Current as of: March 9, 2011
55 questions

Therapeutic Group Home (ThGH) Questions & Answers

Bed Capacity

Q1: Is there some pertinence to the 8 bed limitation that is being presented in this proposal. This would dramatically cut beds not only for us, but for others in the community. Also, without room and board already, the 8 bed reduction would make it less likely that this option would be financially feasible for a facility such as us?

Response: The 8 bed limitation is related to clinical evidence that a small community-based setting is more effective for the youth population targeted in these facilities. In addition, it would be feasible for facilities to operate two ThGHs under CMS guidelines without the institution being considered an Institution for Mental Disease (IMD) and being excluded from Medicaid reimbursement entirely if the two facilities combined have 16 beds or under.

As per federal regulations, Medicaid is unable to reimburse for room and board in this facility type, but they can reimburse for all other medical services not in the rate separately. The facility will still have the ability to bill the family or guardian for room and board.

Q2: If the reduction to 8 occurs would facilities still fall under GH licensure for State, as we were grandfathered under previous code and any construction would make us lose the grandfather status and again be cost prohibitive to a facility such as ours.

Response: As proposed, the current facility would be grandfathered under ThGH, as well as GH, and permitted to operate as a ThGH under new staffing ratios and requirements but with a grandfathered bed capacity. Any construction or relocation undertaken by the facility would need to comply with the new bed capacity limitations.

Q3: Could a facility split dorms and share common space. Meaning could we have an eight female and eight male ThGH with common kitchen and work rooms.

Response: The intent is small community-based facilities that are not located on the grounds of large institutions/facilities or physically co-joined in operations with a large facility. Operating two separate ThGHs is feasible if they are not two co-joined facilities, are located in a community, are not on the same campus and are less than 17 beds in total.

Q4: The small bed numbers per facility was a surprise and is not helpful to the providers.

Response: While this may or may not be helpful to the providers, the small bed number and community setting is the most effective size and setting for the children being treated that we have identified. Other states [e.g., Wraparound Milwaukee in Wisconsin and Maryland] have found this model successful in terms of clinical outcomes. Also, the literature on longer term residential treatment does not demonstrate positive outcomes. Sources ranging from the 1999 Surgeon General's Report on mental health (cited in the ThGH model document) to specific studies (Lyons, et al., 2001[1]) have shown residential treatment overall to be ineffective or, at best, mixed in their outcomes for addressing the primary reasons for admission. Furthermore, there is no evidence of a relationship between any outcomes achieved in residential treatment and subsequent functioning in the community (see for example Bickman, et al., 2000[2]). Research also points to the residential milieu itself as problematic because children in congregate care enter a situation where their primary peers are other troubled children – a major risk factor for later behavioral problems (Dishion, et al., 1999[3]).

Q5: Is there a limit to the number of beds?

Response: Yes, Medicaid will not reimburse for ThGH provided in an IMD. (See definitions of IMD and the 16 bed limitation elsewhere). There is an overall bed capacity of 8 for the ThGH model. Refer to Q2 for information on the proposed grandfathering of current facilities.

Q6: If renovations are being done on an organization's existing facility, to decrease beds capacity would be a financial burden that could put the facility in jeopardy, as the total space has already been committed and costs/expenses associated with that space would remain unchanged. The total capacity would need to be maintained in order to ensure the appropriate economies that will cover costs associated with this facility.

Response: See the response to Q2.

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[1] Lyons, J. S., Terry, P., Martinovich, Z., Peterson, J., & Bouska, B. (2001). Outcome trajectories for adolescents in residential treatment: a statewide evaluation. *Journal of Child and Family Studies*, 10:333–345.

[2] Bickman, L., Lambert, E. W., Andrade, A. R., & Peñaloza, R. V. (2000). The Fort Bragg continuum of care for children and adolescents: Mental health outcomes over 5 years. *Journal of Consulting and Clinical Psychology, 68*(4), 710-716.

[3] Dishion T. J., McCord J., & Poulin F. (1999). *When Interventions Harm: Peer Groups and Problem Behavior,* American Psychologist, 54, 755 – 764.

