive alternatives. This means teams should brainstorm about all potential options that could address the behavioral health issues in the least intrusive manner (such as intensive supports to the child and family in their own home and community).

NARBHA has established a 'Length of Stay' (LOS) standard for HCTC Services. The 12-18 month LOS is based on national 'Treatment Foster Care' standards. LOS should be less if the child meets his/her behavioral health treatment goals sooner or if there is an opportunity to continue treatment in a less restrictive setting with other services and supports. CFTs are required to focus efforts on discharge planning and should regularly discuss progress and 'what it will take' to achieve successful discharge.

Permanency Planning for Children in CPS Custody: Permanency, Long-term Connections, Permanent Relationships and Support through Transitions

State systems will always be faced with budget crises, staff turn-over, high case loads, limited placement and support resources along with increasing numbers of children with complicated personal

and family issues entering care. Therefore it is imperative for the Behavioral Health and Child Welfare systems to work collaboratively to find creative ways to develop permanent supports for the children we serve. State systems should not be in the business of long-term parenting, but rather function as brokers to find life-long family and community placements and supports for kids in out-of-home care.

The Adoption and Safe Families Act of 1997 requires states to focus on children's needs for safety, permanency, and well-being within shortened timeframes. Emphasis is placed on effective teamwork, behavioral health intervention, CPS casework and permanency planning starting the moment a child enters care. Children with special needs require specific focus and attention. Child Protective Services believes that children should remain with their family whenever possible. If the court finds, after a thorough CPS investigation, that out of home placement is necessary to ensure the health and safety of the child, the initial case plan goal is usually Family Reunification. The order of preference for Permanency goals are:

- Remain with Family
- Family Reunification
- Adoption (Relative or Non-relative)
- Legal Guardianship (Relative or Non-relative)
- Long-Term HCTC Care
- Independent Living

The primary goal of HCTC is intensive, time-limited treatment of children, not long-term placement. Children should be moved on to less restrictive settings once treatment goals have been realized in the HCTC Home.

As in regular foster care settings, it is understood that attachments develop between the HCTC Parents and child. This is seen as an important aspect of the treatment process. However, HCTC Parents also understand the need for children to move on from a treatment environment and to form secure attachments with others through long-term, permanent relationships. This process of engagement, attachment and transition between HCTC Parents and children is one of the most critical elements of the HCTC Program.

Philosophical Foundation for Permanency Planning (Whitfield et al, Spaulding For Children, 1998): Behavioral health service planning cannot be done without a roadmap of where the child is going. Integration of permanency planning into behavioral health service planning is critical. Consider the following philosophical foundation:

- No child is un-adoptable (*instead of saying a "child is not ready for a family", say "what do we need to do to prepare and support a family to meet this child where he/she is at)*

- The safety of the child is of principle concern through all assessment, planning and preparation activities
- Children need and deserve, permanent-nurturing relationships within families and communities in order to develop and grow
- Child assessment and preparation should be continuously explored throughout the child's journey through care and are the foundations for appropriate planning in the best interest of each individual child
- Children need assistance to explore their strengths, challenges, hopes and fears, and areas of vulnerability in relation to preparation for permanency
- We must explore, honor and respect the importance of a child's former attachments in order to help integrate the past with the present
- When preparing children for permanency, we must employ creative methods and resources to accommodate, develop, and empower children to be successful
- Children's caregivers, birth, kin, and other community and natural supports are a key part of the child's assessment, preparation and planning process
- Collaboration among agencies and all Team Members is critical to the success of the assessment, preparation and planning process
- Assessment and preparation of children can be accomplished most effectively through a strengths-based, developmental and ecological approach which honors the voice and choice of the child while also identifying barriers and resource needs over time

Tools and Techniques*: Specific Tools the Team may want to consider as resources for permanency planning include:

- Placement History Summary
- Permanency Reviews
- Life Lines
- Life Books
- Genograms
- Ecomaps
- Strengths, Needs and Cultural Discoveries
- Family Group Decision Making or Team Decision Making
- Child Specific recruitment
- Identification of natural and formal support through-out the child's life

* See the 'Unique Needs' training at www.cftraining.com for more specific information on use of these tools in permanency planning.

Divide and Conquer: divide tasks among Child and Family Team members while defining roles. Find the best match between the task and the team member. Utilize family members, CPS Case Managers, CASAs, parent aides, case aides, therapists, HCTC Parents, and natural supports to complete specific assessment and preparation tasks.

Start an on-going dialogue with the child and caregiver to discuss permanency issues, hopes and fears of the child, contact with or thoughts about the natural family, life book development and support needs. These are powerful therapeutic tools that can help the child and the whole Team feel ownership in planning.

Tips for Child and Family Teams about approaching permanency differently:

- Explore and challenge your own beliefs about permanency
- Help children deal with loss and grief
- Help children and teens consider permanency and explore their hopes and fears
- Address issues of support and resistance to permanency by all Team Members
- Re-evaluate barriers at all levels
- Re-explore past connections even if Termination of Parental Rights has been completed
- Find natural supports and placements that agree to provide unconditional commitment and life-long connections
- Provide initial and on-going training and support to care providers
- Address issues related to the foundation of adolescent permanence: loyalty, loss, self-esteem, behavior management, and self-determination (Lewis and Heffernan, 2002)
- Develop ways to honor the child's past
- BE CREATIVE!

Other people may be called upon to assist the Child and Family Team with difficult cases regarding permanency planning, building permanent relationships, discharge planning and other transitions. People may include NARBHA Children's Services Department Staff, CPS Management, or other HCTC Parents.

Maintaining Stability in HCTC Services

When children disrupt from a homes, it results in additional trauma and feelings of failure. Therefore, the HCTC Parents and the Child and Family Team are committed to preserving the child's stability in HCTC care. Appropriate crisis prevention planning by the CFT prior to initiating HCTC services and on-going, flexible support after a child enters this service is critical. It is also important for Team Members to communicate regularly on any difficulties or support needs.

Developing and adhering to effective plans designed to prevent separating the child from his/her HCTC Home cannot be overemphasized. This planning is initiated at the time of referral with specific consideration made to create a good “match” between the HCTC Family and the child who has been referred to the home. Utilizing the Child and Family Team as well as the skills and feedback from the In-Home Consultant/Family Therapist, respite, and peer/family support are important strategies to use for stabilizing services during high risk periods, such as the first 30 days of the placement and prior to discharge. It is extremely important for HCTC Parents to identify and discuss barriers, or areas that feel inadequately addressed, to the Team in order for resolutions and appropriate supports to be put into place for the child and HCTC Home.

Whenever a CFT member becomes aware that a child’s HCTC services have potential to disrupt, they should immediately request an emergency CFT meeting.

HCTC Disruption Reviews

A “**disruption**” is defined as any change of care setting of a child that is not a part of a planned discharge to a less restrictive environment. This includes moves between HCTC Providers and moves to higher levels of care. It does not include temporary moves to a hospital or detention if the child returns to the same HCTC Home on discharge from the temporary facility.

If separation from the HCTC Home remains the best option for the child, designated members from Child and Family Team will meet to review and discuss the antecedents and potential consequences of the decision. The purpose of this staffing is to conduct a detailed assessment of the treatment and crisis prevention plan for the child as well as develop a plan for minimizing the negative impact of the child’s separation from the HCTC Home. The outcome desired from this meeting is to gain a better understanding of what components of the plan were ineffective so that future referrals are more successful.

