Nebraska Division of Behavioral Health

Service Definition Manual for Mental Health and Substance Use Disorders



Updated: November 1, 2026
Supported by Title 206 of the Administrative Code for Behavioral Health Services

MISSION STATEMENT

THE DIVISION OF BEHAVIORAL HEALTH'S MISSION IS TO PROVIDE LEADERSHIP AND RESOURCES FOR A SYSTEM OF CARE THAT PROMOTES AND FACILITATES RESILIENCE AND RECOVERY FOR NEBRASKANS.

TABLE OF CONTENTS

General Definitions.....5
General Provider Requirements.....8
- Specific Provider Requirements.....13

General Service Requirements.....19

DBH-Only Service Definitions

- **Crisis Services**
  - 24-Hour Crisis Line..... 30
  - Emergency Community Support..... 31
  - Hospital Diversion.....34
  - Mobile Crisis Response *(formerly Crisis Response -MH or SUD)*.....37
  - Respite (*formerly Mental Health Respite*).....40
- **Outpatient Services**
  - Client Assistance Program (CAP).....42
  - Intensive Community Services..... 45
  - Therapeutic Consultation (Adult).....48
  - Therapeutic Consultation (Youth & Adolescent) 51
- **Rehabilitation Services**
  - Coordinated Specialty Care.....54
  - Day Support.....59
  - Professional Partner Program (PPP)..... 62
  - Recovery Support..... 68
  - SOAR..... 71
  - Supported Employment-Extended Services (ES).....74

Professional Partner Program (PPP) Appendix.....78

General Service Limitations..... .96

- Specific Service Limitations.....96

DBH-Only Medical and Therapeutic Leave..... 96

- Specific Service Limitations..... 96

DBH Services Fee Code Guide..... 99

Shared Service Definitions

Medicaid and DBH Shared Service Definitions can be found in the MLTC Provider Manual of Mental Health, Substance Use, and Applied Behavior Analysis Service.

- **Crisis Services**
  - Crisis Psychotherapy..... *MLTC Service Definition Manual*
  - Crisis Stabilization..... *MLTC Service Definition Manual*
  - Emergency Psychiatric Observation..... *MLTC Service Definition Manual*
  - Supervised Detoxification (Social Detox)..... *MLTC Service Definition Manual*

- **Assessments**
  - Initial Diagnostic Interview..... *MLTC Service Definition Manual*
  - Initial Diagnostic Interview Addendum..... .. *MLTC Service Definition Manual*
  - Substance Use Disorder Assessment..... *MLTC Service Definition Manual*
  - Substance Use Disorder Assessment Addendum..... *MLTC Service Definition Manual*
  - Family Assessment.....*MLTC Service Definition Manual*
- **Clinic and Community-Based Services**
  - Assertive Community Treatment (ACT)..... *MLTC Service Definition Manual*
  - Certified Peer Support Services..... *MLTC Service Definition Manual*
  - Community Support..... *MLTC Service Definition Manual*
  - Medication Management..... *MLTC Service Definition Manual*
  - Opioid Treatment Program (OTP).....*MLTC Service Definition Manual*
  - Psychotherapy-Individual, Group, and Family..... *MLTC Service Definition Manual*
- **Partial Outpatient Services**
  - Day Rehabilitation.....*MLTC Service Definition Manual*
  - Day Treatment..... .....*MLTC Service Definition Manual*
  - Intensive Outpatient.....*MLTC Service Definition Manual*
- **Residential Services-MH**
  - Psychiatric Residential Rehabilitation.....*MLTC Service Definition Manual*
  - Psychiatric Residential Treatment Facility.....*MLTC Service Definition Manual*
  - Therapeutic Group Home.....*MLTC Service Definition Manual*
  - Secure Psychiatric Residential Treatment.....*MLTC Service Definition Manual*
- **Residential Services-SUD**
  - ASAM 3.1-Adult SUD Clinically Managed Low-Intensity Residential Treatment.....*MLTC Service Definition Manual*
  - ASAMA 3.1-Adult SUD Therapeutic Community.....*MLTC Service Definition Manual*
  - ASAM 3.1-Adult SUD Intermediate Therapeutic Residential Treatment (Co-occurring Capable) ....*MLTC Service Definition Manual*
  - ASAM 3.5-Adult SUD Co-occurring Enhanced Residential.....*MLTC Service Definition Manual*
  - ASAM 3.5 Adult SUD Dual-Disorder Residential Treatment (Co-occurring Enhanced)..... .....*MLTC Service Definition Manual*
- **Inpatient Services**
  - Acute and Subacute Inpatient Psychiatric Hospitalization.....*MLTC Service Definition Manual*
  - ASAM 3.7-Medically Monitored Inpatient Withdrawal..... ..*MLTC Service Definition Manual*

For additional information, please reference the DBH Network Operations Manual.

Mental Health and Substance Use Disorder Services

General Definitions:

Adult Services: Services provided to individuals 21 years of age or older*

Annually: Per state fiscal year (July 1 – June 30th)

ASD: Autism Spectrum Disorder

Caregiver: A family member, friend or neighbor who provides unpaid assistance to a Medicaid recipient

Collateral Contact: Contacts which occur outside the provider organization without the beneficiary present and are related to the beneficiary's individual treatment, rehabilitation, and recovery plan

Continually Engaged in Treatment: Continuous engagement in mental health or substance use disorder treatment is defined as an individual who has ongoing participation in treatment and has attended at least one appointment in the past three calendar months

Daily-Once per 24-hour period between 12:00am and 11:59pm.

Dual Diagnosis: The condition of having a diagnosis of both a mental health disorder and a substance use disorder at the same time

EPSDT: Early and Periodic Screening, Diagnostic and Treatment

IDD: Intellectual or Developmental Disability

In-Person: A visit in which the provider is in the same physical space as the member while services are provided

Institution for Mental Disease (IMD). An institution for mental disease (IMD) is defined as an entity with more than 16 beds that primarily provides inpatient or residential treatment for beneficiaries with mental diseases, according to federal regulations

Licensed Clinicians: Individuals who hold an active license to practice medicine, nursing, psychology, applied behavior analysis, mental health or substance use disorder treatment. Licensed clinicians must meet the qualifications outlined in this document. Licensed clinicians must operate within their professional competencies, including documented training or experience in applied behavior analysis, or mental health or substance use disorder treatment as appropriate. Licensed clinicians may only include:

- Psychiatrist

- Physician
- Psychologist
- Provisionally licensed psychologist
- Advanced practice registered nurse (APRN)
- Physician Assistant (PA)
- Licensed Independent Mental Health Practitioner (LIMHP)
- Licensed Mental Health Practitioner (LMHP)
- Provisionally Licensed Mental Health Practitioner (PLMHP)

If providing treatment for substance use disorders only, licensed clinicians may also include:

- Licensed alcohol and drug counselor (LADC)
- Provisionally licensed alcohol and drug counselor (PLADC)

Medical Necessity: Mental health, substance use disorder, and applied behavior analysis services must be provided in accordance with the medical necessity guidelines outlined in 471 NAC 1-002.02A

Medication Management: Medication management is the service provided by a physician, physician assistant (PA), or advanced practice registered nurse (APRN) focused on the monitoring and prescribing of psychopharmacologic agents

Non-Licensed Staff: Individuals who do not hold an active license to practice medicine, psychology, nursing, mental health or substance use disorder treatment

Hospital Outpatient: An outpatient is defined as a person who has not been admitted as an inpatient but is registered on the hospital records as an outpatient and receives services, rather than supplies alone

Professional Competencies: Knowledge, skills, and abilities that enable licensed clinicians and unlicensed staff to provide effective, ethical, and skillful care in a specialized area of care, such as substance use treatment. Providers must be able to demonstrate professional competency through documentation of education or experience in a subject area

Supervision: Supervision by the supervising practitioner is defined as the critical oversight of a treatment activity or course of action that is intended to ensure quality care and promote professional development of the supervised practitioner

Serious Mental Illness (SMI): Individuals with serious mental illness are defined as individuals that meet the following criteria:

1. A Diagnostic and Statistical Manual of Mental Disorders (DSM) (current edition) diagnosis consistent with a long standing serious and persistent mental illness with

symptoms of sufficient severity and duration that it is expected to cause significant, ongoing, disabling functional impairments. These impairments are beyond the scope of the person's informal support system to remediate and require professional assistance to guide the individual to recovery

2. Persistent mental illness as demonstrated by the presence of the disorder for the last 12 months or which is expected to last 12 months or longer and will result in a degree of limitation that seriously interferes with the individual's ability to function independently in an appropriate manner in two of three functional areas:

    a. Activities of Daily Living: Inability to consistently perform the range of practical daily living tasks for basic adult functioning in three of five of the following:

        i. Grooming, hygiene, washing clothes, meeting nutritional needs
        ii. Care of personal business affairs
        iii. Transportation and care of residence
        iv. Procurement of medical, legal, and housing services, or
        v. Recognition and avoidance of common dangers or hazards to self and possessions

    b. Vocational/Education:

        i. Inability to be employed or an ability to be employed only with extensive supports
        ii. Deterioration or decompensation resulting in inability to establish or pursue educational goals within normal time frame or without extensive supports, or
        iii. Inability to consistently and independently carry out home management tasks

    c. Social skills:

        i. Repeated inappropriate or inadequate social behavior or ability to behave appropriately only with extensive supports
        ii. Consistent participation in adult activities only with extensive supports or when involvement is mostly limited to special activities established for persons with mental illness, or
        iii. History of dangerousness to self/others

Upon Admission: Immediately as an individual is admitted to the facility

Week: A period of seven days, beginning on Sunday and continuing through the following Saturday

Youth Services: Services provided to individuals 20 years of age or younger*

*Nebraska covers all medically necessary services needed to correct and ameliorate health conditions for EPSDT youth age 20 and younger, regardless of the age of service noted in this manual. Requirements for coverage of EPSDT services are outlined in [NAC 471, chapter 33: Health Check (Early Periodic Screening, Diagnosis and Treatment [EPSDT] Services)/ EPSDT provider manual section].

General Provider Requirements

To participate in DHHS-Division of Behavioral Health (DBH) services, mental health and substance use providers must comply with all applicable provider participation requirements in Title 206 of the Nebraska Administrative Code (NAC) for Behavioral Health Services.

All licensed and non-licensed individuals providing mental health and substance use disorder services must be enrolled with Nebraska Medicaid.

To participate in Nebraska Medicaid, providers of mental health, substance use, and applied behavior analysis services must comply with all applicable provider participation requirements codified in Title 471 Nebraska Administrative Code (NAC) 2 and 3. In the event provider participation requirements in Title 471 NAC 2 or 3 conflict with requirements outlined in 471 NAC 20, 32, or 35 the individual provider participation requirements in 471 NAC 20, 32, or 35 will govern.

Enrollment

All licensed and non-licensed individuals providing mental health and substance use disorder services must be enrolled with Nebraska Medicaid. Providers who are located in a state other than Nebraska must also be enrolled with Medicaid in the state where they are located.

Medicaid should serve as the payor for all Medicaid-eligible individuals, and DBH will always be considered the payor of last resort.

Provider Certification and Accreditation

Mental Health Substance Abuse Treatment Centers (MHSATCs) must be licensed by the DHHS Division of Public Health and accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF), the Joint Commission (TJC), or the Council on Accreditation (COA), and accredited to provide the level of care applicable to the services they provide as required by DHHS Division of Medicaid and Long-Term Care (MLTC) and the DHHS Division of Behavioral Health (DBH).

Accreditation

In order to meet accreditation requirements, providers must meet network requirements as outlined in the Network Operations Manual (NOMS) and Medicaid and Long-Term Care (MLTC) accreditation requirements.

Providers who are enrolled with Medicaid and DHHS Division of Behavioral Health as one of the following provider enrollment types must be licensed by the DHHS Division of Public Health and accredited by TJC or AoA and must be accredited to provide the level of care applicable to this service as required by DHHS Division of Medicaid and Long-Term Care (MLTC) and the Division of Behavioral Health (DBH):

- Hospital
- Hospital Clinic

Providers who are enrolled with Medicaid and DHHS Division of Behavioral Health must be accredited by CARF, TJC, or COA, and accredited to provide the level of care applicable to the services they provide as required by DHHS Division of Medicaid and Long-Term Care (MLTC) and the DHHS Division of Behavioral Health:

- Professional Clinic
- Assertive Community Treatment
- Community Support

Licensure Requirements

All providers subject to licensure must be appropriately licensed by the DHHS Division of Public Health, as required by the DHHS Division of Medicaid and Long-Term Care (MLTC) and the DHHS Division of Behavioral Health, and must maintain current licensure.