Model

Q7: If this choice was chosen, what would we have to show or prove to indicate the treatment planning and milieu program we are choosing to run under, i.e., if we go with ASAM which is what we are currently most similar to, what do we need to prove we are running under that evidence-based philosophy or program?

Response: Compliance with all aspects of the specific EBP/ASAM chosen will need to be documented (not just similarity to the treatment). The requirements vary; some require training and certification by the developer; others have fidelity protocols or manualized requirements for which documentation can be provided. If there is not an annual certification process required by the developer, then the State would require an annual fidelity audit conducted by a mutually agreeable third party.

Q8: Is it intended that this model would be for PRTFs or does this become a different type of service?

Response: This is a different type of service. PRTFs and IMDs may not provide this service.

Q9: On Page 1-There is a reference to the Boys Town Model. How does this reference pertain to the proposed model? The reference is outdated – please consider more relevant and recent data.

Response: The reference to the Boys Town model in the footnote on page 1 was provided as part of a description of the historical development of the ThGH model. It was not intended as a suggestion of a research-based program. The research-based program models suggested on pages 4 – 6 were not meant to be exhaustive. Other research-based programs can be proposed in accordance with the following requirements from page 6:

> *In addition, programs may propose other models, citing the research base that supports use of that model with the target population (e.g., gender-specific approaches). They may also work with the purveyors of research-based models to develop more tailored approaches, incorporating other models (much in the same way that FIT and Functional Family Probation were developed).*
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> *The specific research-based models to be used should be incorporated into the program description and submitted to the State for approval. All research-based programming in ThGH settings much be approved by the State.*

Q10: Is this Concept paper intended a model for Treatment Group Homes that are deemed PRTFs?

Response: No. There will no longer be Treatment Group Homes in the State of Nebraska. PRTFs and IMDs may not provide Therapeutic Group Home (ThGH) care.

Q11: Is this Concept Paper intended as an alternative to Treatment Foster Care?

Response: This is not intended to replace foster homes serving one child but would replace TGH and ETGH care.

Q12: Is this Concept Paper intended as a model related to a child welfare service?

Response: No. This is a Medicaid treatment service. Medicaid may not reimburse for care of residents in Child Welfare homes with more than 16 beds serving a majority of children with behavioral health diagnoses (e.g., IMDs).

Q13: We could utilize the Residential Wraparound approach.

Response: The research-based program models suggested on pages 4 – 6 were not meant to be exhaustive. Other research-based programs can be proposed in accordance with the following requirements from page 6:

> *In addition, programs may propose other models, citing the research base that supports use of that model with the target population (e.g., gender-specific approaches). They may also work with the purveyors of research-based models to develop more tailored approaches, incorporating other models (much in the same way that FIT and Functional Family Probation were developed).*
>
> *The specific research-based models to be used should be incorporated into the program description and submitted to the State for approval. All research-based programming in ThGH settings much be approved by the State.*

Q14: I like the size of up to 8 youth; let's find somewhere off our campus.

Response: That would be acceptable if operated separately from the IMD and its campus. Refer to the document "NE IMD Principles 112310.doc" provided by DHHS on November 24, 2010.

Q15: We get the DSM-IV-TR and ASAM connection.

Response: N/A

Q16: In terms of Standardized Assessment and Planning Tools we use: ACES, Trauma Symptom Checklist for Children, CANS-MH, SASSI, CASI, and ASAM

Response: Rather than a broad array of assessments, the use of standardized assessment and planning tools must be used for all children in the facility in a consistent manner. The State is

working toward a standardized assessment tool (Child and Adolescent Needs and Strengths – Mental Health version or CANS-MH[4,5]) and encourages the facilities to use the CANS-MH as a standardized assessment tool for all children. The CANS should ideally be at intake and discharge to monitor changes in functioning, as well as every 90 days for longer term stays.