A copy of the HCTC Provider Agency’s ‘Disruption Review Summary’ will be sent to NARBHA so that trends and patterns involved in disruptions can be reviewed. NARBHA and or the HCTC Provider Agency may then identify and recommend measures for improvement such as additional trainings or supports for HCTC Parents.

Disruption Review Summaries should assess the following factors:

- What factors contributed to the disruption?
- Was there a Crisis Prevention Plan in place?
- Was the plan implemented?

- Was the family appropriately matched for this child?
- If not, are any changes in the license or additional trainings recommended?
- Were there any other services/supports that might have helped to preserve the services?
- Do the HCTC Parents or Team have any other information or recommendations that would be helpful in assessing this disruption?

Services and Supports

Services Provided by HCTC Parents

HCTC services are not the same as foster care services. They are treatment services provided by a licensed foster family focused on the behavioral health issues of the child being served. HCTC services are funded through Medicaid dollars as a covered behavioral health treatment service for eligible youth. Pay rate for HCTC services reflect the different skill level and service expectations.

As a professional member of the Team, the HCTC Parents in conjunction with the In-home Consultant/Family Therapist provide family-based treatment for seriously emotionally troubled youth who may have experienced abuse or neglect. This approach maximizes the child's opportunity to experience the Arizona 12 Principles. The home serves as a therapeutic environment in which family processes, interactions and activities provide opportunities for needed intervention. Aspects of healthy family life, parenting, and structure are used purposefully to help the children reach their goals. Support from the in-home family therapy process helps build trusting relationships, provides opportunities for problem-solving, and helps establish a therapeutic relationship between child and HCTC Parent.

To accomplish this, HCTC Parents engage in a number of activities including:

- Assisting the child in transitioning into the HCTC Home. This may include pre-service visits
- Participate in the Shared Parenting component of the HCTC Program as outlined in PS-MAPP and the HCTC Advanced Curriculum
- Providing a supportive, safe environment for the child. Children may be coping with significant grief and loss issues due to separations from their families, previous placements, and communities
- Meeting the individualized physical, emotional, and spiritual needs of children placed in HCTC
- Actively participating in the Child and Family Team Meetings with the child including treatment, discharge, and permanency planning
- Advocating for, and assisting children in achieving and maintaining stability in the community, school and home and avoid delinquency
- Participating in family meetings to explore and problem solve issues specific to the household
- Providing behavior management and crisis intervention, as needed
- Providing life and independent living skills instruction based upon individualized needs of the children
- Providing 24/7 supervision of children placed in HCTC, unless outlined in the plan developed by the CFT

- Assisting in implementation of the behavioral aspects of the child's Behavioral Health Service Plan by providing structure, supervision and nurturance
- Supporting Shared Parenting practices in-line with PS-MAPP and Advanced Curriculum competencies in consultation with the CFT
- Demonstrating competency with the core abilities in the PS-MAPP and HCTC Advanced Curriculum
- Engaging in ongoing consultation with the HCTC In-Home Consultant/Family Therapist
- Participating in Family Therapy Sessions with the In-Home Consultant/Family Therapist
- Provide regular recreational opportunities for child
- Assisting with medical/medication management - Over-the-Counter Medications, Herbs, Special Diets and Homeopathy plans must be followed as prescribed. The use of all medications must be discussed with the child's physician or psychiatrist and with the legal guardian
- Providing primary transportation for children to meet their needs
- Participating in Foster Care Review Board meetings and court hearings (if applicable)
- Adhering to all NARBHA and OLCR discipline policies and contract requirements
- Engaging in regular communication with Child and Family Team Members on treatment needs, including progress, strengths and challenges for the youth

Shared Parenting

Children in placed apart from their families experience grief and loss in many ways, whether it is through removal, death of a parent, parent incarceration, placement outside of their home community, separation from siblings, or mourning of the loss of the parent-child relationship or their idea of what the relationship could or should have been. Therefore, the HCTC Program requires our HCTC Homes to actively participate in Shared Parenting in order to provide mentoring and coaching for natural families as well as promote continued engagement and communication with the child's family. Children need the opportunity to maintain safe connections with their natural parents and extended family members when possible. A high percentage of children who exit congregate care due to aging out return to the families from which they were removed. Our systems have in the past missed valuable opportunities to preserve the family-child connection through the development of safe, supported interactions.

Shared parenting approaches allow for modeling of healthy skills and the opportunity for parents to practice in a safe setting for the child. When Team members can demonstrate appropriate boundaries, healthy communication and shared goals, children may more easily develop trust and feel less drawn to loyalty binds.

Building effective alliances with others who are sharing parenting responsibilities with the HCTC Parents is paramount to treating children who have experienced trauma and maltreatment. In order for

children to experience successful outcomes during and after placement in HCTC, it is crucial for HCTC Parents and the Child and Family Team to honor and incorporate a family's culture and tradition in activities designed to meet the treatment needs of the child. As HCTC Parents create, encourage, and nurture opportunities to increase parent/family involvement, children's opportunities for experiencing healthier transitions out of HCTC or reunions with natural family placements are increased. Some of the components included in the Shared Parenting responsibilities are describing and modeling personal parenting techniques, mentoring, maintaining safe environments during the shared parenting experience, and helping families assess and meet the individual needs of their child.

In circumstances when members of the natural family are available and no legal barriers or safety risks exist, the CFT should work actively towards facilitating shared parenting which may include telephone/written contact, visits, shared decision-making, and family therapy. Even if there are no immediate plans for the youth to return to his/her natural family, shared parenting can still be pursued.

“Therapeutic visitation” is not a covered behavioral health service therefore CFTs need to discuss shared parenting, visitation, contact, etc. as distinct from the need for family therapy.

Under no circumstance should the CFT or HCTC Providers suspend shared parenting or contact or withdraw it for punitive purposes. If CFT members feel that interactions with the natural family are counter productive or detrimental to the youth, these concerns should be brought to the CFT's attention and addressed appropriately. Shared parenting can be emotionally challenging for youth, their natural family, and the HCTC Family and should therefore be facilitated deliberately and with diligent therapeutic oversight.

Shared parenting is the responsibility of the whole CFT, not just the HCTC Parents. CFTs should discuss any specific needs or supports which might assist HCTC Providers in their role.

Natural Supports

Behavioral health treatment is only one part of helping children in HCTC services be successful. It is important for Child and Family Teams to consider informal resources and how those resources can be engaged in promoting successful outcomes for children and their families. The use of natural supports that exist in the community may be an alternative in assisting an individual or family in developing a sense of social belonging, dignity and self-esteem. Natural supports may include friends, neighbors, and members of a faith organization, peers from work, volunteers from community programs or others that exist naturally in the family's support system. Natural supports usually know the family well, often have a level of trust established with them already, and they will often remain a part of the family's life after formal service delivery has ended. Use of natural supports can be promoted through involvement

in community programs, activities, and projects; volunteer experience; or social contact with one's immediate family, relatives, friends and neighbors.

Transition to Adulthood

(Reference the 'Unique Needs' Training; the DBHS 'Transition to Adult Services' Practice Protocol; and Provider Policy 3.17 'Transition of Persons' for more information.)

Nationally, there are more than 20,000 young adults who "age-out" of the foster care system each year. Many of these young adults have limited family connections and are not prepared to make it on their own. A disturbing number face disheartening outcomes, including: homelessness, unemployment, imprisonment, addiction, young parenthood, discontinuation of education, and even death; while others have a chance at lasting connections, leadership, employment, higher education, and social and emotional success.