All providers subject to certification must be appropriately certified by the DHHS Division of Public Health, the DHHS Division of Behavioral Health, or the appropriate certifying entity, and must maintain current certification.

All providers who bill Medicaid and DHHS Division of Behavioral Health services must ensure that their staff meets the requirements outlined in this document.

All licensed and non-licensed staff providing mental health, substance use disorder, or applied behavior analysis services must:

1. Work within their scope of practice to provide treatment

2. Have documented training in rehabilitation, recovery principles, and trauma-informed care
3. Have documented training in cultural competence
4. If providing treatment for individuals diagnosed with substance use disorder: Have documented training in the biopsychosocial dimensions of substance use disorder

Supervision Requirements

Supervision is a process in which the supervisor participates with supervisees to ensure quality of clinical care and professional development. Supervision is not a billable service for mental health and substance use disorder services.

All licensed and non-licensed staff who are not eligible to practice independently under Nebraska state law must be supervised. The supervising provider must be:

1. Currently licensed and eligible to practice independently under Nebraska state law
2. Currently enrolled with Nebraska Medicaid and an entity contracted with the DHHS Division of Behavioral Health network and eligible to provide Medicaid and DHHS Division of Behavioral Health services
3. Eligible to provide supervision to the supervisee under Nebraska state law and this document
4. Within their professional competencies to prescribe and oversee the service being provided

Supervision entails:

1. Oversight of treatment activity and course of action
2. Review of each individual's treatment plan and progress notes
3. Individual-specific case discussion
4. Periodic assessments of the individual
5. Diagnosis, treatment intervention or issue-specific discussion

When applicable, the supervisor's involvement must be reflected in the Initial Diagnostic Interview, the treatment plan, and the documentation of interventions provided.

Supervision of Initial Diagnostic Interviews

Licensed and provisionally licensed clinicians who are eligible to complete Initial Diagnostic Interviews (IDI) in consultation with an independently licensed clinician include:

- Licensed mental health practitioner (LMHP)
- Provisionally licensed mental health practitioner (PLMHP)
- Provisionally licensed psychologist

- Specially licensed psychologist

The consulting clinician must be one of the following:

- Physician
- Psychologist
- Licensed Independent Mental Health Practitioner

When an IDI is performed by a clinician listed above, the following requirements must be met in order to bill for the Initial Diagnostic Interview:

- The IDI must be performed in consultation with an independently licensed clinician, who functions as a consultant clinician in accordance with the requirements outlined in this document, and the requirements of the DHHS Division of Public Health, Licensure Unit
- The consultant clinician must be licensed in Nebraska and enrolled with Nebraska Medicaid and DHHS Division of Behavioral Health
- The consultant clinician must be immediately available to furnish assistance and direction, either face-to-face or via telehealth, and show evidence of supervision by signing the IDI.
- The clinician who is performing the IDI must be able to demonstrate one of the following:
    - That they are an employee of the consultant clinician
    - That they are an employee of the legal entity that employs the consultant clinician
    - That they have a formal, documented supervision arrangement with the consultant clinician

Medical and Clinical Directors

Medical directors and clinical directors take clinical responsibility for care provided and are essential elements to ensure program fidelity and accordance with national best practices. Medical and clinical directors are expected to be in-person at each program to provide medical and clinical oversight. Each service outlines medical and clinical director requirements specifically to the program's focus area and acuity.

Medical and Clinical Directors in mental health or substance use treatment centers must have experience and education in the treatment of mental health disorders, substance use disorders, or both, as appropriate to the treatment provided by the facility. Clinical directors in programs working with ASD or IDD treatment must have experience and education in the treatment of ASD or IDD, or both.

Clinical Directors must provide consultation and support to all program staff and the individuals served and are responsible for all clinical decisions. The Clinical Director must continually incorporate new clinical information into the program to assure program effectiveness and viability, ensure accurate organization and management of clinical records, and other program documentation.

Medical Director Requirements

Medical Directors must be able to dedicate sufficient daily and weekly time to the program to ensure medical oversight. Depending on the size of the program, they may also serve as the clinical director.

Geographically Deprived Areas:

A geographically deprived area is an area where a medical director with the appropriate specialization for the program is not available in the community, or within a reasonable driving distance of the community, to provide services. For mental health programs, this includes board-certified psychiatrists or psychiatric APRNs. For substance use programs, this includes physicians or APRNs with board certification in addiction medicine or equivalent substance use-related board certification.

In geographically deprived areas, a physician or APRN who is qualified, skilled, and experienced in the diagnosis and treatment of substance use or mental health disorders, as appropriate to the program, may serve as an alternative. A resume detailing the physician or APRN's mental health or substance use disorder education and experience must be submitted to and approved by Nebraska Medicaid prior to beginning medical director duties. The physician or APRN is subject to all policy requirements outlined for psychiatrists and APRNs, respectively. Services and oversight provided by the physician or APRN must not exceed six months without documented consultation between the physician or APRN providing the service and a psychiatrist, psychiatric RN, or physician or APRN with board certification in addiction medicine or equivalent, as appropriate to the service.

Request for telehealth exceptions to Medical Director requirements:

If a residential or inpatient treatment program cannot identify an in-person medical director who meets the requirements outlined in this manual, exceptions to allow a medical director to provide services via telehealth must be requested through the Division of Medicaid and Long-Term Care (MLTC) and approved by the director. Exceptions will be filed with the department and must be renewed yearly.

To request an exemption, the provider must provide:

- The reason for requesting the exemption

- Documentation showing that the requested telehealth provider meets the requirements for the position as outlined in this manual
- A copy of a formal contract with the requested telehealth provider, including requirements that the provider dedicate sufficient daily and weekly time to the program to ensure medical and clinical oversight, and that they can be present in-person at the physical location of services at least 2 times per calendar year.
- A copy of a formal contract with an MD or APRN who is located within 30 minutes of the physical location where services are provided, who will respond in-person in the case of medical emergencies or urgent clinical need
- Documentation that there is sufficient medical staff available on-site (RN or LPN) to ensure safety and medical oversight of the program

Program Staffing and Ratios

For all services, providers must have sufficient staff on-site or on call during their hours of operation (24/7 in residential and inpatient programs) to maintain integrity of care for the range and severity of problems that may be addressed within the service. Providers must meet required staffing ratios as outlined in each service definition, determine the level of staffing needed to safely operate the program, and follow requirements from the DHHS Division of Public Health as applicable. Staffing ratios are listed for each service in the "staffing ratio" section of the service description.

Specific Provider Requirements

Licensed Clinicians

All licensed clinicians must have current licensure in Nebraska and be enrolled with Nebraska Medicaid and DHHS-DBH.

Advanced Practice Registered Nurse (APRN)

Supervision required: no supervision required after completion of a transition-to-practice agreement as required by Nebraska state law

	Minimum Requirements:
All Services	Psychiatric experience

Licensed Alcohol and Drug Counselor (LADC)

Supervision required: None

	Minimum Requirements:
All Services	• May provide services for substance use disorders only • Dual licensure as an LMHP or LIMHP is preferred
Youth Services	• Equivalent of one year of full-time work experience or graduate studies in direct child or adolescent services, ASD or IDD services

Provisionally licensed alcohol and drug counselor (PLADC)

Supervision required: Must be supervised by a Physician, Psychologist, or LADC

	Minimum Requirements:
All Services	• May provide services for substance use disorders only • Dual licensure as an LMHP or LIMHP is preferred
Youth Services	• Equivalent of one year of full-time work experience or graduate studies in direct child or adolescent services, ASD or IDD services

Licensed Independent Mental Health Practitioner (LIMHP)

Supervision required: None

	Minimum Requirements:
All Services	If providing treatment for individuals diagnosed with substance use disorder, dual licensure as an LADC is preferred
Youth Services	Equivalent of one year of full-time work experience or graduate studies in direct child or adolescent services, ASD or IDD services

Licensed Mental Health Practitioner (LMHP)

Supervision required: None

	Minimum Requirements:
All Services	If providing treatment for individuals diagnosed with substance use disorder, dual licensure as an LADC is preferred
Youth Services	Equivalent of one year of full-time work experience or graduate studies in direct child or adolescent services, ASD or IDD services

Provisionally Licensed Mental Health Practitioner (PLMHP)

Supervision required: Must be supervised by a Physician, Psychologist, LIMHP, or LMHP

	Minimum Requirements:
All Services	If providing treatment for individuals diagnosed with substance use disorder, dual licensure as an LADC is preferred
Youth Services	Equivalent of one year of full-time work experience or graduate studies in direct child or adolescent services, ASD or IDD services

Licensed Practical Nurse (LPN)

Supervision required: Must be supervised by a Physician, APRN, or RN

	Minimum Requirements:
All Services	Experience or education in the treatment of mental health disorders preferred

Physician (MD or DO)

Supervision required: None

	Minimum Requirements:
All Services	Board certified or board eligible psychiatrist preferred
ABA Assessment	Must have specific training and expertise in Applied Behavior Analysis

Physician Assistant (PA)

Supervision required: Must be supervised by a Physician

	Minimum Requirements:
All Services	Experience or education in the treatment of mental health disorders preferred

Psychologist

Supervision required: None

	Minimum Requirements:
All Services	No requirements beyond licensure
ABA Assessment	Must have specific training and expertise in Applied Behavior Analysis

Provisionally licensed psychologist:

Supervision required: Must be supervised by a psychologist

	Minimum Requirements:
All Services	One year of supervised professional experience

Psychologist associate, psychologist assistant, specially licensed psychologist

Supervision required: Must be supervised by a psychologist

	Minimum Requirements:
All Services	Must be registered with the Nebraska Department of Health and Human Services, Division of Public Health

Specially licensed psychologist

Supervision required: Must be supervised by a psychologist

	Minimum Requirements:
All Services	No requirements beyond licensure

Psychiatrist

Supervision required: None

	Minimum Requirements:
All Services	Physician (MD or DO) who is a board-certified or board-eligible psychiatrist

Registered Nurse (RN)

Supervision required: None

	Minimum Requirements:
All Services	Experience or education in the treatment of mental health disorders preferred

NON-LICENSED STAFF

Care Coordinator (in Preferred Partner Program)

Supervision required: Must be supervised by a Licensed or Provisionally Licensed Psychologist, APRN, NP, Psychiatrist, LIMHP, LMHP, or PLMHP.

.