Q17: Models for developing Trauma-informed Behavioral Health Systems and Trauma-Specific Services that we have been influenced by include but not limited to: (several models listed) I would like the following models to be cited for "examples of specific research-based approaches that could be used for various sub-populations of clients include:

- Sanctuary and ARC that move beyond the ones they listed on page 4. I really think they do not truly understand what goes into the Sanctuary Model (page 5) when they saw "Preliminary research would allow us to characterize this as a promising practice" as it is beyond that…

Response: The research-based program models suggested on pages 4 – 6 were not meant to be exhaustive. Other research-based programs can be proposed in accordance with the following requirements from page 6:

> *In addition, programs may propose other models, citing the research base that supports use of that model with the target population (e.g., gender-specific approaches). They may also work with the purveyors of research-based models to develop more tailored approaches, incorporating other models (much in the same way that FIT and Functional Family Probation were developed).*
>
> *The specific research-based models to be used should be incorporated into the program description and submitted to the State for approval. All research-based programming in ThGH settings much be approved by the State.*

Q18: Overall, I like the small community oriented approach.

Response: N/A

Q19: Is the Teaching Family Model that Boys Town uses a requirement for this?

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[4] *Lyons J.S., Griffin E., Fazio M., & Lyons M.B. (1999). Child and Adolescent Needs and Strengths: An Information Integration Tool for Children and Adolescents with Mental Health Challenges (CANS-MH), Manual. Chicago: Buddin Praed Foundation.* See http://www.praedfoundation.org/CANS-MH%20Manual.pdf for the CANS-MH manual.

[5] *Anderson, R.L., Lyons, J.S., Giles, D.M., Price, J.A., & Estle, G. (2003). Reliability of the Child and Adolescent Needs and Strengths-Mental Health (CANS-MH) Scale, Journal of Child and Family Studies, Vol. 12, No. 3, pp. 279–289.*

Response: No. See response to Q9.

Q20: Is the State considering being more proscriptive regarding which approach to use in the ThGH model (e.g., must use DBT)?

Response: No. There are multiple models that can be used and new models are continuously in development over time. In order to maximize the effectiveness of this modality and allow it to improve in effectiveness over time, the State is requiring simply that the model be research-based and demonstrated to be effective for the target population. For specific guidance, see the requirements on page 6 of the ThGH model document.

Q21: Will the State consider using the same milieu approach for data comparison as it would provide a common language for providers, payers, families, members. The providers in Ontario did this.

Response: See the response to Q20. In addition,

> *"programs may propose other models, citing the research base that supports use of that model with the target population."*

Q22: Looks like this could be implemented in out-state, if the doctor only has to cert the intake. WE would have to build in quality program assurances if this is true.

Response: This is anticipated to be provided in the youth's community and not out of state.

Q23: Does Medicaid have specific documentation templates that they are requiring to show fidelity monitoring?

Response: The provider will be required to submit an annual fidelity audit conducted by a mutually agreed upon third party. Providers will have the opportunity to work with the State on an acceptable format. See the response to Q7.

Rates

Q24: Fixed costs ignore difficulty of individual youths and risks "cherry-picking" by providers. Agree on fixed costs for treatment costs, room and board, but not on monitoring. Could there be a surveillance/monitoring rate be added individually to kids to address their unique needs and potential difficulties?

Response: Federal requirements prohibit "cherry picking". Nebraska's waiver renewal effective July 1, 2011 will clarify this and institute penalties consistent with federal civil monetary penalties. The waiver states the following:

The State operates the Nebraska Behavioral SPCM - Specialty Physician Case Management (Statewide Mental Health Program) utilizing a SPCM under a 1915(b)(4) authority (42 CFR 331.55 (c)). The State will require Medicaid beneficiaries enrolled with the SPCM programs to obtain services through the SPCM contractor. Beneficiaries May Choose their Providers: Medicaid beneficiaries may choose to access medically necessary services through any network provider who provides the appropriate level of care.

The State contracts with providers of mental health and substance abuse treatment services who are appropriately licensed and/or certified and meet the state of Nebraska credentialing criteria, who agree to the standard contract provisions, and who wish to participate. The SPCM provides at least as much access to services as exist within Medicaid's fee for service program. Within the provider network, recipients have a choice of the providers which offer the appropriate level of care. The SPCM will be encouraged to collaboratively develop networks with service accessibility and with providers necessary to fill any service gaps existing in the provider network.