Young adults have a combination of unique needs as they transition into adulthood. This is particularly true when they jointly include the areas of mental health, substance abuse, child welfare system involvement, housing and educational needs. Perhaps no other change in age involves as many significant adjustments as that of a young person in the child welfare system that turns age eighteen.

- Service providers or availability of services and supports may change.
- The child now becomes the primary decision maker (instead of the parent or legal guardian).
- Legal status changes may occur, such as leaving the child welfare system or becoming a legally independent adult.
- He or she may be permitted to get a driver's license for the first time.
- Housing, finances, food and other necessities of life become the primary responsibility of the young adult.
- The young adult may experience other transitions including placement and community changes.
- Social expectations may exist for the person to "act like an adult" and manage these changes with minimal difficulty or adjustment.
- He or she may experience adjustments that his or her peers do not have to face, such as balancing completion of high school with maintaining his or her own budget and housing and such.

Youth who are in out of home care during the stages of transition to adulthood face unique vulnerabilities. While receiving services in an HCTC Home, many opportunities are created for youth to learn and practice skills related to adult responsibilities and challenges.

Through the CFT process, skills specific to this transition can be identified in the Behavioral Health Service Plan and implemented while in an HCTC home. The HCTC provider plays a valuable role in supporting practice opportunities, assessing further transition needs, and monitoring progress in such areas as:

- Independent living skills
- Developing natural supports and long-term connections
- Behavioral health needs
- Housing
- Employment
- Education
- Community safety
- Social skills
- Decision making and problem solving
- Accessing services and supports

The sole responsibility does not fall upon the HCTC Family to provide these services and training but rather allow for a safe environment where these skills can be practiced. It is the task of the CFT to determine which natural or formal supports are most appropriate to provide the formal skills training.

Covered Behavioral Health Services Provided Outside of the Home

Children placed in an HCTC Home often need additional services outside the home. Examples might include: psychiatric care, individual, family, group psychotherapy or other covered services. The RA is responsible for securing covered services in accordance with the DBHS Covered Services Guide (<http://www.azdhs.gov/bhs/covserve.htm>). Services should be identified by the Child and Family Team based on the individualized needs of the child.

The RA must identify a primary point of contact for the child/family in the behavioral health system. Responsibilities include: developing partnerships that will coordinate individualized service plans with the child/family and other entities; and advising the team of natural supports, resources, services and providers that might benefit the family. The Behavioral Health Representative also partners with the family to make sure the process runs smoothly, goals are achieved, discharge planning is accomplished, services are coordinated and successes are recognized.

Covered Service Manual Billing Code Guidelines

HCPSC Code: S5109 HA-Home Care Training to Home Care Client, per session (Child) –
Age 0-17 years
Billing Provider Type: Behavioral Health Therapeutic Home (A5)
Place of Service: Home (12) Other (99)
Billing Unit: Per diem

Billing Limitations

As per the ADHS/DBHS Covered Services Guide, the following billing limitations apply for HCTC Services:

1. Personal care services, skills training and development and home care training family services (family support) are provided by the behavioral health therapeutic home provider and are included in the HCTC rate. All other counseling, evaluation, support and rehabilitation services provided to the ADHS/DBHS member may be billed using the appropriate procedure code.

The following exception applies:

Based on behavioral health recipient needs, the following support services may be provided and billed on the same day that HCTC services are provided through a manual over-ride process. The clinical rationale for providing these additional services must be specifically documented in the Service Plan and Progress Note.

- Personal Care Services (T1019)
 - Skills Training and Development (H2014/H2014HQ)
 - Home Care Training Family Services (S5110)
 - Self-help /Peer Services (H0038)
 - Psychosocial Rehabilitation Services (H2017)
2. The HCTC procedure code does not include any professional services; therefore, professional services provided should be billed by the appropriate provider using the appropriate CPT codes.
 3. The HCTC procedure code does not include day program services, this service should be billed by the appropriate provider using the appropriate procedure code. Room and board services are to be billed separately. The State-funded HCPSC code for room and board is to be used for all persons except for state-placed children (i.e., DES or AOC) whose room and board should be paid by the placing agency.
 4. A licensed professional who supervises and trains the behavioral health therapeutic home provider may not bill these functions. Employee supervision and training has been built into the procedure code rate.
 5. Pre-training activities associated with the HCTC setting is included in the rate.
 6. This service may not be billed outside the HCTC procedure code rate by either the licensed professional or behavioral health therapeutic home provider.

7. Prescription drugs are not included in the rate and should be billed by appropriate providers using the appropriate NDC procedure codes.
8. Over-the-counter drugs and non-customized medical supplies are included in the rate and should not be billed separately.
9. Emergency transportation provided to an ADHS/DBHS member is not included in the rate and should be billed separately by the appropriate provider using the appropriate transportation procedure codes.
10. Non-emergency transportation is included in the rate and cannot be billed separately.
11. Any medical services provided to persons, excluding those medical services included in the ADHS/DBHS covered service array as set forth in this guide should be billed to the member's health plan.
12. HCTC Services cannot be encountered/billed on the same day as service code S5151, Unskilled respite care, not hospice; per diem.

Transfer of Services to New Responsible Agencies (Intra-RBHA Transfer)

When a child transitions into an HCTC Home, they may require a change in RA. Transfers may occur based on parent/guardian choice or a placement change for the child. Transfer of services should be discussed at the CFT and a detailed transition plan put into place. Transition plans should include a timeframe for the transfer and planning to ensure interim service needs are met. The current RA representative is responsible for coordinating the transition with the new RA. NARBHA requires use of the 'Transition Checklist'. (Reference NARBHA Provider Policy 3.17: *Transition of Persons* for more detailed information; PM Form 3.17.2: *NARBHA Intra-RBHA Transfer Checklist*, and PM Form 3.17.3: *Universal General Consent to Treatment*).

NARBHA's members may transfer RAs for two reasons:

- Member or Parent/Guardian Choice
- Member Move

The philosophy on transferring to a local RA for HCTC Placements is based on the idea of maintaining a child-centered team and wrapping services around the child in the home and community in which they are placed. Teams need to address the plan for how parent and extended family involvement will be maintained through the CFT process. This may include consideration of use of video-conferencing for Team Meetings.

When planning and implementing an Intra-RBHA Transfer, the CFT from both the Transfer To and the Transfer From agencies must discuss and address clinical considerations in order to ensure coordination and continuity of care. Member moves should be handled in a clinically appropriate

manner and discussed at the CFT. The member or guardian must be in agreement with the transfer. Transfers of adolescents within six months of turning 18 are discouraged.

Services Provided by In-Home Consultant/Family Therapist

The role of the In-Home Consultant includes the provision of in-home family therapy, and support and consultation to the HCTC Provider. They advise the HCTC Provider on referral decisions and provide ongoing clinical consultation, which includes participation on the Child and Family Team. They are required to be available 24/7 to provide consultation in order to assist in de-escalation and stabilization in the home (i.e. crisis intervention).

Consultation and supervision services provided by the In-home Consultant/Family Therapist include:

- Participating in referral decisions and review of HCTC Services packets
- Developing and supporting the therapeutic environment in the home
- Coaching on behavioral management strategies
- Consultation with the HCTC Family on characteristic of behavioral health diagnoses
- Assistance in the development and implementation of Shared Parenting skills
- Participating in crisis prevention and intervention
- Consulting with the Child and Family Team
- Providing feedback on parenting strengths and areas for development (i.e. attitudes, beliefs, family culture, problem solving, behavior management approach, nurturing, religious beliefs, child development, and personalizing the child's behaviors)
- Partnering with HCTC Parents on their professional development opportunities

In home family therapy is recommended weekly, but no less than twice per month and must take place in the HCTC Home. The In-home Consultant/Family Therapist facilitates these meetings and it is required that both HCTC Parents and all children be present as well as anyone else who shares living quarters in the house (exceptions are to be negotiated between the HCTC Parents, the therapist and the Child and Family Team). The purpose of the meetings is to strengthen the family as a unit and work through any adjustment or communication difficulties the child or family may be experiencing.