	Minimum Requirements:

PPP services	• Background checks completed
	• Have a minimum of a bachelor's degree in a human service-related field or equivalent field experience
	• A minimum of 4 contact hours of orientation/training in topics that may include, but are not limited to:
	  ○ program policies and procedures
	  ○ wraparound process and fidelity procedures
	  ○ goal setting and objective writing
	  ○ suicide screening/prevention, tools, and crisis intervention techniques
	  ○ boundaries and ethics
	  ○ youth behavioral health
	• A minimum of 40 hours of core training and shadowing experience including, at not limited to:
	  ○ the wraparound process, fidelity procedures, and the WFI tool
	  ○ screening/enrollment/discharge procedures
	  ○ confidentiality and ethics
	  ○ youth mental health/ substance use
	  ○ CAFAS/PECFAS and other tool utilization
	  ○ POC development
	  ○ crisis/safety planning
	  ○ family-centered practice
	• At least 12 continuing education hours completed every 2 years from start date of employment. Topics may include, but are not limited to:
	  ○ cultural competency

	○ diagnostic health/therapeutic interventions for youth ○ wraparound, trauma ○ evidence-based practices IEP process

Certified Peer Support Specialist

Supervision required: Must be supervised by a Physician, Psychologist, APRN, PA, LIMHP, or LMHP. May be supervised by a LADC if providing substance use services only

	Minimum Requirements:
All Services	• High school diploma or equivalent and one of the following: ○ Two years of coursework in a human service field, or ○ Two years of work experience in a human service field, or ○ Combination of work experience and education in a human service field, with one year of education substituting for one year of experience, or ○ Two years of lived recovery experience with demonstrated skills in treatment of individuals with a behavioral health diagnosis • Complete a Nebraska training program, with 60 hours or more training, and pass the certification exam to obtain Nebraska certification as a Certified Peer Support provider • Maintain Nebraska certification by completing continuing education requirements as identified by the certifying organization. The supervising practitioner assumes professional responsibility for the services provided by the Certified Peer Support provider

Community support worker

Supervision required: Must be supervised by a Physician, Psychologist, APRN, PA, LIMHP, or LMHP. May be supervised by a LADC if providing substance use services only

	Minimum Requirements:
All Services	• High school diploma or equivalent and one of the following: ○ Two years of coursework in a human service field, or ○ Two years of work experience in a human service field, or ○ Combination of work experience and education in a human service field, with one year of education substituting for one year of experience, or ○ Two years of lived recovery experience with demonstrated skills in treatment of individuals with a behavioral health diagnosis

Direct care staff

Supervision required: Must be supervised by a Physician, Psychologist, APRN, PA, LIMHP, or LMHP. May be supervised by a LADC if providing substance use services only

	Minimum Requirements:
All Services	• High school diploma or equivalent and one of the following: ○ Two years of coursework in a human service field, or ○ Two years of work experience in a human service field, or ○ Combination of work experience and education in a human service field, with one year of education substituting for one year of experience, or ○ Two years of lived recovery experience with demonstrated skills in treatment of individuals with a behavioral health diagnosis

General Service Requirements

All providers of services described in this document are subject to the following requirements:

Crisis Assistance

Crisis assistance must be available to all individuals served 24 hours a day, 7 days a week. If a provider is not able to provide access to 24/7 crisis services, they may refer individuals to telephonic, text, and chat crisis intervention call centers that meet 988 Suicide & Crisis Lifeline standards for risk assessment and engagement of individuals at imminent risk of suicide. The resources provided and a plan for access must be included in the individual's Individualized Treatment, Rehabilitation and Recovery Plan.

Provider Competencies and Trauma-Informed Care

All services must be trauma-informed, and providers should have training and competencies in effectively delivering services that meet the social, developmental, cultural, and linguistic needs of patients. Staff should receive appropriate training and demonstrate the ability to effectively interact with people across different cultures and backgrounds.

Treatment environments and procedures should be adjusted and adapted to account for an individual's symptoms or sensory sensitivities as needed, such as lighting, sound, and touch preferences.

Documentation

All documents submitted to Nebraska Medicaid and DHHS Division of Behavioral Health must contain sufficient information for identification of the member and provider. Additional documentation from the clinical record may be requested prior to considering authorization of payment so that determination of medical necessity or indication of active treatment can be objectively verified.

The beneficiary's clinical record must include:

Assessments and Diagnosis

Copies of all required assessment reports that have been completed with documentation of the individual's diagnosis, rationale for that diagnosis, and intervention recommendations.

Assessments must contain timely information on patient diagnosis and symptoms in order to recommend the appropriate level of care for the individual, including clinical justification and criteria. To ensure that treatment is based on accurate and timely information, patients should be reassessed regularly via treatment plan reviews and periodic repeated assessments and assessment addendums to track progress and determine any diagnostic changes. Reassessments also inform treatment plan reviews and guide updates to the treatment plan. Treatment plan review and reassessments should be used along with continued stay and discharge criteria to determine whether an individual needs treatment at a more or less intensive level of care, or whether continued treatment at their current level of care is appropriate.

For individuals receiving treatment for substance use disorders, level of care assessments should be administered and regularly updated to identify treatment needs across all appropriate ASAM dimensions.

Coordination of Care

The clinical record must contain documentation verifying any coordination with other treating providers, including when more than one provider is involved with the individual and family, or when referrals are made to other providers for medical, psychological, and psychopharmacology needs.

Discharge Planning and Transition Plans

Discharge plan

Discharge planning should begin at the onset of treatment and is an ongoing process throughout the duration of service. The transition plan must be strengths-based, person-centered, recovery-

oriented, and trauma-informed. The discharge plan must be documented in the individual's record. The discharge plan must:

- Begin on admission and be updated on an ongoing basis with the direct and active participation of the individual, as well as family, guardians, or other supports, as authorized by the individual.
- Be a component of the Individualized Treatment, Rehabilitation, and Recovery plan and be consistent with the goals and objectives identified with the direct and active participation of the individual, family, or legal guardian as appropriate and authorized by the individual.

Transition plan

The transition plan (formerly Discharge Summary) must be developed with the individual's input and must include family, guardians, or other supports, if appropriate and authorized by the individual. If the individual is unable to participate in the development of the plan (e.g. due to administrative discharge), the lack of participation and reason must be included in the transition plan documentation. The individual's involvement with discharge planning should be appropriate to their age and ability, and providers may need to adapt their communication strategies to meet the individual's needs, including visual aids, clear and concise language, or alternative communication methods for those with speech and language difficulties.

The transition plan must be documented in the individual's clinical record and contain the signature of the staff who wrote the plan, the supervising clinician, and the date of signatures. The transition plan must:

1. Be provided within the time frame specified in the program's policies and procedures, which considers the prompt transfer of clinical records and information to ensure continuity of care
2. Provide a narrative summary of services provided
3. Document the individual's progress in relation to the individual's treatment, rehabilitation, and recovery plan, addressing recovery-oriented goals identified by the individual and how strengths have been utilized
4. Describe the reason(s) for discharge
5. Document referral information, and
6. Include recommendations and/or arrangements not limited to:
    a. Any ongoing treatment and rehabilitative service needs
    b. Accessing and using medication
    c. Accessing physical health care
    d. Employment
    e. Transportation

7. Be made available to Nebraska Medicaid or DHHS Division of Behavioral Health or delegate as requested in order to facilitate case management and coordination of care.

Family and Community Involvement

The individual's family, guardians, or other supports must be offered the opportunity to participate in the individual's treatment (assessment, treatment and recovery planning, psychotherapy and discharge planning), if appropriate and authorized by the individual. This participation or lack of participation must be documented in the individual 's clinical record.

Progress notes

Each clinical record must contain a chronological record of all mental health, substance use disorder, or applied behavior analysis services provided to the individual, the date performed, the duration of the session (including session start and end times), and the staff member who conducted the session. Progress notes must document implementation of the individual's treatment, rehabilitation, and recovery plan. Progress notes must be completed within the time frame specified in the program's policies and procedures and document the unit(s) provided to the individual. Progress notes must:

- Include the date, place, and modality of the service (e.g., in-person, telehealth).
- Substantiate each service(s) provided through narrative description, including a summary of activities and interventions delivered during the service
- Include an accurate start and end time for the service
- Indicate how services provided relate specifically to goals and priorities identified in the individual's treatment, rehabilitation, and recovery plan
- Document the individual's participation in the service, and revision of goals and treatment activities as needed
- Periodically, the progress note should document collaborative review of progress measures and their patterns over time, directly with individuals to ensure care remains aligned with their goals, supports shared decision-making, and promotes meaningful progress toward improved well-being. These periodic measures of person-focused progress tracking should be standardized reports of symptom burden and/or functional status from the individual or their guardian.

Medications

A chronological account of any medications prescribed, the name, dosage, and frequency to be administered, and the individual's response.

Treatment Planning

Initial treatment plan

The initial treatment plan is an individualized, preliminary plan that addresses the short-term goals the program plans to achieve during the period from admission to completion of the Individualized Treatment, Rehabilitation, and Recovery Plan. The initial treatment plan shall be in effect until the Individualized Treatment, Rehabilitation, and Recovery Plan has been developed. If an initial diagnostic interview or substance use disorder assessment has been completed within three months prior to admission, and is determined to be relevant to the service provided by the admitting clinician, the recommendations from these assessments may serve as the initial treatment plan.

Individualized Treatment, Rehabilitation, and Recovery Plan

The Individualized Treatment, Rehabilitation, and Recovery Plan must be developed with the individual and must include family, guardians, and other supports as appropriate and authorized by the individual. Each record must contain an Individualized Treatment, Rehabilitation, and Recovery Plan that is recovery-oriented for all services provided based on the individualized and person-centered assessment of the individual and the requirements of this manual.

Treatment plan recommendations must be in accordance with the results of diagnostic interviews, testing, and assessments performed. Regular, thorough reviews of the individual's progress, including documentation of progress and revision of goals as needed, must occur on a regular schedule, as outlined in each service-specific definition in this manual. These reviews do not require a full reassessment of an individual and must occur regardless of insurance authorization period.

The individual's involvement with treatment planning should be appropriate to their age and ability, and providers may need to adapt their communication strategies to meet the individual's needs, including visual aids, clear and concise language, or alternative communication methods for those with speech and language difficulties.

This plan must:

1. Be oriented to and apply the principles of recovery, including but not limited to inclusion, direct and active participation, and a meaningful life in the community of one's choosing
2. Incorporate and be consistent with best practices
3. Include the individual's individualized goals and expected outcomes in their own words if possible
4. Contain prioritized objectives that are measurable and time-limited

5. Describe therapeutic interventions that are trauma-informed, person-centered, strength-based, and recovery-oriented
6. Identify staff responsible for implementing the therapeutic interventions
7. Specify the planned amount, frequency, and duration of each therapeutic intervention
8. Delineate the specific criteria to be met for discharge or transition to a lower level of care
9. Include a component to avoid crises or admission to a higher level of care using principles of recovery and wellness, including 24/7 crisis resources
10. Document that the individual treatment, rehabilitation, and recovery plan is completed within the time frame specified in Nebraska Medicaid and DHHS Division of Behavioral Health regulations and this manual
11. Document that the plan has been developed, reviewed, updated, and revised with the direct and active involvement of the individual and their parents or guardians, as appropriate and authorized by the individual. If documentation shows that the individual is not achieving their goals, timely revision of the plan must be documented
12. Include the signature of the individual or guardian, or both, to indicate agreement with the plan. If the individual served is under the age of 18, the plan must be signed by a parent or guardian
13. Be approved and signed by the licensed clinician or supervisor if provisionally licensed

Medication Management and Administration

Medication management:

Medication management includes the prescribing and monitoring of medications and is not required unless indicated in the definition in this manual for the service being provided. If medication management is listed as a required component of the service, it must follow the guidelines outlined in the medication management definition in this manual and may not be reimbursed separately.

Medication administration:

Medications must be administered under the supervision of an RN, or an LPN under RN supervision. Staff without a medical or nursing license who administer medications must hold a current Medication Aide certification from the DHHS Division of Public Health.

Nursing assessment and Physical Examination

Nursing assessments are not required unless indicated in the definition in this manual for the service being provided. If required, a nursing assessment must include the following elements

and must be documented in the individual's clinical record and contain the signature of the nurse and date of signature.

Nursing Admission Assessment Summary

1. Past medical and psychiatric history: Prior hospitalizations, major illnesses, and surgeries
2. Assess pain: Location, severity, and use of a pain scale
3. Allergies: Medications, foods, and environment; nature of the reaction and seriousness; intolerances to medications
4. Medications: Confirm accuracy of the list, names, and dosages of medications, including supplements and over-the-counter medications
5. Activities: Check functional abilities (ADLs) and need for assistive equipment.
6. Falls and general risk assessment
7. Psychosocial: Identify any signs of agitation, restlessness, hallucinations, depression, suicidal ideation, or substance use- may require a more focused assessment
8. Nutrition: Appetite, changes in body weight, any nutritional needs
9. Vital signs: Temperature, heart rate, respiratory rate, blood pressure, pain level on admission, oxygen saturation
10. Any handoff information from other departments or agencies

Physical Examination

11. Cardiovascular: Heart sounds; pulse regularity, presence of swelling, edema, or cyanosis
12. Respiratory: Breath sounds, breathing pattern, cough, dyspnea on exertion
13. Gastrointestinal: Bowel sounds, abdominal tenderness, any masses, bowel movements, nausea, vomiting, abdominal pain
14. Genitourinary: Identify any voiding issues, for females any menstrual issues (if applicable)
15. Neuromuscular: Level of consciousness; speech clarity; pupil reactivity and appearance; extremity movement equal or unequal; steady gait; trouble swallowing
16. Integument: general skin condition, any signs of skin breakdown, acute or chronic wounds

"Providing Access"

Providers must facilitate access to outside treatment, including Medication Assisted Treatment (MAT) and physical examinations. This should not be interpreted to mean that every provider must offer MAT and physical examinations. Providing access means investigating whether the individual has a need for the service or is already participating in the service (in the case of MAT) and ensuring that the individual can access that service.