Enrollees will have free choice of providers within the SPCM and may change providers as often as desired. If an individual joins the SPCM and is already established with a provider who is not a member of the network, Nebraska will make every effort to arrange for the consumer to continue with the same provider if the consumer so desires. In this case, the provider would be requested to meet the same qualifications as other providers in the network. Finally, except in certain situations, enrollees will be given the choice between at least two providers. Exceptions would involve highly specialized services which are usually available through only one agency in the geographic area.

The SPCM must have credentialing and recredentialing policies consistent with federal and state regulations including EPSDT rehabilitation and Psychiatric Rehabilitation Treatment Facilities. The SPCM must evaluate every prospective provider's ability to perform the activities to be prior authorized prior to authorizing care with any provider or subcontractor. The SPCM is not obligated to prior authorize any provider unable to meet state or federal standards. In addition, the SPCM is not obligated to continue to prior authorize care with a provider who does not provide high quality services or who demonstrates utilization of services that are an outlier compared to peer providers with similarly acute populations and/or compared to the expectations of the SPCM and the State. The SPCM's provider selection policies and procedures cannot discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. The SPCM and the State will have a written policy that specifies the activities and report responsibilities required of the provider at each level of care; and provides for revoking prior authorization, terminating provider agreements, or imposing other sanctions if the provider's performance is inadequate.

The SPCM must monitor all providers' performance on an ongoing basis and subject it to formal review according to a periodic schedule established by the State, consistent with industry standards or State laws and regulations. The SPCM must identify deficiencies or areas for improvement, and the provider must take corrective action. In addition per 1915(b)(4) authority, the State has the right to terminate providers not compliant with the State's corrective action plan, quality measures, accessibility standards or state and federal requirements including discrimination. The State and the SPCM through this waiver have the ability to impose penalties on and terminate providers within the SPCM network who act contrary to the intent of federal requirements at 42 CFR 438.700(3), .704(b)(3), .708 and "acts to discriminate among enrollees on the basis of their health status or need for health care services. This includes termination of enrollment for refusal to reenroll a recipient, except as permitted under the Medicaid program, or any practice that would reasonably be expected to discourage enrollment by recipients whose medical condition or history indicates probable need for substantial future medical services."

Q25. Is the cost for routine medical care included or excluded in the proposed model?

Response: Excluded

Q26: If there must be 24/7 availability of Crisis and or mental health services AND the child also requires 24 hour care, this meets the criteria of an "inpatient/residential definition. With that in mind has Medicaid decided to develop a cost structure that reimburses for the 24 hour mandated services?

Response: This is not meant to imply an inpatient or PRTF level of care, as the criteria for these levels of care go well beyond those mentioned in the question. The crisis supports required are 24/7 crisis back-up or on-call supports such as those provided by community-based mental health providers. Medicaid will not pay for room or board in this model.

Q27: With the expectation of the Psychiatrist/Psychologist, as the supervising practitioner, is responsible for the overall care and service delivery; and the expectation that this professional is available and on-call 24/7, the cost structure will need to adequate build this component in.

Response: The psychiatrist/psychologist is not expected to be on site 24/7 but he or she is expected to be on call 24/7. Medicaid will reimburse for the treatment and therapy expected to be provided in these settings when it is provided. The Medicaid cost structure will build in expected treatment costs including clinical supervision of direct care staff (e.g., unlicensed and licensed staff). Medicaid will not reimburse for 24 hour supervision of the child. That is a room and board component that Medicaid cannot reimburse for under the ThGH model.

School

Q28: It states that the youth attend public school. Can youth who are appropriate for the ThGH attend our Morton School if that allows them to be successful in the ThGH?

Response: Successful ThGH models require integration of the youth into the community. It is not anticipated that the ThGH youth will attend a facility-based or IMD-based school.