- The therapy sessions create a structured time and place for processing current family events and urgent matters (i.e.: family conflict, a new child placed in the home, a farewell, etc.)
- The therapist utilizes family dynamics, family interaction, and individualized roles in order to facilitate the development of a constructive dialogue between family members
- Family therapy encourages all individuals to speak up about issues with which they may be dealing and may include creative therapeutic interventions such as (i.e. role play, art activities, therapeutic board games, etc.)

- Therapy should integrate aspects of each child's individual treatment plan and must include goals, objectives and outcomes
- Family therapy gives family members insight into their own roles, and utilizes the strengths and resourceful dynamics of the family
- Special attention is given to new family members in order to ease their transition into the family and into family therapy sessions
- The Consultant/Therapist should be familiar with and have a copy of the Crisis Prevention Plan and the Safety Plan (if applicable), and should check in to make sure things are working and recommend adjustments back to the CFT if necessary.

Support Services Provided by the HCTC Provider Agency

The HCTC Provider Agency provides supportive services to the HCTC Home as follows:

- Attend and facilitate (or co-facilitate with an RA representative) monthly professional development meetings
- Be available to the family to assist in navigating “the system”
- Promote and support plans for Shared Parenting
- Maintain contact with In-home Consultant/Family Therapist to coordinate additional supports needed in the home
- Attend scheduled CFTs as needed
- Coordinate Annual Site Visit
- Develop and monitor Improvement Plans for HCTC Families that need to address areas of improvement
- Recruit and develop HCTC Respite Homes

Services Provided by DES/Child Protective Services (CPS)

For children in the care and custody of the State, the CPS Case Manager represents the child as the legal guardian. The CPS Case Manager has the responsibility of coordinating the child welfare related planning for the child. CPS provides the Room and Board portion of the HCTC daily rate and DES respite services.

It is important for the CPS Case Manager to bring issues related to Safety, Permanency, and Well-being to the CFT so that CPS case planning integrates smoothly with behavioral health service planning and HCTC services. The CPS Case Manager should also partner with the Team to address any issues related to Shared Parenting.

Behavioral Health Respite

The purpose of behavioral health respite is for the rest and relief of the caregiver, while maintaining quality care of the individual in order to meet their social, emotional and physical needs. Respite care is an effective tool that can revitalize and strengthen families. There is a national collective body of evidence that shows that rest and relief for the primary caregiver increases the quality of care and longevity of care provided to the individual by the primary caregivers. In this section NARBHA clarifies:

1. Discussion of respite occurring at Child and Family Team meetings
2. Appropriate care and supervision during respite
3. Medical necessity and documentation
4. Types of respite
5. Decisions and modifications to respite services
6. Requirements of Licensed/Certified Respite Agency
7. Requirements of Respite Provider/Staff Member
8. Claims/Billing Information

1. Discussion of Respite at Child and Family Team meetings

Respite care can be an essential part of the overall support that families may need to care for a child with a special need or challenging behavioral health issues. The family/caregiver's need for rest and relief to maintain quality of care and longevity of care for the child is to be discussed at the Child and Family Team. Information about respite, as a behavioral health service, will be shared with families and individuals at the Child and Family Team. This will ensure that a discussion and decisions can be made at the team meeting to determine if respite is needed and the appropriate use of this service. This is also a good time to identify respite needs in a child's Crisis Prevention Plan or Service Plan, including unplanned or emergency respite. The family/caregiver will determine how respite will be used. Respite is not intended to be used as a "placement" for a child because other services, supports are not available.

2. Appropriate Care and Supervision During Respite

Since not all families have the same needs, respite care should always be geared to individual child/family needs, by identifying the type of need and matching that need to the appropriate services (see ADHS/DBHS Covered Services Guide). In the event of regular and ongoing supervision for the member, the team should look at the most appropriate setting, skills of the provider, and objectives to determine the appropriate service to meet the needs of the individual. The need should be clearly stated on the Behavioral Health Service Plan with appropriate services listed. Respite will be discussed, reviewed, and evaluated for efficiency and effectiveness for the child and the family on a regular basis.

Matching the needs of the child with a provider is critical. The team must identify the qualities of people, including natural supports, whom already are successful with the child and what is needed for the child at this time.

3. Medical Necessity and Documentation

All behavioral health respite services must be determined by the Child and Family Team as a medically necessary covered service and must be included in the Behavioral Health Service Plan. The availability and use of natural supports and other community resources that meet the caregiver's or child's need, must also be considered and documented on the Behavioral Health Service Plan. Documentation, according to the ADHS/DBHS/NARBHA Provider Manual, of the member's needs, diagnosis, etc. and the supports needed is to be found in the member's chart.

Respite need and service will be discussed, reviewed, evaluated and documented for efficiency and effectiveness for the individual and the family, at a minimum, on an annual basis.

4. Types of Respite

There are several types of respite services available. They include in-home, out of home, HCTC, community/center based, and emergency respite. Respite can be planned, unplanned, or put into place in an emergency. Respite is available hourly, daily or overnight. Children in HCTC placement can access any of these respite services (they are not limited to services through HCTC Providers).

- **In-home respite** care takes place in the home of the caregiver. This has the advantage of convenience and familiarity for the child. In-home respite may be provided by another HCTC-Licensed Parent, staff from DBHS Certified Community Service Agency (CSA), or behavioral health staff from a licensed behavioral health clinic.
- **Out-of-home respite** takes place in a qualified respite provider's home, including another HCTC Home, or other location other than the individual's home by staff from a CSA or Licensed Behavioral Health Clinic.
- **Home Care Training (HCTC)** providers may provide respite services for Home Care Training clients to support other Home Care Training families in the NARBHA network. Home Care Parents may provide daytime and/or overnight respite services. This service, as with all other respite services, must be discussed, reviewed and approved for appropriateness through the Child and Family Team and documented in the Behavioral Health Service Plan.
- **Community/Center** based respite care by CSA facilities or licensed behavioral health facilities may provide daytime or overnight care for the individual. This may include after school and weekends and usually occurs in a group setting.

- **Emergency Respite** offers a temporary, limited placement for an unexpected circumstance due to an acute behavioral health need or other need as defined by the family (i.e., medical emergency) with the intent that the family or caregiver will resume care of the child as defined by the CFT. Approval of this type of care will occur between the Behavioral Health Representative (BHR) and guardian/caregiver with the agreement that respite needs will be discussed, reviewed and determined to be medically necessary through the Child and Family Team and a Crisis and Safety Plan, or other service needs will be identified and provided.

5. Decisions and Modifications

Any changes in respite and the behavioral health service plan must be made with the child's family/caregiver and team's knowledge and contribution.

Covered behavioral health services may include living skills training, personal care, behavioral health day programs or other services that are geared to the individual and family needs. This is based on the Child and Family Team decision with the child and family.

If natural supports and community resources are an option, but, there is a need for training of these resources, the team can enlist the expertise, skills and resources of the Child and Family Team, community, other families, clinics and NARBHA to create and provide the training to increase the capacity of the natural supports and community.