MAT: Providers must not deny admission to an individual due to participation in MAT services. Residential providers should assist with arranging transportation to MAT appointments while the individual is participating in the program.

Physical examinations: Providers should ask individuals about their physical health and whether they have had a recent examination. If the individual reports that they have not had an exam in the past 12 months, providers should assist the individual with accessing physical health care services.

The extent of the assistance provided may vary as appropriate to the service – e.g., outpatient therapists may provide resources; providers of case management or residential services should assist with identifying a provider, scheduling the appointment, and identifying or providing transportation. Where more extensive involvement is required, it is specified in the service requirements. Providers should collaborate with the individual to identify the amount of assistance needed based on the individual's skill and severity of need.

Individuals may refuse to provide information on MAT or physical examinations or may refuse to allow a provider to assist with access. In these cases, the provider should document the attempt and refusal.

Psychoeducational groups

Psychoeducational groups are informative sessions led by licensed clinicians, nurses, or direct care staff operating within their professional competencies that promote knowledge, skill development, and support in an interactive group setting. Psychoeducational groups must provide education, skill development, or support that is relevant to the individual's diagnoses and symptoms, and oriented towards one of the following areas:

- Mental health or substance use disorder diagnoses and symptoms
- Mental health or substance use disorder treatment strategies
- Crisis intervention planning
- Positive coping strategies and symptom management
- Wellness and recovery tools
- Self-help or support groups
- Substance use education
- Community resources and navigation
- Family dynamics and healthy relationships
- Positive leisure and recreational activities
- Vocational or educational resources
- Social skills and healthy communication
- Physical health and nutrition
- Independent living skills
- Medication education

Psychoeducational groups must be provided under the supervision of a licensed clinician. Groups must be face-to-face, and may be provided by licensed clinicians, nurses (RN or LPN under RN supervision), or direct care staff as appropriate to their education, experience, and professional competencies. Medication education, if provided, must be provided by a pharmacist, physician, APRN, RN, or LPN under RN supervision.

Psychotherapy Treatment Models

All psychotherapy treatments and interventions must identify a specific model and process and document reasonable fidelity to the validated process related to that model of psychotherapy.

Play, art, or music therapy or eye movement desensitization and reprocessing (EMDR) may be provided when determined by a licensed practitioner to be clinically appropriate based on their professional competencies and medical necessity for the individual. Play, art, or music therapy, or EMDR may be incorporated as part of individual, family, or group psychotherapy sessions as a complementary element to other treatment models used during psychotherapy services. These treatment models may not be used as the sole model of treatment for an individual.

Providers of play, art, or music therapy, or EMDR, must be able to demonstrate, upon request, that they have documented training and competence in the chosen treatment model.

Setting

Allowable settings for services are outlined by category as defined below. The exact determination is based on the appropriateness of the environment and the services provided.

Institutions for Mental Disease (IMDs): Medicaid does not reimburse for services provided in IMDs except as outlined in Nebraska Administrative Code Title 471, Chapters 20, 32, and 35.

Definitions:

Home: Location, other than a hospital or other facility, where the patient receives care in a private residence.

- **Nursing facilities (NFs) and Assisted living facilities (ALFs):** services allowed in a home setting may be provided in an ALF or NF if the individual meets admission criteria for the service, unless the requirements in this manual specify they are disallowed in an ALF or NF setting

Hospital: An inpatient facility which provides medical and psychiatric services by, or under, the supervision of physicians

Community: A location other than a home that is not part of a hospital or residential treatment facility that is appropriate for the provision of outpatient services. Appropriateness should be determined by the treating clinician and include assessment of safety and access to privacy

Limitations: The following settings qualify as a community location only if they meet the criteria outlined below:

- **School**: Services allowed in a community setting may be provided in a school if they are non-duplicative of school services, and the requirements within this manual do not specify that they are disallowed in a school setting. Medicaid does not reimburse providers for educational services, or services that are the legal responsibility of school districts
- **Outpatient services provided by a hospital:** Hospitals billing outpatient psychiatry and psychology services must follow CMS coding guidelines for psychiatry and psychology services

Facility: A non-hospital facility that is not a skilled nursing facility which provides treatment to live-in residents who do not require acute medical care

Office or Clinic: A location that provides mental or physical health care on an outpatient basis. Includes services provided by an outpatient-only clinic that is part of a hospital.

Support Services

Providers are expected to assess individuals' needs for housing support and community resources, and refer to external supports as appropriate. The intensity of assistance varies by the level of service and is indicated in the Support Services section of each service definition. Individuals should be assessed at intake for housing and vocational needs, and these needs should be addressed at discharge.

Telehealth

Services which may be provided by telehealth are indicated on the MLTC Mental Health and Substance Use fee schedule, DHHS DBH's Fee Code Guide, and/or the CCBHC Fee schedule if the following criteria are met:

- Telehealth is provided in alignment with the requirements outlined in Nebraska Administrative Code Title 471, Chapter 47
- There is clinical documentation that the use of telehealth will adequately meet the needs of the individual as determined by the clinician

- The reason for the use of telehealth is documented and appropriate for the service. Lack of transportation, distance, and other barriers that affect access to services are an allowable reason for the use of telehealth
- Telehealth is not used solely for the convenience of the provider or the individual or caregivers or guardians
- There are documented plans in place to keep the individual's environment safe
- There are documented plans in place to ensure protection of patient privacy
- The individual or their caregiver or guardian has regular access to technology and a secure internet connection
- There are documented plans in place for access to in-person services in cases of crisis, or if telehealth is no longer meeting the needs of the individual
- Telehealth services are performed within ethical guidelines for each provider's professional competencies and license

If the fee schedule or coding guide does not indicate a telehealth option, then the service is not allowed via telehealth.

DBH-Service Specific Requirements

DHHS Division of Behavioral Health-Only Services

24-Hour Crisis Line

The 24-Hour Crisis Line is a dedicated telephone line that is available 24 hours a day, 7 days a week, 365 days a year. A live voice answers this line to assist callers in pre-crisis or crisis situations related to a behavioral health problem. The caller can be connected to a licensed behavioral health professional, law enforcement, and/or other emergency services, as needed. The goal is to ensure the caller's safety during distress that could lead to a life-threatening situation.

SERVICE CATEGORY	Mental health disorder, substance use disorder, or both
ALLOWABLE SETTINGS	May be provided in the following settings: • Office or Clinic
BILLING INFORMATION	Fee codes for this service are: • 24 Hour Crisis Line-MH • 24 Hour Crisis Line-SUD **Telehealth** This service is provided via phone.
ADMISSION CRITERIA	The individual must meet all of the following admission guidelines to be admitted to this service: • Verbal report of a current behavioral health pre-crisis or crisis situation • Verbal request for assistance in the pre-crisis or crisis situation • It is expected that the individual will be able to benefit from this service • This level of care is the least restrictive setting that will produce the desired results in accordance with the needs of the Individual
SERVICE REQUIREMENTS	**Assessments** • Perform brief screening of the intensity of the crisis situation **Support Services** • Work with the individual to immediately provide relief of the pre-crisis and crisis situations; reduce the risk of escalation of a crisis; arrange for emergency on-site responses when necessary; and refer to appropriate services when other or additional intervention is required • Provide access to a licensed behavioral health professional consultation, as needed • Establish collateral relationship with law enforcement and other emergency services • Advertise a 24-Hour Crisis Line throughout the Region

	• Provide free access to the 24-Hour Crisis Line • Provide language compatibility when necessary • Provide access to Nebraska Relay Service or TDD and staff appropriately trained on the utilization of the service
LENGTH OF SERVICE	Call continues until the individual agrees to safely resume their activities or emergency assistance arrives, or the caller voluntarily ends the call
STAFFING REQUIREMENTS	**Direct Care Staff**: sufficient to meet staffing ratios **Additional Requirements** • Must have an LMHP, LIMHP, Social Worker, Psychiatrist, Psychologist, or Nurse Practitioner on staff or a consultative agreement with • All program staff must be trained in crisis de-escalation interventions through a nationally accredited training program • Direct link to law enforcement and other emergency services • Personal recovery experience is preferred for all positions
STAFFING RATIO	Adequate staffing to handle call volume.
HOURS OF OPERATION	24 hours a day, 7 days a week, 365 days a year
CONTINUED STAY REQUIREMENTS	• The call continues until the pre-crisis or crisis is resolved, or a licensed behavioral health professional, law enforcement, or other emergency service is deemed necessary and arrives to assist and support, or the individual voluntarily ends the call
DESIRED INDIVIDUAL OUTCOME	• The individual experiences a reduction in distress and/or a reduction in risk of harm to self or others • The individual is referred to appropriate services

Emergency Community Support

Emergency Community Support helps individuals who need high levels of support due to an urgent behavioral health need. This service can support individuals who are at risk of losing their housing due to a behavioral health crisis, are unhoused, and/or are transitioning from a psychiatric hospital into a community setting. This service stabilizes individuals during a behavioral health crisis by providing case management, behavioral health referrals, assistance with daily living skills, and coordination among the Individual, their formal and informal support system, and behavioral health providers.

SERVICE CATEGORY	Mental health disorder, substance use disorder, or both
ALLOWABLE SETTINGS	• Community • Home
BILLING INFORMATION	Fee codes for this service are: • Emergency Community Support-MH

	• Emergency Community Support-SUD **Telehealth** This service is allowed via telehealth. See DBH Fee Code Guide.
ADMISSION CRITERIA	The individual must meet all of the following admission guidelines to be admitted to this service: • Currently experiencing a behavioral health crisis • At risk of needing a higher level of care if support is not provided • Individual demonstrates a need for support in coordinating treatment/recovery/rehabilitation options in the community • It is expected that the individual will be able to benefit from this service • This level of care is the least restrictive setting that will produce the desired results in accordance with the needs of the individual

SERVICE REQUIREMENTS	**Assessments**
	• Conduct a risk assessment including brief mental health status and develop a safety plan (such as the Stanley Brown safety plan) within 3 days of referral
	  ○ If the individual is hospitalized when referred, complete the risk assessment and safety plan within 3 days of their discharge from the hospital
	• Complete a strengths-based assessment with the individual within 14 days of referral
	
	Treatment Planning
	• An initial treatment plan must be developed within 5 days of admission for staff guidance and direction of service
	• Under clinical supervision, develop an individualized treatment, rehabilitation, and recovery plan, including a crisis prevention plan, with the individual within 14 days of admission
	• Clinical consultation on the individual's service plan must occur at least every 30 days
	
	Support Services
	• Direct contact, per month, is expected for all individuals as follows:
	  ○ For individuals transitioning from a hospitalization: A minimum of 4 direct contact hours and 2 indirect contact hours per month (totaling a minimum of 6 hours per month)
	  ○ For individuals not transitioning from a hospitalization: A minimum of 3 hours per month and 1 indirect contact hour per month (totaling a minimum of 4 hours per month)
	  ○ Documentation of rationale for not achieving either contact requirement (6 hours per month or 4 hours per month) should be documented in the individual's plan.
	• Provide assistance in initiating resources (such as SSI, housing, SNAP, and Medicaid), as needed

	• Education to individual/family/significant others with the individual's permission, as needed • Referrals to appropriate community-based behavioral health services and/or coordination to a lower, or higher, level of care as clinically indicated • Collaboration with psychiatric hospital and hospital emergency personnel, and community agencies, as needed • Arrange alternatives to psychiatric hospitalization, as needed **Discharge Planning** • Discharge planning is an ongoing process that occurs throughout the duration of service. A documented discharge plan must be completed upon admission as part of the initial treatment, recovery, and rehabilitation plan • A transition plan must be completed prior to discharge. A copy of the transition plan must be given to the individual and to providers at the individual's next level of care, as applicable
LENGTH OF SERVICE	Service continues until the initial behavioral health crisis is resolved and the individual is connected to behavioral health treatment, as needed. Less than 90 days
STAFFING REQUIREMENTS	**Program Director** Must have the following: • A bachelor's degree or higher in psychology, sociology, or a related human services field is required. A master's degree in the human services field is preferred • Demonstrated experience, skills, and competencies in behavioral health management **Direct Care Staff:** sufficient to meet staffing ratios **Additional Requirements** Access to consultation with licensed professional(s) in the fields of medicine, psychopharmacology, behavioral health, and program design, as needed
STAFFING RATIO	1 Staff: 15 Individuals
HOURS OF OPERATION	24 hours a day, 7 days a week, and provide crisis services 24 hours a day, 7 days a week, 365 days a year
CONTINUED STAY REQUIREMENTS	All of the following criteria must be met for continuing treatment at this level of care: • The acuity of the individual's symptoms continues to necessitate treatment at the current level of care based on admission criteria • The individual does not require a more intensive level of services and no less intensive level of care is appropriate • The individual's treatment plan is up to date, with targets that are appropriate and related to improvement in the individual's symptoms and achievement of their goals.