Q29: Although community school is always the goal, there are many youth, especially those with addiction issues, where remaining in their 'home school' with their peer group is counter productive to the treatment process and initial recovery process. Additionally, if a youth is being served outside their 'home community', the process of transferring the youth to a new 'community-based' school is lengthy and difficult. A youth could be sitting out of any school for 1-2 weeks, while the transfer is being processed.

Response: See the response to Q28.

Staff Level/Education

Q30: If this level of care is lower as suggested, why can't an LIMHP be overseer of such a program instead of psychiatrist or psychologist?

Response: It is Nebraska's goal to improve the effectiveness of these programs. Clinical oversight of a more broadly trained practitioner is anticipated to improve outcomes.

Q31: There is no indication of the criteria for other staffing. There is mention of Master level counselors to provide 3 hour of txt group, one individual and two hours per month of family, but there is no indication as to the direct care staff. The only mention is overnight staff with a Bachelors.

Response: Staffing requirements specified in the section entitled "Staffing, Ratios, and Staff Qualifications" define minimum requirements. Actual staffing will depend on the requirements of the specific EBPs implemented.

Q32: Language: "ongoing psychiatric assessment and intervention" needs clarification; clarify what is called psychological, psychiatric and medical.

Response: "Ongoing psychiatric assessment and intervention" refers to assessment and intervention provided by a psychiatrist. Other required and EBP-specific clinical staff can provide assessment and intervention within the scope of their respective licenses.

Q33: Page 6 – please clarify BH staff and define further.

Response: These are the staff described in the section beginning on page 7 entitled "Staffing, Ratios, and Staff Qualifications." See that section for definitions and requirements.

Q34: Does the minimum of one staff on duty being CPR certified meet the Child Caring Agency requirements?

Response: Child caring agency requirements are not as prescriptive as to designate a specific number of staff per child that are required to be CPR certified. Providers must include in their Policies and Procedures their plan for responding to immediate medical needs of the youth as well as who to notify in such an event. For Medicaid ThGH requirements, at least one staff per shift must be CPR and First Aid certified.

Q35: Is it the intent of Medicaid that LPNs can not fulfill this requirement?

Response: An RN is required for the hours outlined in the policy.

Staffing

Q36. We have contracted nurses instead of nurses on staff. Will we be able to continue our contracts with these nurses to meet this standard? Or do we have to have them on staff only?

Response: Contracted nurses are fine.

Q37: The ratio of 1 to 4 is a residential standard and seems too intense for that level of care. It would necessitate more staff.

Response: The ThGH model is intended to be a residential standard of medical care.

Q38: It calls for an overlap of shifts which also will require more staff to implement.

Response: Yes, that is correct.

Q39: If a therapeutic group home is really considered a less than long term care type facility why is the ratio higher, the ratio presently is 1 to 8 while asleep and 1 to 6 awake. The way it is written it suggests that awake it is 1 to 4 and asleep it is 2 no matter what. How is it that we lose beds, the care is lower level and yet now the staffing would be higher?

Response: The State of Nebraska is requiring all facilities to comply with federal requirements and national standards of care including evidence-based practices. This will require all facilities to increase treatment levels and improve the effectiveness of the treatment delivered to its youth.

Q40: Under #1 (Staff on Duty): This is a contradictory… do you mean a minimum of two staff on duty during WAKING hours and one staff on duty during SLEEPING hours? Or do you mean two staff on each shift, and at least one of the two must be awake during sleep hours?

Response: This will be clarified in the revised ThGH model document. There must be two staff at all times. All staff must have the ability to call in additional staff as necessary. Of the two staff at night, one staff person must be awake at all times.

Treatment

Q41: Treatment plan reviews every 14 days seems a little extreme, especially if they are done as comprehensively as they currently are being done.

Response: Successful ThGH models are intended to be short-term treatment settings. If progress is not being made then therapy adjustments need to be made quickly or children should be discharged into a setting where rapid progress can be made. ThGH are not anticipated to be living settings for youth. Fourteen day reviews of treatment plans in a short-term setting is clinically appropriate.