6. Requirements of a Licensed/Certified Respite Agency:

- Provide the medically necessary respite services identified by the Child and Family Team
- Demonstrate communication and coordination with RA regarding the respite services
- Ensure proper documentation including any specific needs for additional supervision or crisis and safety planning to protect the child and/or others
- Ensure qualified staff meet the needs of children receiving services
- Provide safe transportation to regularly scheduled programs, and appointments, including school or work, as appropriate
- Submit an Excel Tracking Sheet to NARBHA by the 10th of each month for the month prior (i.e., by April 10, 2008 for respite hours utilized during the month of March 2008). **Quality Management Data Analyst, NARBHA 1300 S. Yale St. Flagstaff, AZ 86001 or fax to 928-774-5665**
- Send any accidents or unusual incidents on required forms to the **Director of Quality Management, NARBHA 1300 S. Yale St. Flagstaff, AZ 86001 or fax to 928-774-5665**

7. Requirements of the Respite Provider/Staff Member:

- Secure all medical and transportation releases, instructions and emergency contacts from the caregiver, including any specific needs for additional supervision or crisis and safety planning to protect the child and/or others
- Receive instructions from the caregiver (or in concert with the RA, as appropriate) regarding the individual's needs as well as the Behavioral Health Service Plan
- Provide supervision for the period of time authorized
- Ensure medications are taken as prescribed (including written medication authorization and instructions for use of medication by the guardian/caregiver)
- Provide first aid and appropriate attention to illness or injury
- Provide for the appropriate nutritional needs of the individual (including any special dietary needs)
- Provide safe transportation to regularly scheduled programs and appointments, including school or work, as appropriate
- Report any accidents or unusual incidents on required forms
- Ensure individualized progress notes are documented consistently and in sufficient detail to allow a review for quality and appropriateness of services provided, including:
 - type and place of service provided (i.e., in-home or facility respite)
 - the date and time of service
 - duration
 - a brief description of the service provided related to the individual's identified needs, (what actually occurred, such as taking a walk, going to a community event, reading, etc.)
 - a brief description of the client's response to respite
 - staff signature and date signed

8. Billing Guidelines and Requirements (per the DBHS Covered Behavioral Health Services Guide):

- Two codes can be utilized for respite services: S5150 for up to 12 hours in a day (in 15 minute units) and S5151 for more than 12 hours in a day (1 per diem unit). S5150 and S5151 cannot be billed on the same day. S5150 has a maximum of 48 units or 12 hours per member per day.
- Respite is billed based on a calendar day (12:00a.m. to 11:59p.m.) Only use the per diem code, S5151, when respite services are provided for greater than 12 hours in any one calendar day. Example: If a member is in overnight respite from 10a.m. Saturday through 8a.m. Sunday morning the billing would be as follows:
- Day 1 (Saturday): 10a.m. through 11:59p.m. = 14 hours = S5151 for 1 per diem unit

- Day 2 (Sunday): 12 midnight through 8a.m. = 8 hours = S5150 for 32 units (1 unit = 15 minutes)
- Unfortunately, this can negatively impact a family by reaching the maximum of 30 days or 720 hours of respite services per year; however, this is a Covered Behavioral Health Services Guide billing requirement. S5151, the per diem code, “counts” as 24 hours.
- Respite services for an enrolled member are limited to a maximum of 30 days or 720 hours of respite services for each contract year (July 1st-June 30th) per person. Individuals enrolled in both the DES/DDD system and the behavioral health system receive a combined total of 720 hours as a maximum allocation.
- Title XIX funds cannot be utilized to pay for services over the 720 hours. If an RA authorizes respite services in excess of the 720 hours, the RA will be responsible for paying the Fee For Service (FFS) provider either directly or via payment made by NARBHA for the respite services rendered in excess of the 720 hours utilizing Non-Title XIX funds. The FFS provider may not be paid for Non-Title XIX services depending on the availability of funds.
- Home Care Training for the Home Care Client (HCTC) services cannot be encountered/billed on the same day as respite per diem (S5151). This means that HCTC Parents may use and bill respite or a portion of a day (S5150, under 12 hours) while also billing for a full day of HCTC Services, but may not bill for a day of HCTC services (other than Room and Board) while the child is receiving the per diem rate for respite (S5151, over 12 hours). Children who are placed in an HCTC Home may use another HCTC Home for respite OR any other approved/contracted behavioral health respite provider. Children who are not placed in HCTC Services may not access respite in that type of home.
- There is no group billing for respite services; respite services are billed individually for each member. For example, if a provider provides three hours of respite for three children, then three hours of respite services may be billed under each of the three children for a total of 9 hours of billable respite services.
- A respite provider who also transports the behavioral health member cannot bill respite services for the amount of time that the member was being transported. If a respite provider picks up a member at home, school or elsewhere, or transports the member to a scheduled program or appointment during the respite period, this service would be billed with only the appropriate transportation codes. For example, the respite provider picks the member up after school at 3 p.m. and transports them to the respite facility, traveling 12 miles and 30 minutes. The provider would encounter 12 miles with the appropriate transportation code. When the child arrives at the respite location at 3:30p.m., respite begins and the time spent in respite is billed with the appropriate respite code. The provider bills either respite or transportation, but not time spent providing both services simultaneously.

Use of Emergency Safety Responses (ESRs)

As per ADHS/DBHS Provider Policy 7.3: “Seclusion and restraint may not be used by any community service provider. Seclusion and Restraint may only be used by licensed Level I facilities or by a mental health agency licensed to provide crisis services, and only to the extent that such seclusion or restraint is expressly permitted by and in compliance with these rules and other applicable licensing rules and statutes for that inpatient facility or provider of crisis services.”

- Personal Restraint is defined as the application of physical force without the use of any device, for the purpose of restricting the free movement of a behavioral health recipient’s body.
- Seclusion is defined as the involuntary confinement of a behavioral health recipient in a room or an area from which the person cannot leave.

As per R9-20-602, HCTC providers are not permitted to use seclusion or restraint; this includes ‘therapeutic holds’. HCTC providers must comply with R9-20-216 for use of ‘Emergency Safety Responses’. Emergency Safety Response refers to physically holding a client to safely manage a sudden, intense, or out-of-control behavior to prevent harm to the client or another individual.

It is the responsibility of the Licensing Agency to provide and document training and monitor for appropriate use of ESRs. As per R9-20-216, an emergency safety response:

A. Is used only:

- 1 In an emergency that is an immediate threat to the life or health of a client or other individual,
- 2 When less restrictive methods have been attempted and were unsuccessful,
- 3 For the shortest possible duration of time needed to bring the client’s behavior under control or to prevent harm to the client or another individual **and not longer than five minutes**,
- 4 With the least amount of force needed to bring the client’s behavior under control or to prevent harm to the client or another individual,
- 5 Not more than twice in a period of 60 minutes, and
- 6 Not more than four times within a 12 hour period of time;

B. Is documented, reported, and reviewed as follows:

1. Is documented within one day from the date of the emergency safety response including:
 - a. The date and time of the emergency safety response;
 - b. The name of the client for whom the emergency safety response was used;
 - c. The names of each person using the emergency safety response;
 - d. The specific type of emergency safety response that was used;
 - e. The precipitating factors that created a need for use of the emergency safety response;
 - f. The outcome of the emergency safety response, including any injuries resulting from the emergency safety response;

In-home Consultant/Family Therapist

Qualifications, Training, and Supervision

Qualifications

The HCTC Program requires that an In-home Consultant/Family Therapist be assigned to work with every HCTC Family.