	• The individual is making progress towards rehabilitation goals, and they are showing progress towards symptom reduction as demonstrated by objective behavioral measurement of functional improvement or standardized report from the member or guardian of symptom and/or functional improvement. • If progress has not been made or symptoms have increased, the treatment plan has been modified to focus on any new symptoms or to address barriers to progress. • There is evidence that the treatment team is working towards a transition plan to meet the individual's treatment needs once this level of care is no longer appropriate.
DESIRED INDIVIDUAL OUTCOME	• The individual has substantially met the treatment, rehabilitation, and recovery plan goals and objectives • The precipitating condition has stabilized such that there is sustained improvement in the health and psychosocial functioning • The individual's condition can be managed without the professional external supports and interventions at this level of care • The individual has alternative support systems secured to help maintain active recovery and stability in the community • The individual is connected to the next appropriate level of care necessary to treat the condition

Hospital Diversion

Hospital Diversion is a peer-operated service designed to assist individuals in decreasing psychiatric distress that could lead to hospitalization. Hospital Diversion offers individuals the opportunity to take control of a crisis, or potential crisis, and develop new skills through a variety of traditional self-help and proactive tools designed to maintain wellness. Certified Peer Support Specialists provide contact, support, and/or referrals for services as requested during and after the stay and operate a Warm Line. Hospital Diversion settings are fully furnished for comfort.

SERVICE CATEGORY	Mental health disorder, substance use disorder, or both
ALLOWABLE SETTINGS	• Home • Facility
BILLING INFORMATION	Fee codes for this service are: • Hospital Diversion Less Than 24 hours-MH • Hospital Diversion Greater Than 24 hours-MH **Telehealth** This service must be provided in-person
ADMISSION CRITERIA	The individual must meet all of the following admission guidelines to be admitted to this service: • The individual must demonstrate symptomatology consistent with a diagnosis as outlined in the current edition of the Diagnostic and

	Statistical Manual (DSM) of Mental Disorders published by the American Psychiatric Association, which requires and can reasonably be expected to respond to therapeutic intervention • The individual is medically stable and does not meet acute inpatient hospitalization criteria • The individual has already implemented a personal crisis/relapse prevention plan and requires additional support • The individual must voluntarily admit themselves but can be referred by a professional or family member. The individual must provide their own transportation • It is expected that the individual will be able to benefit from this service • This level of care is the least restrictive setting that will produce the desired results in accordance with the needs of the individual
SERVICE REQUIREMENTS	**Assessment** • Conduct a risk assessment including brief mental health status and substance use disorder screening tools such as SBQR, ASQ, CAGE-AID, CSSRS to ensure the Individual is assessed for suicidality, homicidally, substance use disorder, and current symptoms. The assessment must be sufficient to determine the appropriate level of care for the individual and to evaluate whether the individual can be safely managed at that level of care **Support Services** • The setting has available common spaces, as well as private areas, and makes space available for food, storage, and management of medications • The setting is equipped with self-help and proactive tools to maintain wellness, and education is available on behavioral health disorders, treatments, community resources, topics related to mental health and co-occurring disorders, and an array of pre-crisis and crisis/relapse prevention tools • Follow-up calls should be made within 24 hours of discharge • Peer-to-peer engagement, activities, supports; presence/or absence of other services; WRAP review (stressors, resolution, etc.); contact with current services if requested • Support may include a referral for visits with a Certified Peer Support Specialist to provide post-discharge support • Warm Line available **Treatment Planning** • Interview and registration information completed to gain understanding of how to best support the individual and tailor the Wellness Recovery Action Plan (WRAP) • Review and/or implementation or provision of a WRAP **Discharge Planning**

	• Discharge planning is an ongoing process that occurs through the duration of service and must be completed prior to discharge
LENGTH OF SERVICE	Until the individual no longer needs to be diverted from a higher level of care, the initial urgent issue has substantially resolved, and the individual is connected to follow-up care as needed
STAFFING REQUIREMENTS	**Program Manager** Must have the following: • A bachelor's degree or higher in a human services field or equivalent coursework, 2 years of experience/training with demonstrated skills and competencies in treatment of individuals with a behavioral health diagnosis • Be on site and/or be available (via phone) 24 hours a day,7 days a week **Optional Staffing:** Certified Peer Support Specialists, Direct Care Staff, and/or Volunteers, as needed **Additional Requirements** • Staffed at all times when individuals are present and to cover the Warm Line hours • All staff, including volunteers, must be trained to assist individuals in developing and implementing Wellness Recovery Action Plans (WRAP) and providing peer and recovery support • All staff, including volunteers, must be oriented to program management and safety procedures
STAFFING RATIO	1 Staff: 5 Individuals Warm line hours and coverage: to meet call volume
HOURS OF OPERATION	24 hours a day,7 days a week access to service
CONTINUED STAY	All of the following criteria must be met for continuing treatment at this level of care: • The acuity of the individual's symptoms continues to necessitate treatment at the current level of care based on admission criteria • The individual does not require a more intensive level of services and no less intensive level of care is appropriate • There is evidence that the treatment team is working towards a transition plan to meet the individual's treatment needs once this level of care is no longer appropriate.
DESIRED INDIVIDUAL OUTCOME	• The individual has reviewed and/or developed a personal Wellness and Recovery Service Plan and substantially met their individualized goals and objectives • The precipitating condition has stabilized such that there is sustained improvement in the health and psychosocial functioning • The individual's condition can be managed without the professional external supports and interventions at this level of care

	• The individual has alternative support systems secured to help maintain active recovery and stability in the community • The individual is connected to the next appropriate level of care necessary to treat the condition

Mobile Crisis Response (MH or SUD) *(formerly Crisis Response-MH/SUD)*

Mobile Crisis Response uses natural support(s) and resources to manage and resolve an immediate mental health or substance use crisis in the least restrictive environment by creating and implementing a crisis intervention plan with the individual. This service is delivered in person in the individual's home or community setting. The desired outcome is crisis resolution, ensuring safety, and making necessary referrals and linkages.

SERVICE CATEGORY	Mental health disorder, substance use disorder, or both
ALLOWABLE SETTINGS	• Community • Home • Jail (for DBH-Only, non-CCBHCs providers) • Hospital (for DBH-Only, non-CCBHC providers)
BILLING INFORMATION	Fee codes for this service are: • Crisis Response-MH • Crisis Response- SUD Fee codes for this service in a CCBHC: • Crisis ResponseinCCBHC-MH • Crisis ResponseinCCBHC- SUD Telehealth: This service is allowed via telehealth; see DBH Fee Code Guide.
ADMISSION CRITERIA	The individual must meet all of the following admission guidelines to be admitted to this service: • Individual demonstrates active symptomatology consistent with a Diagnostic and Statistical Manual (DSM), current version, diagnosis • Exhibits potential for risk of harm to self or others if support is not provided • Prompt, in-person crisis evaluation and intervention is needed • At risk of being placed in Emergency Protective Custody and/or hospitalized if support is not provided
SERVICE REQUIREMENTS	**Assessments** • In-person meeting with the individual in crisis within one hour from the time of dispatch of Mobile Crisis. In rural and frontier settings, provide an in-person or telehealth meeting with the individual within 2 hours of dispatch, with a response time not to exceed 3 hours. • Conduct an evaluation including brief mental health status, suicide screening, and substance use disorder screening tools such as

	SBQR, ASQ, CAGE-AID, or CSSRS to ensure youths and adults will be assessed for suicidality, homicidality, substance use disorder, and current symptoms. **Safety Planning** • Develop a safety plan (such as the Stanley Brown safety plan) with the individual and support system **Clinical Services** • Mobile Crisis response, in-person, by 2 team members is preferred • One or more staff may respond to a crisis and must include or have access to a Licensed Clinician 24/7 • Provide mental health and/or substance use disorder interventions and crisis management • Provide linkage to information and referral, including appropriate community-based mental health and/or substance use disorder services • Ensure consultation with hospital emergency personnel, law enforcement, and community agencies as needed • Provide linkage to information and referrals, including appropriate community-based mental health and/or substance use disorder services • Provide post-crisis follow-up support, with the first attempt made within 24 hours of referral and 3 total attempts made within 72 hours, including crisis disposition (review of the case and additional referrals for the individual) • Arrange for alternatives to psychiatric hospitalization if appropriate • A licensed clinician must be available at all times to provide support, guidance, and direction to the Mobile Crisis Response Team. The clinician will respond within 30 minutes of contact by the team member(s). The response may indicate a need for the clinician to arrive in person • Non-licensed Certified Peer Support Specialists and Direct Care must be accompanied by another staff member until they have completed all training
LENGTH OF SERVICE	Mobile crisis service continues until the crisis is resolved, the risk of harm to self or others decreases, and the individual is connected to behavioral health treatment as needed.
STAFFING REQUIREMENTS	**Licensed Clinicians:** At least one on staff or via consultative agreement to provide clinical direction and support **Direct Care Staff:** Must be trained to recognize and respond to behavioral health crisis **Certified Peer Support Specialist or Community Treatment Aide:** Must be trained to recognize and respond to behavioral health crisis

	Staff answering the phones and providing triage for crisis assistance must have:
	• The ability to demonstrate skills and competencies in treatment with individuals with a behavioral health diagnosis, demonstrated by at least one of the following:
	  • Two years of direct care experience in a human services field; two years of training in a human service field; or a bachelor's degree or higher in psychology, sociology, or related human service field, which is preferred
	
	Additional Requirements
	All staff must be trained in:
	  ○ CPR and First Aid
	  ○ Accessing interpretation services
	  ○ Opioid Overdose Safety (e.g., Narcan)
	  ○ Trauma-Informed Services
	  ○ Mental Health First Aid (All non-licensed staff)
	  ○ At least one suicide intervention and response framework, such as Question, Persuade, Refer (QPR), Assessing and Managing Suicide Risk (AMSR), CAMS-Care Suicide Prevention Training and Response, or Counseling on Access to Lethal Means (CALM)
	  ○ Administering standardized suicide risk screening tools, such as Suicide Behaviors Questionnaire – Revised (SBQ-R), Ask Suicide-Screening Questions Toolkit (ASQ), Columbia-Suicide Severity Rating Scale (CSSRS)
	  ○ Administering substance use screening tools, such as the Cut, Annoyed, Guilty, and Eye – Adapted to Include Drugs (CAGE-AID) questionnaire
	  ○ Developing safety plans, such as the Stanley-Brown Safety Plan
	• Mobile Crisis Response teams that provide services to youth must complete youth-specific training such as adolescent development, working with CFS or Probation-involved youth, EPC alternatives for youth 18 years and under
	• Direct link to law enforcement and other emergency services
	• Personal recovery experience is preferred for all staffing positions

STAFFING RATIO	• Minimum one-to-one in person; two-to-one is preferred • Response must include or have access to a Licensed Clinician 24/7
HOURS OF OPERATION	24 hours a day, 7 days a week
CONTINUED STAY REQUIREMENTS	All of the following criteria must be met for continuing treatment at this level of care: • Individual continues to meet Admission Requirements

DESIRED INDIVIDUAL OUTCOME	• The crisis intervention plan for the individual is developed and implemented • The crisis is resolved, and the individual can safely remain in the community or is transferred to another level of care that is deemed safer and is the least restrictive setting for ongoing care

Respite (Mental Health and Substance Use Disorder) *(formerly MH Respite)*

Respite (MH and SUD) is a short-term program designed to provide shelter and assistance by addressing immediate needs for individuals transitioning between residential settings and/or those who benefit from a break from their current home or residential setting. Respite provides a safe, supported residential environment for people with serious mental health and/or a substance use disorder. This service supports individuals throughout a transition or break, provides linkages to needed mental health and/or substance use services, and assists with a timely transition back into the community.