Q42: I'm not understanding what level of youth we would take where 14 days of treatment would be considered a viable option – if a youth only needs 14 days, why wouldn't a child caring group home or emergency shelter placement with services do? At the very least wouldn't 30 days be a more adequate minimum – otherwise are we really treatment or crisis intervention. We are not psychiatric and there is no intention for crisis intervention only, particularly at a dual treatment.

Response: Treatment is reviewed every 14 days to ensure medical necessity and active treatment, but the length of stay will vary by the presenting problem, program type, and the child's needs and resources. However, the focus of the program should be on stabilization and return to the community for ongoing care as quickly as possible, rather than ongoing care in the group home setting.

Q43: Please describe the 14 day length of stay that is typically a shelter stay and the 14 day treatment reviews?

Response: As noted in the response to Q42, treatment is reviewed every 14 days to ensure medical necessity and active treatment, but the length of stay will vary by the presenting problem, program type, and the child's needs and resources.

Here is an example of a case that could benefit from a short-term stay of under 14 days. The focus of treatment is on stabilization and return to the community for ongoing care as quickly as possible, rather than ongoing care in the group home setting:

Rob, a 15-year-old male, was originally referred for services because of multiple counts of criminal damage to property. He was diagnosed with attention deficit disorder and major depression that make it difficult for him to succeed in school and played a role in leading him to engagement with anti-social peers. He is currently using marijuana and alcohol. His family wants to keep him at home and had been participating with intensive family therapy but his current behavior is too disruptive for him to be safe in the home. Aunts and uncles who had been providing respite are feeling overwhelmed by his non-compliant behavior. Rob will be admitted for a brief stay in ThGH so that he can be in a safe environment while continuing treatment focusing on managing his depression and impulsivity through dialectical behavior therapy (DBT). Concurrently, Rob's parents will participate in skill development and be able to continue family therapy while he is in placement. Once Rob's behavior is stabilized and crisis plan is revised, he will be ready to return home.

Q44: In page 3-it reference less intensive level of treatments. What is considered less intensive level of treatment?

Response: *Less intensive levels of care would include outpatient treatment and community-based care provided by an interdisciplinary team.*

Q45: Describe what is considered treatment and what is placement in this Concept?

Response: Any child in this type of facility must have a medical necessity for the treatment. This is considered a medical service not a "placement".

Q46: Page 6-outcomes section – how will the 14 days and the timeframes of supervision and progress reports impact those providers in rural areas?

Response: In Medicaid, rural providers are held to the same clinical standards as urban providers.

Q47: Page 8 – what is active treatment and how is it defined?

Response: Active treatment includes documented therapeutic activities delivered by the licensed and appropriately supervised clinical staff of the facility within the scopes of their allowed practice to deliver Medicaid rehabilitative services to accomplish the current goals specified in the individualized treatment plan of the child/youth. Generally, services must involve "active treatment", which means implementation of a professionally developed and supervised individual plan of care, is developed and implemented no later than 14 days after admission; and designed to achieve the recipient's discharge from admission at the earliest possible time. The plan of care must be a written plan developed for each recipient to improve his condition to the extent that residential care is no longer necessary. The plan of care must 1) be based on a diagnostic evaluation that includes examination of the medical,

psychological, social, behavioral and developmental aspects of the recipient's situation and reflects the need for residential care; 2) be developed by a team of professionals in consultation with the recipient; and his parents, legal guardians, or others in whose care he will be released after discharge; 3) state treatment objectives; 4) prescribe an integrated program of therapies, activities, and experiences designed to meet those objectives; and 5) include, at an appropriate time, post-discharge plans and coordination of residential services with partial discharge plans and related community services to ensure continuity of care with the recipient's family, school, and community upon discharge. The plan must be reviewed every 14 days by the team specified to determine that services being provided are or were required on an residential basis, and recommend changes in the plan as indicated by the recipient's overall adjustment as an inpatient. The individual plan of care must be developed by an interdisciplinary team of professionals who are employed by, or provide services to patients in, the facility. The team must have education and experience in treating children with behavioral health diagnoses, preferably including competence in child psychiatry. The team must be capable of 1) assessing the recipient's immediate and long-range therapeutic needs, developmental priorities, and personal strengths and liabilities; 2) assessing the potential resources of the recipient's family; 3) setting treatment objectives; and 4) prescribing therapeutic modalities to achieve the plan's objectives. The team must include, as a minimum, either – 1) a board-eligible or board-certified psychiatrist; or 2) a psychologist who is licensed in the State of Nebraska..