- If the DES Licensed HCTC Provider Agency hires employees, the In-home Therapist must be a Master's-level clinician.
- If the DES Licensed HCTC Provider Agency contracts with independent practitioners, the practitioner must be Master's-level and hold an independent level license in good standing with the Arizona Board of Behavioral Health Examiners.

The HCTC Provider Agency shall ensure that the In-Home Consultant/Family Therapist has the knowledge and skills necessary to perform the duties consistent with the HCTC Program.

Training

HCTC Provider Agencies utilize In-Home Consultants/Family Therapists who are master's level clinicians and have experience in working with family systems, childhood abuse, trauma and behavioral management. They must have an understanding of the unique behavioral health needs of children involved with CPS and of Positive Behavioral Support concepts. They are required to be trained in and comply with the Arizona Vision and 12 Principles and the Northern Arizona HCTC Handbook. In-Home Consultant/Family Therapists contracted by HCTC Provider Agencies are strongly encouraged to complete the Advanced HCTC Training hosted by the Provider Agency.

The HCTC Provider Agency will ensure the In-home Consultant/Family Therapist receives orientation and training that at minimum includes:

- Information on NARBHA, the public behavioral health system and other state agencies
- Overview of the Arizona Children's Vision and 12 Principles
- Information regarding the unique behavioral health service needs for children involved with CPS (reference www.cftraining.com)
- Child and Family Team Practice (reference www.cftraining.com)
- Northern Arizona HCTC Handbook
- Shared Parenting

- Positive Behavioral Support Concepts
- Confidentiality/HIPAA and PHI
- Cultural competency
- Coordination of care
- Practices in the treatment and prevention of behavioral health disorders, including the DBHS Clinical Guidance Documents
- Overview of covered services
- Proper documentation and record keeping
- Ethical behavior such as staff and client boundaries
- Prevention and intervention with violent behaviors
- Management of crisis situations
- Symptomology of persons diagnosed with behavioral health problems
- Effects of medication

The HCTC Provider Agency shall ensure that verification of the trainings listed above is documented as follows:

- Name of the staff member
- Name and date of training
- Signature and professional credential or job title of the individual who verified the staff member received the training

Supervision

The HCTC Provider Agency shall ensure that the In-Home Consultant/Family Therapist develops, implements, monitors, and complies with a written plan for clinical supervision for the agency. A written plan for clinical supervision shall ensure that clinical supervision addresses the treatment needs of all clients/families.

The HCTC Provider Agency shall ensure that clinical supervision is provided to the In-home Consultant/Family Therapist by an individual who has skills and knowledge in the behavioral health services that the agency is authorized to provide and the populations served by the agency; and is one of the following:

- A behavioral health professional (BHP), or
- A behavioral health technician (BHT) with a combination of full-time behavioral health work experience and post high school education in a field related to behavioral health totaling at least six years.

The HCTC Provider Agency shall ensure that:

- A BHT, or BHP not licensed at the independent practitioner level, who works full time receives at least (4) hours of clinical supervision in a calendar month;
- A BHT, or BHP not licensed at the independent practitioner level, who works part time receives at least (1) hour of clinical supervision for every 40 hours worked; and
- Clinical supervision occurs on an individual or group basis and may include clinical supervision in response to an incident.

The HCTC Provider Agency shall ensure that clinical supervision includes:

- Reviewing and discussing client behavioral health issues, behavioral health services, or records;
- Recognizing and meeting the unique treatment needs of the clients served by the agency;
- Reviewing and discussing other topics that enhance the skills and knowledge of staff members.

The HCTC Provider Agency shall ensure that the (4) hours of clinical supervision required for a behavioral health technician or behavioral health professional not licensed at the independent practitioner level is documented at least once a month, to include:

- The date of the clinical supervision,
- The name, signature, phone number, and professional credential or job title of the staff member receiving clinical supervision,
- The signature and professional credential or job title of the individual providing clinical supervision and the date signed,
- The duration of the clinical supervision,
- A description of the topic or topics addressed in clinical supervision
- Whether clinical supervision occurred on a group or individual basis, and
- Identification or recommendation of additional training that may enhance the staff member's skills and knowledge.

Administrative Requirements

Confidentiality

Confidentiality must be maintained at all times. All records must be stored in a locked cabinet. Documentation on personal computers must be copied onto a separate disk that can be locked away. All confidential information must be deleted from the hard disk (children could easily access information on the hard disk of a PC). All e-mail communication containing Protected Health Information (PHI) must only be sent by encrypted/secure e-mail.

HCTC Providers must be well informed of and comply with HIPAA (Health Insurance Portability and Accountability Act) regulations on the use and disclosure of individuals' PHI. This is to assure that individuals' health information is properly protected while allowing the flow of health information needed to provide and promote high quality health care and to protect the public's health and well being.

Administrative Requirements for HCTC Parents

- Maintain AHCCCS, NARBHA, OLCR, and HCTC Provider Agency status as a provider in good standing
- Demonstrate income and expense management
- Obtain and maintain required professional liability insurance
- Document, on a daily and monthly basis, child's progress according to standards required by DBHS, the HCTC Provider Agency and NARBHA
- Maintain program records, as required by AHCCCS, DBHS, NARBHA, and the HCTC Provider Agency. Information on each child should be maintained in a separate binder. Upon discharge and on request, deliver all information to the HCTC Provider Agency
- HCTC providers must comply with documentation requirements outlined in DBHS Provider Policy 4.2 – Behavioral Health Medical Records Standards; reference section 4.2.6-F for specific requirements for HCTC providers; and PM Form 4.2.1 – Clinical Record Documentation Form. Documentation must include required elements outlined in the policy. The minimum written requirement for each person's record must include:
 - The service provided and the time increment;
 - The date the service was provided;
 - The name of the person providing the service; and
 - A mechanism to track this information to the encounter, as well as to the person's comprehensive clinical record ([PM Form 4.2.1, Clinical Record Documentation Form](#), may be used as a mechanism to capture this information).

- Each 30 days, a summary of the person's clinical progress must be transmitted from the
- HCTC Provider to the Responsible Agency. [PM Form 4.2.1, Clinical Record Documentation Form](#), may be used as monthly summary.

Administrative Requirements for HCTC Provider Agencies

- Maintain licensing file as required which includes a copy of current license for each home
- In the licensing file, or in a separate file, keep records specifically pertaining to the HCTC Program
- In separate files keep documentation from CFT meetings, including the current treatment plan and the HCTC Family's monthly report, incident reports and any other child specific documentation
- Comply with OLCR and NARBHA contract requirements
- Coordinate the HCTC Referral List with the NARBHA HCTC Program Coordinator
- Maintain regular communication with NARBHA regarding HCTC Home Inventory and census information
- Submit Quarterly Reports to NARBHA (See monitoring requirements section)
- Ensure that each staff member completes an orientation before providing services. Orientation of a staff member includes reviewing (at minimum):
 - Client rights
 - Agency policies and procedures necessary for the performance of the staff member's duties
 - An overview to the TXIX behavioral health system
 - The Northern Arizona HCTC Handbook
 - An overview to Child and Family Team Practice
 - The staff member's job description
 - Procedures for responding to a fire, a disaster, a hazard, a medical emergency, and a client experiencing a crisis situation
 - Informing the staff member of the requirement to immediately report suspected or alleged abuse, neglect, or exploitation or a violation of a client's rights
 - Identifying the location of client records and how client records and information are protected
- Ensure that on-going training is provided as needed and documented to maintain or enhance staff skills in meeting the unique needs of the client populations served by the agency

Emergency Relocation Procedure

HCTC Services in Northern Arizona are spread across numerous provider agencies, homes, RAs, and a large geographic area. In the event that an HCTC Home has to be emergently displaced or relocated due to a natural disaster (forest fire, weather, flood), local emergency (house fire, municipal matter,

environmental hazard), or otherwise; it's imperative to have a process in place where HCTC Clients can be accounted for and their safety assured.