SERVICE CATEGORY	Mental health disorder, substance use disorder, or both
ALLOWABLE SETTINGS	• Facility
BILLING INFORMATION	Fee codes for this service are: • MH Respite-MH • MH Respite-SUD **Telehealth** This service must be provided in person.
ADMISSION CRITERIA	The individual must meet all of the following admission guidelines to be admitted to this service: • The individual must demonstrate symptomatology consistent with a diagnosis as outlined in the current edition of the Diagnostic and Statistical Manual (DSM) of Mental Disorders published by the American Psychiatric Association, which requires and can reasonably be expected to respond to therapeutic intervention • At risk of needing a higher level of care if support is not provided • The individual requires 24-hour observation and supervision but not the constant observation of an inpatient psychiatric setting • Individuals may be voluntarily and/or referred by a professional or family member with input from the individual • It is expected that the individual will be able to benefit from this service • This level of care is the least restrictive setting that will produce the desired results in accordance with the needs of the individual
SERVICE REQUIREMENTS	**Support Services** • Support and supervision by staff 24 hours a day, 7 days a week

	• On-site services include periodic safety checks and monitoring, personal support services, medication monitoring, assistance with activities of daily living, limited transportation, and overnight accommodation including food and lodging • Consultation and/or linkages to behavioral health services, psychiatric treatment, pharmaceutical services, healthcare services, and emergency care • Provide referrals to behavioral health and other community resources as needed • Opportunities to be involved in a variety of community activities and services **Treatment Planning** • An initial treatment plan, including discharge plan, must be developed within 5 days of admission for staff guidance and direction of service **Discharge Planning** • Discharge planning is an ongoing process that occurs through the duration of service and must be completed prior to discharge
LENGTH OF SERVICE	Brief, transition-focused care up to 7 days. Stays greater than 7 days must be authorized.
STAFFING REQUIREMENTS	**Program Manager** Must have the following: • A bachelor's degree or higher in a human services field or equivalent coursework, 2 years of experience/training with demonstrated skills and competencies in treatment of individuals with a behavioral health diagnosis **Direct Care Staff:** sufficient to meet staffing ratios **All Staff Must** • Have access to licensed professionals (LMHP, LIMHP, PLMHP, LADC, PLADC, Psychiatrist, Psychologist, Psychiatric APRN, LPN, or Registered Nurse) to aid, support, and direct on-site staff members
STAFFING RATIO	During awake hours: 1 Direct Care Staff : 12 or fewer Individuals During sleeping hours shift: 1 Awake Direct Care Staff: 16 or fewer Individuals. with on-call support staff available
HOURS OF OPERATION	24 hours a day,7 days a week
CONTINUED STAY	All of the following criteria must be met for continuing treatment at this level of care: • The acuity of the individual's symptoms continues to necessitate treatment at the current level of care based on admission criteria • The individual does not require a more intensive level of services and no less intensive level of care is appropriate

	• There is evidence that the treatment team is working towards a transition plan to meet the individual's treatment needs once this level of care is no longer appropriate.
DESIRED INDIVIDUAL OUTCOME	• The individual has substantially met the treatment, rehabilitation, and recovery plan goals and objectives • The precipitating condition has stabilized such that there is sustained improvement in the health and psychosocial functioning • The individual's condition can be managed without the professional external supports and interventions at this level of care • The individual has alternative support systems secured to help maintain active recovery and stability in the community • The individual is connected to the next appropriate level of care necessary to treat the condition

Client Assistance Program (CAP)

The Client Assistance Program (CAP) provides up to 5 brief sessions (including sessions focused on screening and/or brief interventions) annually without an Initial Diagnostic Interview (IDI). Each session is focused on screening current difficulties, identifying appropriate resources and/or referrals, and providing brief interventions for presenting issues. CAP is an early intervention approach to address these issues before they become unmanageable. This service supports individuals and families who do not appear to need long-term intervention, or who need help identifying needs, matching services, and completing referrals for the presenting problem(s).

SERVICE CATEGORY	Mental health disorder, substance use disorder, or both
SETTING	• Community • Office or Clinic
BILLING INFORMATION	Fee code(s) for this service: • CAP-MH • CAP-SUD Billing for this service is entered per unit (.25 hours per unit, up to 4 units per session) **Telehealth** This service is allowed via telehealth. See DBH Fee Code Guide.
ADMISSION REQUIREMENTS	The individual must meet all of the following admission guidelines to be admitted to this service: • The individual must demonstrate symptomatology consistent with a diagnosis as outlined in the current edition of the Diagnostic and Statistical Manual (DSM) of Mental Disorders published by the American Psychiatric Association, which requires and can reasonably be expected to respond to therapeutic intervention

	• The individual demonstrates a need for support in coordinating treatment/recovery/rehabilitation options in the community that could reasonably be seen to be resolved in less than 5 sessions • It is expected that the individual will be able to benefit from this treatment • This level of care is the least restrictive setting that will produce the desired results in accordance with the needs of the Individual
SERVICE EXPECTATIONS	**Assessment** • Conduct a risk assessment including brief mental health status and substance use disorder screening tools such as SBQR, ASQ, CAGE-AID, CSSRS to ensure the Individual is assessed for suicidality, homicidality, substance use disorder, and current symptoms. The assessment must be sufficient to determine the appropriate level of care for the individual and to evaluate whether the individual can be safely managed at that level of care • If it is determined the individual needs intervention exceeding 5 hours, the individual should be discharged from CAP and referred for further assessment and the most appropriate level of care ○ At this point, an Initial Diagnostic Interview (IDI) must be completed, and subsequent outpatient psychotherapy sessions should be provided and billed accordingly **Support Services** • Implementation of strategies such as SBIRT (Screening, Brief Intervention, and Referral to Treatment) to support the Individual. Coping strategies and motivational enhancement strategies may be used as brief interventions to support the Individual while identifying any referral recommendations • The results from the risk screening, brief interventions, and referrals/ recommendations shall include active family involvement, unless contraindicated • The provider will coordinate care with the individual's primary medical provider, as applicable, and refer to other necessary services • Referrals to crisis assistance must be available 24 hours a day, 7 days a week **Treatment Planning** • An initial treatment plan, including a discharge plan, must be developed within 24 hours of admission to guide each upcoming session with the provider that created the plan **Discharge Planning** • Discharge planning is an ongoing process that occurs through the duration of service and must be completed prior to discharge • A transition plan must be completed prior to discharge

LENGTH OF SERVICE	Up to 5 sessions per calendar year (Each session equals 4 units of 15 mins each)
STAFFING	**Licensed Clinicians (**For SUD-Only CAP Sessions: Provisionally Licensed or Licensed Alcohol and Drug Counselor)
STAFFING RATIO	1 licensed clinician: 1 Individual
HOURS OF OPERATION	To ensure access for all individuals, providers should be able to provide services during evening and weekend hours in addition to typical business hours. Weekend and evening hours may be by appointment as appropriate for established clients if the provider is not typically open outside of business hours.
CONTINUED STAY REQUIREMENTS	All of the following criteria must be met for continuing treatment at this level of care: • The acuity of the individual's symptoms continues to necessitate treatment at the current level of care based on admission criteria • The individual does not require a more intensive level of services and no less intensive level of care is appropriate • The individual's treatment plan is up to date, with targets that are appropriate and related to improvement in the individual's symptoms and achievement of their goals • The individual is making progress towards rehabilitation goals and they are showing progress towards symptom reduction as demonstrated by objective behavioral measurement of functional improvement or standardized report from the member or guardian of symptom and/or functional improvement. • If progress has not been made or symptoms are increased, the treatment plan has been modified to focus on any new symptoms or to address barriers to progress. • There is evidence that the treatment team is working towards a transition plan to meet the individual's treatment needs once this level of care is no longer appropriate.
DESIRED INDIVIDUAL OUTCOME	• The individual or family has the ability to reach a more manageable level of functioning • The individual has support systems secured as needed OR • Referral for and linking to medical, psychological or psychiatric services, including assessment • The individual has established formal and informal community supports

Intensive Community Services

Intensive Community Services promote independence, develop community living skills, and prevent the need for a higher level of care. Services are designed for individuals with serious

mental illness, including those with co-occurring disorders, who experience frequent and debilitating symptoms resulting in high utilization of acute, intensive levels of care.

SERVICE CATEGORY	Mental health disorders
ALLOWABLE SETTINGS	• Community • Hospital • Office or Clinic • Facility
BILLING INFORMATION	Fee codes for this service are: • Intensive Community Services-MH • Intensive Community Services-SUD **Telehealth** This service is allowed via telehealth-see DBH Fee Code Guide.
ADMISSION REQUIREMENTS	The individual must meet all of the following admission guidelines to be admitted to this service: • The individual must demonstrate symptomatology consistent with a diagnosis as outlined in the current edition of the Diagnostic and Statistical Manual (DSM) of Mental Disorders published by the American Psychiatric Association, which requires and can reasonably be expected to respond to therapeutic intervention • Serious mental illness as evidenced by functional limitations related to the diagnosis that seriously interfere with the Individual's ability to function independently in an appropriate manner in two of three functional areas: ○ Instrumental activities of daily living: inability to be employed or an ability to be employed only with extensive supports; or deterioration or decompensation resulting in inability to establish or pursue educational goals within a normal time frame or without extensive supports; or inability to consistently and independently carry out home management tasks ○ Social functioning: repeated inappropriate or inadequate social behavior or ability to behave appropriately only with extensive supports; or consistent participation in adult activities only with extensive supports or when involvement is mostly limited to special activities established for persons with mental illness; or history of dangerousness to self/others ○ Activities of Daily Living: Inability to consistently perform the range of practical daily living tasks required for basic adult functioning as evidenced by functional limitations in at least three of the 5 following areas: • Grooming, hygiene, washing clothes, meeting nutritional needs • Care of personal business affairs • Transportation and care of residence

	• Procurement of medical, legal, and housing services • Recognition and avoidance of common dangers or hazards to self and possessions • The functional deficit requires daily rehabilitation interventions (3 to 5 days a week and/or 6 hours per day) in a structured day setting • It is expected that the individual will be able to benefit from this service • This level of care is the least restrictive setting that will produce the desired results in accordance with the needs of the individual
SERVICE EXPECTATIONS	**Assessments** • If an IDI was completed within 12 months prior to admission, and is determined to be clinically relevant, it may serve as the admission IDI. If there has been a gap in treatment of six months or more, or if there is new information available, an IDI addendum must be completed and may serve as the admission IDI • If an Initial Diagnostic Interview (IDI) has not been completed within the 12 months prior to admission, a new IDI or IDI addendum must be completed within 24 hours of the beginning of treatment. The IDI must meet the requirements as noted in the Initial Diagnostic Interview definition in this manual **Support Services** • Care coordination activities, including coordination or assistance in accessing medical, psychiatric, psychopharmacological, psychological, social, education, housing, transportation or other appropriate treatment/support services as well as linkage to other community services identified • Frequency of contacts must be determined based on the presenting problem(s), with at least 6 total hours of contact per month (of the 6 hours, a minimum of 3 hours must be face-to-face contact) • Provision of active rehabilitation and support interventions with focus on vocational/education, social skills, and/or activities of daily living, and other independent living skills that enable the individual to reside in the community • Provide education, support, and coordination with the appropriate services prior, during, and after crisis interventions • If hospitalization or residential care is necessary, facilitate, in cooperation with the treatment provider, the individual's transition back into the community upon discharge **Treatment Planning** • An initial treatment plan must be developed within 24 hours of admission to guide each upcoming session with the provider that created the plan • Under clinical supervision, develop an individualized treatment, rehabilitation, and recovery Plan, including discharge plan, with the Individual within 30 days of admission

	• Review and update the individualized treatment, rehabilitation, and recovery plan every 90 days or more often as clinically indicated, with the individual and must include family, guardians, and/or other natural supports **Discharge Planning** • Discharge planning is an ongoing process that occurs through the duration of service and must be completed prior to discharge • A transition plan must be completed prior to discharge
LENGTH OF SERVICE	Length of the service is individualized and based on clinical criteria for admission and continuing stay. The amount, duration, and frequency of the service should be documented in the treatment plan.
STAFFING	**Clinical Supervisor** Must have the following: • Clinical supervision by a licensed person (APRN, RN, LIMHP, LMHP, PLMHP, Psychologist) who is working within the program to provide clinical consultation on the Individualized Treatment, Rehabilitation, or Recovery plan at least once a month **Program Manager** Must have the following: • Demonstrated experience, skills, and competencies in behavioral health management. A master's degree in the human service field is preferred. **Direct Care Staff:** sufficient to meet staffing ratios
STAFFING RATIO	1 Staff: 10 Individuals
HOURS OF OPERATION	24 hours a day, 7 days a week, 365 days a year and access to service during weekend/evening hours, or in time of crisis with the support of a mental health professional
CONTINUED STAY REQUIREMENTS	All of the following criteria must be met for continuing treatment at this level of care: • The acuity of the individual's symptoms continues to necessitate treatment at the current level of care based on admission criteria • The individual does not require a more intensive level of services and no less intensive level of care is appropriate • The individual's treatment plan is up to date, with targets that are appropriate and related to improvement in the individual's symptoms and achievement of their goals. • The individual is making progress towards rehabilitation goals and they are showing progress towards symptom reduction as demonstrated by objective behavioral measurement of functional improvement or standardized report from the member or guardian of symptom and/or functional improvement.