Q48: Page 1-can you clarify nursing supports?

Response: Nursing services include the following: 1) completes nursing assessment at admission, 2) attends and participates in treatment planning as a team member, 3) medication teaching and education, 4) supervises dispensing and storage of medication, 5) reviews and implements all physician orders, 6) provides all nursing interventions and, 7) completes accurate clinical records on each youth.

Q49: In regard to the supervising practitioner's involvement, it reads that the Supervising Practitioner only is mandated to see the patient once, upon intake and (if I understand it correctly) can prescribe the care for any period of time and never have to re-assess the youth? Is this accurate? It also makes no mention that the Sup Prac has to be involved in or review treatment planning? I am just unclear as to what the SP's involvement would be on an ongoing basis?

Response: The psychologist or psychiatrist must see the client at least once, prescribe the type of care provided, and, if the services are not time-limited by the prescription, see the child and review the need for continued care at least every 14 days. Although the psychologist or psychiatrist does not have to be on the premises when his/her client is receiving covered services, the supervising practitioner must assume professional responsibility and is accountable for all treatment services provided and must assure that the services are medically appropriate.

Q50: Needs clarification of exactly how many hours of individual, group and family will be required

Response: The minimum requirements must be met but if additional sessions are needed to meet the needs of child, the needs must be addressed. If the facility is unable to provide treatment levels leading to effective outcomes for the child, then the child should be discharged and transferred to another facility.

Miscellaneous

Q51: We were encouraged to go this route, therapeutic group home, yet the standards presented would not make that a reasonable route, we'd do better going PRTF. Is that still an option?

Response: Yes

Q52: If we were dual – does that mean we could take only MH or only CD, as currently Magellan has blocked this and we only can truly take dual clients through we have capability to serve either sect or clients that are dual.

Response: ThGHs may serve clients with dual diagnoses and clients with only mental health or only substance abuse diagnoses. However, research-based or evidence-based practices must be in place and approved by the State for treatment specific to the individual client's diagnoses. If the client is dual diagnosed, then both diagnoses must be treated. In addition, staff must be trained in the applicable research-based or evidence-based practice.

Q53: Under Nebraska principles for determining if facilities should be viewed as a single institution (page 9)…it lists out a variety of scenarios…I am particularly interested in #5: "If facilities share an owner/governing body & CEO for administrative operations and NO medical staff is shared, then a component that is licensed separately and is geographically separate and not contiguous to other shared ownership facilities is considered to be not feasible to operate as a single institution. Geographically separate means facilities that are not in close proximity or adjacent and the facilities do not share operational responsibilities and staffing responsibilities between facilities." Although this helps, I am concerned that it doesn't also address shared human resources, finance and facility maintenance departments… what if these separate facilities, who do not share Medical staff, do share general support departments – like HR, billing and facility management?

Response: If the facilities solely share HR and billing then this would not be viewed as a single institution. However, if facility maintenance is shared, then the facilities are considered to be a single institution. See item #6 on page 2 of the principles document (If facilities share an owner/governing body and a centralized CEO, payroll, and human resources for administrative operations, then if the facilities share administrative staff for

lawn maintenance, laundry, facility maintenance or shared cafeteria and food service, the facilities are a single institution because the facilities cannot operate separately [even if no direct care staff are shared]).

Q54: Will ThGH providers be able to "specialize" as they currently do or would the expectation be that they would need to be able to treat any youth (for example, Sexual Offender, Chemical Dependency populations)?

Response: Yes, specialization is anticipated but would need to be based upon evidence-based practices or research-based treatment models documented for children and adopted in facilities with trained staff.

Q55: Address "Shared Human Resources, Finance and Facility Maintenance" in terms of if these are shared, do they have to be considered to be part of the Single Institution?

Response: See the response to Q53.