Each Provider Agency will develop an emergency response procedure. It is their responsibility to train HCTC Families on the Agency's emergency protocol prior to family accepting referrals. This protocol should at least address the following:

- Maintaining emergency contact information for HCTC Providers (names, home/cell phone, address, etc.). In the case of a large scale evacuation the emergency contact persons should reside outside of the HCTC Home's immediate geographic area whenever possible.
- Protocol for families to contact Agency in the event of an emergency relocation
- Provider Agency's process for contacting the HCTC Client's guardian, natural family, RA, etc.
- In the case of an emergency relocation, the Provider Agency will report the above information to NARBHA including measures being taken to assure clients' safety and the plan for interim service delivery.

Significant Incident Reporting

If, during the time that HCTC Services are provided, an incident occurs that involves a suicide attempt, self-injurious behavior, an injury to a member; a medication error or adverse medication reaction, a member's AWOL, a crime committed on the premises, or any other incident that causes harm to the member or requires the member to receive medical care, the incident is reported and documented as follows:

- Within one working day notification is provided to: the natural parent and/or guardian, the Responsible Agency (RA) Behavioral Health Representative and the NARBHA Quality Management Department
- The incident must be reported to DES/CPS on Form FC-122
- The incident is investigated within five working days. After the notification above a written report is developed and provided to the natural parent and/or guardian, the RA Representative, and the NARBHA Quality Management Department that includes:
 - The agency name and license or certification number
 - The date and time of the incident
 - The name of the member or members involved in the incident
 - The location of the incident
 - A description of the incident, including events leading up to the incident
 - The names of individuals who observed the incident
 - A description of the member's physical and behavioral health condition before and after the incident
 - A description of the action taken by the HCTC Home, including the names and dates of

individuals notified of the incident

- Whether the client received or was referred for medical services as a result of the incident
- A description of the action taken by the HCTC Home to prevent a similar incident from occurring in the future
- The name, title, signature, and date signed of the individual investigating the incident and preparing the report

HCTC Provider Investigations

Investigations of out of home providers shall be conducted following ACYF/DES policy as outlined in ACYF Policy Manual Chapter 5, Section 6d. The following procedures apply regarding CPS investigation of a report of child abuse or neglect occurring in an HCTC Home.

The case may be assigned to a CPS Program Specialist or Case Manager from an office outside of the area serviced by the out of care provider home. The standard for removing children from HCTC Homes in an emergency is the same as any other CPS case; 'Present or Imminent Danger'. In emergency situations, the CPS investigator may remove children prior to consultation; however, the CPS Investigator shall notify the following persons of the removal promptly, but no later than twenty-four (24) hours:

- Child(ren)'s Case Manager
- Parent
- Responsible Agency
- Unit Supervisor
- Child's attorney
- HCTC Provider Agency Licensing Worker
- OLCR
- CASA
- Program Manager or designee, and
- The Assistant Attorney General if the child is placed in the physical custody of the provider

The initiation of a CPS investigation in an HCTC Home will be according to the DES/CPS Aggravated Response Time Policy:

- High Risk: Responds immediately but no later than two (2) hours;
- Moderate Risk: Responds promptly, but no later than twenty-four (24) hours;
- Low Risk: Responds promptly, but no later than forty-eight (48) hours;
- Potential Risk: Responds promptly, but no later than seventy-two (72) hours, excluding weekends and holidays

The Role of CPS during an Investigation:

- CPS takes the lead in conducting and coordinating investigation activities
- If a removal occurs and a new provider is needed, the ongoing case manager will coordinate this with the Responsible Agency and Provider Agency through the CFT process

- CPS will ensure the safety of the child, investigate the allegations to determine their merit, and share concerns (if any) about the provider
- CPS will follow their agency policy and procedures to complete the investigation; this includes appropriate timeframes, coordination with law enforcement if needed, safety and risk assessment, notification to parent(s) and other identified team members, etc.
- Within five working days after completing the investigation convene a case conference that includes the following individuals/agencies:
 - The out-of-home provider
 - The CPS Investigator
 - Each child's case manager and/or his or her supervisor
 - The providers licensing worker and/or supervisor
 - OLCR
 - Responsible Agency Behavioral Health Representative
 - NARBHA
 - In-home Consultant/Family Therapist

(The purpose of the conference will be to process any issues raised by the investigation and attempt to eliminate any residual negative effects.)

The HCTC Provider Agency Licensing Specialist's Role in CPS Investigation:

- Notify the NARBHA Children's Services Manager and Network Monitoring Administrator of the investigation within 24 hours of notification by CPS
- Obtain a release of information from the HCTC parents for CPS and the Provider Agency to be able to share investigation findings with NARBHA
- Refrain from divulging information to the HCTC Parents while investigation is in process
- Participate in conferences with CPS and/or NARBHA as requested to accomplish resolution to the problem
- Assist in development and implementation of corrective actions if necessary
- Address all identified licensing issues or concerns
- Provide information to NARBHA on the outcome of the investigation, including license revocation or corrective actions

The HCTC Provider Agency, in conjunction with the Licensing Authority, may place the HCTC Parent(s) on a corrective action plan to remedy the problem. The plan of corrective action is implemented if the complaint is correctable in a specified period of time without jeopardizing the health or safety of a child.

Criteria to be considered in determining whether to require corrective action:

- The nature of the violation
- Whether the violation can be corrected
- Whether the HCTC Provider understands the violation and shows a willingness and ability to participate in a plan to correct the problem
- The length of time required to correct the problem
- Whether the violation or similar violations have occurred before
- Whether the HCTC Provider has had previous corrective action, and their success in achieving the goals
- Any other similar or comparable factors which would demonstrate the HCTC Provider's willingness and/or ability to follow through with the plan and avoid problems in the future

The Role of NARBHA in HCTC Investigations:

NARBHA may place the HCTC Provider Agency on a corrective action plan to address any issues resulting from the investigation. NARBHA may request or pursue additional information to determine any additional actions that may need to be taken. NARBHA maintains the right to refuse referrals of children to any HCTC Home regardless of licensure status or investigation outcomes if there are concerns regarding the safety or therapeutic reliability and effectiveness of provider.

Monitoring

Licensing and Monitoring of the HCTC Home

HCTC Provider Agencies are responsible for the following licensing and monitoring activities:

- Comply with all OLCR and NARBHA Licensure and Contract requirements
- Conduct initial and annual home inspections
- Conduct monthly home visits
- Cooperate with CPS on investigations resulting from hotline reports
- Conduct licensing inquiries when incidents occur that do not necessitate CPS investigation
- Implement and monitor Corrective Action Plans if needed after an investigation or licensing inquiry
- Make recommendations to OLCR, DES, NARBHA at completion of Corrective Action Plan
- Maintain compliance with OLCR and NARBHA contract requirements
- Monitor documentation and training as required

Annual Site Visit

Each Northern Arizona HCTC Home participates in an Annual Site Visit with their In-Home Consultant/Family Therapist and HCTC Provider Agency. Site visits are scheduled to give each HCTC Family the opportunity to step back and reflect upon their overall treatment environment and to objectively assess the strengths and weaknesses of their program as part of a continuous quality improvement process.