	• If progress has not been made or symptoms are increased, the treatment plan has been modified to focus on any new symptoms or to address barriers to progress. • There is evidence that the treatment team is working towards a transition plan to meet the individual's treatment needs once this level of care is no longer appropriate.
DESIRED INDIVIDUAL OUTCOME	• The individual has substantially met the treatment, rehabilitation, and recovery plan goals and objectives • The precipitating condition has stabilized such that there is sustained improvement in the health and psychosocial functioning • The individual's condition can be managed without the professional external supports and interventions at this level of care • The individual has alternative support systems secured to help maintain active recovery and stability in the community • The individual is connected to the next appropriate level of care necessary to treat the condition

Therapeutic Consultation (Adult)

Therapeutic Consultation provides mental health expertise, training, and technical assistance to assist service providers in supporting an Individual experiencing a mental health and/or substance use disorder. An intervention plan is developed and implemented to assist individuals in functioning in their current environment while ensuring their safety and the safety of others. Therapeutic Consultation is necessary to improve the individual's independence in their community.

SERVICE CATEGORY	Mental health, substance use disorder, or both
SETTING	• Community • Hospital • Office or Clinic • Facility
BILLING INFORMATION	Fee code for this service is: • Therapeutic Consult (30 min unit) ○ Billable activities include meeting with the consumer, report writing, collateral contacts, and meeting with the Individual's support team. Transportation and lodging costs are included in the reimbursement rate. Services are capped at 90 units per fiscal year. **Telehealth** This service is allowed via telehealth-see DBH Fee Code Guide.
ADMISSION CRITERIA	The Individual must meet all of the following admission guidelines to be admitted to this service: • Age: 19 years of age or older • The individual must demonstrate symptomatology consistent with a diagnosis as outlined in the current edition of the Diagnostic and Statistical

	Manual (DSM) of Mental Disorders published by the American Psychiatric Association, which requires and can reasonably be expected to respond to therapeutic intervention • An individualized Diagnostic Interview (IDI) is deemed insufficient to fully identify the root cause of the problematic behaviors and/or mental health symptoms or to develop an intervention plan that may include environmental modification or behavior replacement • The individual's clinical condition causes significant interference in at least two out of three functional areas (Social, vocational/educational, activities of daily living, and/or safety) • It is expected that the individual will be able to benefit from this treatment
SERVICE EXPECTATIONS	**Assessments** • If an IDI was completed within 12 months prior to admission, and is determined to be clinically relevant, it may serve as the admission IDI. If there has been a gap in treatment of six months or more, or if there is new information available, an IDI addendum must be completed and may serve as the admission IDI • If an Initial Diagnostic Interview (IDI) has not been completed within the 12 months prior to admission, a new IDI or IDI addendum must be completed within 24 hours of the beginning of treatment. The IDI must meet the requirements as noted in the Initial Diagnostic Interview definition in this manual • IDI should include a review of records, safety planning or recommendations for the development of an intervention plan. Observations where the adult participates in activities are conducted at any time of the day or night in person or by Telehealth, depending upon when and where the behaviors occur **Support Services** • Consultation with the individual's support team (face-to-face, phone, or Telehealth) for a minimum of 2 conference meetings per episode of care. More frequent conferences may be necessary based on therapeutic needs. Team consultations must be documented • Behavioral assessment, intervention plan development, and implementation • Behavioral interventions are designed to teach alternative behaviors and strategies, to address community and/or natural supports and create environmental modifications per the needs of the individual • Referrals to crisis assistance must be available 24 hours a day, 7 days a week **Treatment Planning** • An intervention plan for the individual identified as the consumer of this service is developed from the assessment process. The plan includes behavioral interventions that are to be developed, piloted, implemented, evaluated, and revised, as necessary.

	• Individual strategies must be specific and measurable, and the intervention plan will be updated when not indicating progress **Discharge Planning** • Discharge planning is an ongoing process that occurs through the duration of service. A documented discharge plan must be completed as part of the Individualized Treatment, Rehabilitation, and Recovery Plan • A transition plan must be completed prior to discharge.
LENGTH OF SERVICE	From initial consultation until service expectations are met. Typically, consultation and plan development with written recommendations are completed within 30 days, with any additional referral and follow-up completed within 90 days from initial consultation.
STAFFING	**Therapeutic Consultation Provider** Must be one of the following: • Psychiatrist • Psychologist • Provisionally Licensed Psychologist • Advanced Practice Registered Nurse (APRN) • Registered Nurse (RN) • Licensed Independent Mental Health Practitioner (LIMHP) • Licensed Mental Health Practitioner (LMHP) • Licensed Alcohol and Drug Counselor (LADC) • Provisionally Licensed Alcohol and Drug Counselor (PLADC) **Additional Requirements** • Staff should be trained in the best methods to interact with the individual, goals for reduction of behavioral triggers, and/or diversionary activities to minimize behavioral incidents • Education on best practices in intervention strategies, medical and psychological conditions, and/or environmental impact to service delivery is provided to the Individual's team • Access to consultation with licensed clinicians in the fields of medicine, psychopharmacology, and behavioral health, as needed
STAFFING RATIO	N/A
HOURS OF OPERATION	To ensure access for all individuals, providers should provide services during evening and weekend hours in addition to typical business hours. Weekend and evening hours may be by appointment as appropriate for established clients if the provider is not typically open outside of business hours. The service provider will ensure that the Individual, family, or caregiver is educated on accessing crisis services.
CONTINUED STAY REQUIREMENTS	All of the following criteria must be met for continuing treatment at this level of care: • Individual continues to meet admission guidelines • The individual does not require a more intensive level of services and no less intensive level of care is appropriate • There is evidence that the treatment team is working towards a transition plan to meet the individual's treatment needs once this level of care is no longer appropriate

	• All services and treatment are carefully structured to achieve optimum results in the most efficient manner possible consistent with sound clinical practice • Care is rendered in a clinically appropriate manner and focused on the Individual's behavioral and functional outcomes as described in the discharge plan • There is documented active discharge planning
DISCHARGE CRITERIA	• The individual and family or caregiver have identified and implemented recommendations designed to address and minimize behavioral and emotional challenges related to the individual's mental health and/or substance misuse; **and** • The promotion of social-emotional development, interpersonal growth, and self-management skills that are necessary for the individual to participate and function successfully in their family, school, and community are continuing as documented in service plan

Therapeutic Consultation (Youth and Adolescent)

Therapeutic Consultation provides mental health expertise, training, and technical assistance to assist service providers in supporting an individual experiencing a mental health and/or substance use disorder. An intervention plan is developed and implemented to assist individuals in functioning in their current environment while ensuring their safety and the safety of others. Therapeutic Consultation is necessary to improve the Individual's independence in their community.

SERVICE CATEGORY	Mental health or substance use disorder, or both
SETTING	• Community (including approved or accredited schools, licensed childcare centers, afterschool programs, and other youth and adolescent-servicing organizations) • Hospital • Office or Clinic • Facility
BILLING INFORMATION	Fee code for this service is: • Therapeutic Consult (30 min unit) ○ Billable activities include meeting with the consumer, report writing, collateral contacts, and meeting with the individual's support team. Transportation and lodging costs are included in the reimbursement rate. Services are capped at 90 units per fiscal year. **Telehealth** This service is allowed via telehealth-see DBH Fee Code Guide.
ADMISSION CRITERIA	The individual must meet all of the following admission guidelines to be admitted to this service: • Age: 19 years of age or under • The individual must demonstrate symptomatology consistent with a diagnosis as outlined in the current edition of the Diagnostic and Statistical

	Manual (DSM) of Mental Disorders published by the American Psychiatric Association, which requires and can reasonably be expected to respond to therapeutic intervention • An Individualized Diagnostic Interview (IDI) is deemed insufficient to fully identify the root cause of the problematic behaviors and/or mental health symptoms or to develop an intervention plan that may include environmental modification or behavior replacement • The individual's clinical condition causes significant interference in at least two out of three functional areas (Social, vocational/educational, activities of daily living, and/or safety) • It is expected that the individual will be able to benefit from this treatment
SERVICE EXPECTATIONS	**Assessments** • If an IDI was completed within 12 months prior to admission, and is determined to be clinically relevant, it may serve as the admission IDI. If there has been a gap in treatment of six months or more, or if there is new information available, an IDI addendum must be completed and may serve as the admission IDI • If an Initial Diagnostic Interview (IDI) has not been completed within the 12 months prior to admission, a new IDI or IDI addendum must be completed within 24 hours of the beginning of treatment. The IDI must meet the requirements as noted in the Initial Diagnostic Interview definition in this manual • IDI should include a review of records, safety planning, or recommendations for the development of an intervention plan. Observations of the individual participating in activities can be conducted at any time of day or night, in person or via Telehealth, depending on when and where the behaviors occur • The assessment process is completed in collaboration with the staff and family members (when applicable) and includes assessment of risk levels, strengths, needs, and preferences, review of records, safety planning, or recommendations for the development of an intervention plan. Observations of the identified individual participating in activities are conducted at any time of day or night, in person or via Telehealth, depending on when and where specific problematic behaviors occur **Support Services** • Consultation with the individual's support team (face-to-face, phone, or Telehealth) for a minimum of 2 conference meetings per episode of care. More frequent conferences may be necessary based on therapeutic needs. Team consultations must be documented • Behavioral assessment, intervention plan development, and implementation • Behavioral interventions are designed to teach alternative behaviors and strategies, to address community and/or natural supports, and create environmental modifications per the needs of the individual • Referrals to crisis assistance must be available 24 hours a day, 7 days a week

	Treatment Planning • An intervention plan for the individual identified as the consumer of this service is developed from the assessment process. The plan includes behavioral interventions that are to be developed, piloted, implemented, evaluated, and revised, as necessary • The assessment process leads to the development of an intervention plan to teach acceptable alternative behaviors and strategies to address behavioral health to the served youth and adolescent and individuals on their support team. This may include educating staff on best methods for interacting with the youth and adolescent, reduction of behavioral triggers, or diversionary activities to minimize behavioral incidents, best practices in intervention strategies, medical and psychological conditions, and/or environmental impact to service delivery are provided to the individual's team. The team will develop, pilot, implement, evaluate, and revise behavioral interventions as needed. The parent or guardian will be expected to sign the plan indicating their agreement and participation in developing the plan • Individual strategies must be specific and measurable, and the intervention plan will be updated when not indicating progress **Discharge Planning** • Discharge planning is an ongoing process that occurs through the duration of service. A documented discharge plan must be completed as part of the intervention • A transition plan must be completed prior to discharge
LENGTH OF SERVICE	From initial consultation until service expectations are met. Typically, consultation and plan development and written recommendations are completed within 30 days, with any additional referral and follow-up completed within 90 days of initial consultation
STAFFING	**Therapeutic Consultation Provider** Must be one of the following: • Psychiatrist • Psychologist • Provisionally Licensed Psychologist • Advanced Practice Registered Nurse (APRN) • Registered Nurse (RN) • Licensed Independent Mental Health Practitioner (LIMHP) • Licensed Mental Health Practitioner (LMHP) • Licensed Alcohol and Drug Counselor (LADC) • Provisionally Licensed Alcohol and Drug Counselor (PLADC) **Additional Requirements** • Staff should be trained in the best methods to interact with the individual, goals for reduction of behavioral triggers, and/or diversionary activities to minimize behavioral incidents • Education on best practices in intervention strategies, medical and psychological conditions, and/or environmental impact to service delivery is provided to the individual's team