The Annual Site Visit meeting generally requires substantial time in the home to cover the issues in a supportive and problem-solving atmosphere. One of the major goals of this process is to encourage the HCTC Parents to remain open about their program and to gain feedback from others in an attempt to continually improve the quality of the program. The core members of the Site Visit Team include:

- HCTC Agency Program Coordinator
- HCTC Agency Licensing Worker
- In-home Consultant/Family Therapist
- RA Representative – this member of the team can participate by survey or in person.

A Site Visit report is written following the meeting and copied to the HCTC Parents and kept in the Provider Agency Licensing file for the family. Although DES/CPS and NARBHA are not part of the

core members of the Site Visit team, they may choose to participate. The key elements that are required to be addressed in the Site Visit are as follows:

- Home/Physical Environment
- Case Records/Documentation
- Treatment Strategies/Use of In-home Consultant/Family Therapist
- Shared Parenting
- CFTs/ Professional Relationships
- Disruptions
- Stress Management/Use of Respite
- Personal/ Professional Development Goals and Training
- Barriers Encountered/Resolutions
- Recommendations/Comments

Quarterly Reports

Obtaining clear outcome measures is an important part of measuring the effectiveness of services. This information helps guide program development in order to continuously improve the quality of services children are receiving. HCTC Provider Agencies are required to submit a Quarterly Report to NARBHA by the 15th day of October, January, April, and July for the preceding quarter. Data may be aggregated by NARBHA and reviewed by the HCTC Advisory Committee as needed.

The following minimum information will be included in the Quarterly Report:

- Summary of recruitment activities
- Total number of HCTC Homes/beds, HCTC Respite Homes/beds, and youth receiving services by county
- Losses/Gains including the number of new HCTC Homes/beds, Respite Homes/beds and youth by county and any reduction or loss of homes
- Number of youth on the Referral List
- Number of planned discharges and type of discharge (i.e. return to parent, step down, adoption, etc.)
- Number of disruptions (Please use the definitions in this handbook)
- Number and appropriate use of Emergency Safety Response
- Number of Professional Development meetings and/or trainings held by county
- Number of In-home Consultant/Family Therapists and any gaps in coverage (length of time, interim plan)
- Number of HCTC Parents engaged in mentoring of another HCTC Home
- Identification of specific barriers and any plans to address these barriers

NARBHA will review quarterly reports and any additional measures such as complaint data, data validation results, completion of Annual Site Visits, and overall contract compliance at least annually.

HCTC Inventory

NARBHA will coordinate monthly maintenance of the HCTC Inventory. The inventory will include the following information by County:

- HCTC Provider Name
- City/location
- HCTC Provider Agency/Contact Information
- In-home Family Therapist Name
- AHCCCS Provider ID
- Number of approved and licensed HCTC beds per home
- Number of approved and licensed respite or transitional beds per home
- Placement types (e.g. male/female, age restrictions, etc)
- Filled/vacant beds

Provider Agencies are expected to cooperate with regular requests from NARBHA for census information. This includes reporting accurate data and responding to requests in a timely manner.

Program Development and Management

NARBHA's role in HCTC Services is to plan, develop, and monitor programming. NARBHA maintains contracts with service providers, including Responsible Agencies, other behavioral health service providers, and HCTC Provider Agencies that deliver all TXIX Covered Behavioral Health Services to members. As part of this role, NARBHA monitors the program's quality and capacity.

NARBHA monitors HCTC Provider Agencies to ensure the training material and documentation and credentialing and privileging meet the Arizona Department of Health Service/Department of Behavioral Health (ADHS/DBHS) requirements.

HCTC Provider Agencies are monitored at least every three (3) years, unless significant issues with compliance exist and NARBHA determines the need for more frequent reviews.

- NARBHA requests a list including the name, title and credentials of behavioral health staff that have been hired and currently employed by the HCTC Agency.
- NARBHA requests a list of HCTC Parents that are contracted with the HCTC Agency.
- The HCTC Provider Agency is given 30 days to create the lists and send to NARBHA for review.

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- NARBHA reviews the lists to determine how many staff files of each type needs to be available for the on-site visit and notifies the HCTC Agency.

NARBHA performs a file audit of personnel training and/or credentialing files using the HCTC Provider Agency Audit Form.

- The HCTC Provider Agency Audit Form is sent out by NARBHA to the HCTC Provider Agency prior to the scheduled review.
- The HCTC Provider Agency completes the tool and gathers all supporting training materials prior to the scheduled review.
- NARBHA reviews the monitoring tool and supporting documentation and asks for any clarification.
- NARBHA audits the HCTC Agency's personnel training and/or credentialing files for the following elements:
 - Education
 - License
 - Work Experience (Working with Family Systems, Childhood Abuse and Trauma, and Behavioral Management)
 - Training
- NARBHA audits the HCTC Parent files for the following elements:
 - Licensing
 - Re-Certification Reports
 - Annual Site Visit Reports
 - Training Documentation

Documentation is made as to the compliance with ADHS/DBHS, NARBHA, and Licensure requirements.

- NARBHA documents the audit results, recommendations and corrective actions and provides a copy to the HCTC Provider Agency, the NARBHA Network Management Administrator, and the NARBHA HCTC Program Coordinator.
- The HCTC Provider Agency must achieve a score of 80% or higher to be in compliance. If the HCTC Provider Agency did not score 80% or higher, NARBHA requests a Corrective Action Plan be made.
- A notice is sent to the HCTC Provider Agency stating whether NARBHA has accepted or denied their Corrective Action Plan and what additional monitoring may be required.

Mechanisms for Resolving Complaints

Behavioral Health Member/Consumer Complaints: [1-800-640-2123]

All persons enrolled with NARBHA have access to a complaint process for expression of dissatisfaction with any aspect of their care. Complaints about behavioral health services should always be encouraged to be resolved at the lowest possible level, yet it is equally important that persons understand that a formal complaint process is also available when needed.

A complaint is defined as an expression of dissatisfaction. Possible subjects for complaints include, but are not limited to, the quality of care of services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee or failure to respect the enrollee's rights.

NARBHA staffs a customer services unit which is responsible to coordinate communications with eligible and enrolled persons and acts as, or coordinates with advocates, behavioral health providers and others to resolve issues. This unit:

- Educates and notifies persons about their rights and the process for filing complaints in a manner that is understandable
- Resolves complaints in an expeditious and equitable manner and with due regard for the dignity and rights of all persons. NARBHA is required to dispose of each complaint and provide oral or written notice within 14 calendar days
- Maintains confidentiality and privacy of complaint matters and records at all times
- Communicates timely information on matters and decisions related to the complaint to affected parties
- Involves the active cooperation and participation as deemed appropriate of providers with a direct interest in the matter under review

Resolution of System Barriers

NARBHA additionally hosts a quarterly meeting of the Northern Arizona Children's Council (NACC). Part of the meeting is dedicated to reviewing any systemic issues which may require resolution. More information on the NACC can be found on the NARBHA website [www.narbha.org]. System or programmatic issues may also be brought to the HCTC Advisory Committee for review and discussion.

Complaints about Other Agency Involvement

- Complaints about Licensure Issues should be directed to the HCTC Provider Agency
- Complaints about CPS should be directed to the local supervisor, Assistant Program Manager, and/or District Program Manager

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NARBHA is the Regional Behavioral Health Authority for Coconino, Navajo, Yavapai, Apache and Mohave counties. Funds for services are provided through a contract with the Arizona Department of Health Services/Division of Behavioral Health Services and AHCCCS

Notes