	• Access to consultation with licensed clinicians in the fields of medicine, psychopharmacology, and behavioral health, as needed
STAFFING RATIO	N/A
HOURS OF OPERATION	To ensure access for all individuals, providers should be able to provide services during evening and weekend hours in addition to typical business hours. Weekend and evening hours may be by appointment as appropriate for established clients if the provider is not typically open outside of business hours. The service provider will ensure that the individual, family, or caregiver is educated on accessing crisis services.
CONTINUED STAY REQUIREMENTS	All of the following criteria must be met for continuing treatment at this level of care: • Individual continues to meet admission guidelines • The individual does not require a more intensive level of services and no less intensive level of care is appropriate • There is evidence that the treatment team is working towards a transition plan to meet the individual's treatment needs once this level of care is no longer appropriate. • All services and treatment are carefully structured to achieve optimum results in the most efficient manner possible consistent with sound clinical practice • Care is rendered in a clinically appropriate manner and focused on the individual's behavioral and functional outcomes as described in the discharge plan • There is documented active discharge planning
DISCHARGE CRITERIA	• The individual and family or caregiver have identified and implemented recommendations designed to address and minimize behavioral and emotional challenges related to the individual's mental health and/or substance misuse; **and** • The promotion of social-emotional development, interpersonal growth, and self-management skills that are necessary for the individual to participate and function successfully in their family, school, and community is continuing as documented in the service plan

Coordinated Specialty Care

Coordinated Specialty Care is a comprehensive, team-based service that utilizes the NAVIGATE model for individuals experiencing early psychosis. This service promotes easy access to care, shared decision-making, strengths and resiliency, motivational enhancement skills, psychoeducational teaching skills, and collaboration with natural supports. It targets individuals aged 14 to 35 and their families for early intervention, restoration of age-appropriate activities, resiliency, and recovery.

SERVICE TYPE	Mental health disorder
ALLOWABLE SETTINGS	• Community • Office • Home

	• Facility
BILLING INFORMATION	Fee code for this service is: • Coordinated Specialty Care-MH Fee code for this service is: • CSCinCCBHC-MH **Telehealth** This service is allowed via telehealth-see DBH Fee Code Guide.
ADMISSION REQUIREMENTS	The individual must meet all of the following admission guidelines to be admitted to this service: • Age: Individual is 14 years of age through 35 years of age • The individual has a primary diagnosis, as outlined in the current edition of the Diagnostic and Statistical Manual (DSM) of Mental Disorders published by the American Psychiatric Association, that includes psychosis and may include individuals with co-occurring disorders. Accepted diagnoses from this service include: ○ a. F20.0 Paranoid schizophrenia ○ b. F20.1 Disorganized schizophrenia ○ c. F20.2 Catatonic schizophrenia ○ d. F20.3 Undifferentiated schizophrenia ○ e. F20.5 Residual schizophrenia ○ f. F20.81 Schizophreniform disorder ○ g. F20.89 Other schizophrenia ○ h. F20.9 Schizophrenia, unspecified ○ i. F21 Schizotypal disorder ○ j. F22 Delusional disorders ○ k. F23 Brief psychotic disorder ○ l. F24 Shared psychotic disorder ○ m. F25.0 Schizoaffective disorder, bipolar type ○ n. F25.1 Schizoaffective disorder, depressive type ○ o. F25.8 Other schizoaffective disorders ○ p. F25.9 Schizoaffective disorder, unspecified ○ q. F28 Other psychotic disorder not due to a substance or known physical condition ○ r. F29 Unspecified psychotic disorder not due to a substance or known physical condition • Symptoms of a psychotic disorder for a period lasting more than 1 week and no more than 2 years • Serious mental illness as evidenced by functional limitations related to the diagnosis that seriously interfere with the individual's ability to function independently in an appropriate manner in two of three functional areas: ○ Instrumental activities of daily living: inability to be employed or an ability to be employed only with extensive supports; or deterioration or decompensation resulting in inability to establish or pursue educational goals within a normal time

	frame or without extensive supports; or inability to consistently and independently carry out home management tasks ○ Social functioning: repeated inappropriate or inadequate social behavior or ability to behave appropriately only with extensive supports; or consistent participation in adult activities only with extensive supports or when involvement is mostly limited to special activities established for persons with mental illness; or history of dangerousness to self/others ○ Activities of Daily Living: Inability to consistently perform the range of practical daily living tasks required for basic adult functioning as evidenced by functional limitations in at least three of the five following areas: • Grooming, hygiene, washing clothes, meeting nutritional needs • Care of personal business affairs • Transportation and care of residence • Procurement of medical, legal, and housing services • Recognition and avoidance of common dangers or hazards to self and possessions • It is expected that the individual will be able to benefit from this treatment • This level of care is the least restrictive setting that will produce the desired results in accordance with the needs of the individual
SERVICE EXPECTATIONS	**Assessments** • If an IDI was completed within 12 months prior to admission, and is determined to be clinically relevant, it may serve as the admission IDI. If there has been a gap in treatment of six months or more, or if there is new information available, an IDI addendum must be completed and may serve as the admission IDI • If an Initial Diagnostic Interview (IDI) has not been completed within the 12 months prior to admission, a new IDI or IDI addendum must be completed within 24 hours of the beginning of treatment. The IDI must meet the requirements as noted in the Initial Diagnostic Interview definition in this manual • Additional assessments will be provided by the Coordinated Specialty Care team to aid in treatment planning needs, including recovery and resiliency, mental health (including symptoms and functioning, if this has not already been done), illness management, physical health, family and other supports, and basic living needs **Support Services** • The team is expected to meet regularly to discuss referrals, review consumer progress towards treatment goals and discuss care coordination needs • Care coordination activities can include coordination or assistance in accessing medical, psychiatric, psychopharmacological, psychological, social, education, housing, employment, transportation

	or other appropriate treatment/support services as well as linkage to other community services identified • The Coordinated Specialty Care team is expected to provide psychotherapy, family support and education, supported education, medication management, care coordination, and peer support (if the team has access to a certified peer) • Provision of active rehabilitation and support interventions with focus on vocational/education, social skills, and/or activities of daily living, and other independent living skills that enable the individual to reside in the community • The team meets on a weekly basis, is led by the Program Director, and reviews all current active cases • Outreach, primarily by team lead, to the community for education, referrals, and resources • Referrals to crisis assistance must be available 24 hours a day, 7 days a week **Treatment Planning** • An initial treatment plan must be developed within 24 hours of admission to guide each upcoming session with the provider that created the plan • Under clinical supervision, develop an individualized treatment, rehabilitation, and recovery plan, including a discharge plan, with the individual within 30 days of admission. Plan should include input from formal or informal supports that have been chosen by the individual • Review and update the individualized treatment, rehabilitation, and recovery plan every 90 days or more often as clinically indicated. Review must be completed with the individual under the direction of a licensed clinician and must include family, guardians, and/or other natural supports as authorized by the individual **Discharge Planning** • Discharge planning is an ongoing process that occurs through the duration of service. A documented discharge plan must be completed as part of the individualized treatment, rehabilitation, and recovery plan • A transition plan must be completed prior to discharge
LENGTH OF SERVICE	Length of service is individualized and based on clinical criteria for admission and continuing stay
STAFFING	**Clinical Supervisor** Must have one of the following: • A bachelor's degree or higher in psychology, sociology, or a related human service field is required. A master's degree in a human service field is preferred • Demonstrated experience, skills, and competencies in behavioral health management

	Specialty Care Team
	Must include the following:
	• **Team Prescriber**:
	  ○ Must be one of the following: MD, PA, or APRN
	• **Individual Resiliency Trainer**:
	  ○ Must be one of the following: Licensed Mental Health Practitioners (LIMHP, LMHP, PLMHP, Psychologist, Provisional Psychologist)
	• **Family Education Clinician:**
	  ○ Must be one of the following: Licensed Mental Health Practitioners (LIMHP, LMHP, PLMHP, Psychologist, Provisional Psychologist)
	• **Program Director:**
	  ○ May also take the role of the Family Clinician on the team but must be a licensed mental health practitioner (LIMHP, Psychologist, Provisional Psychologist)
	
	Direct Care Staff: Sufficient to meet staffing ratio
	
	Certified Peer Support Specialist: (Optional)
	
	Additional Requirements
	• Supervision of service as required by the practitioner's license
	• All providers are to provide services within their scope of practice
	• Team must be trained in the NAVIGATE model

STAFFING RATIO	1 Team: Up to 50 Individuals
HOURS OF OPERATION	To ensure access for all individuals, providers should be able to provide services during evening and weekend hours in addition to typical business hours with 24/7 access to crisis intervention services. Weekend and evening hours may be by appointment for established clients, as appropriate, if the provider is not typically open outside of business hours.
CONTINUED STAY REQUIREMENTS	All of the following criteria must be met for continuing treatment at this level of care: • The acuity of the individual's symptoms continues to necessitate treatment at the current level of care based on admission criteria • The individual does not require a more intensive level of services and no less intensive level of care is appropriate • The individual's treatment plan is up to date, with targets that are appropriate and related to improvement in the individual's symptoms and achievement of their goals. • The individual is making progress towards rehabilitation goals, and they are showing progress towards symptom reduction as demonstrated by objective behavioral measurement of functional

	improvement or standardized report from the member or guardian of symptom and/or functional improvement. • If progress has not been made or symptoms have increased, the treatment plan has been modified to focus on any new symptoms or to address barriers to progress. • There is evidence that the treatment team is working towards a transition plan to meet the individual's treatment needs once this level of care is no longer appropriate.
DESIRED INDIVIDUAL OUTCOME	• The individual has substantially met the treatment, rehabilitation, and recovery plan goals and objectives • The precipitating condition has stabilized such that there is sustained improvement in the health and psychosocial functioning • The individual's condition can be managed without the professional external supports and interventions at this level of care • The individual has alternative support systems secured to help maintain active recovery and stability in the community • The individual is connected to the next appropriate level of care necessary to treat the condition

Day Support

Day Support is designed to provide social support to individuals who currently receive or have received treatment for serious mental illness and are in the recovery process. The intent of the service is to support the individual's well-being through the benefit of socialization, leisure skill development, communication, and coping skill development.

SERVICE TYPE	Mental health disorder
ALLOWABLE SETTINGS	• Facility
BILLING INFORMATION	Fee code for this service is: • Day Support-MH **Telehealth** This service must be provided in person.
ADMISSION REQUIREMENTS	The individual must meet all of the following admission guidelines to be admitted to this service: • The individual has a primary diagnosis, as outlined in the current edition of the Diagnostic and Statistical Manual (DSM) of Mental Disorders published by the American Psychiatric Association, which requires and can reasonably be expected to respond to therapeutic intervention. • Serious mental illness as evidenced by functional limitations related to the diagnosis that seriously interfere with the individual's ability to function independently in an appropriate manner in two of three functional areas:

	○ Instrumental activities of daily living: inability to be employed or an ability to be employed only with extensive supports; or deterioration or decompensation resulting in inability to establish or pursue educational goals within a normal time frame or without extensive supports; or inability to consistently and independently carry out home management tasks ○ Social functioning: repeated inappropriate or inadequate social behavior or ability to behave appropriately only with extensive supports; or consistent participation in adult activities only with extensive supports or when involvement is mostly limited to special activities established for persons with mental illness; or history of dangerousness to self/others ○ Activities of Daily Living: Inability to consistently perform the range of practical daily living tasks required for basic adult functioning as evidenced by functional limitations in at least three of the 5 following areas: • Grooming, hygiene, washing clothes, meeting nutritional needs • Care of personal business affairs • Transportation and care of residence • Procurement of medical, legal, and housing services • Recognition and avoidance of common dangers or hazards to self and possessions • The individual desires support to engage in a personal recovery process • The individual is medically and psychiatrically stable • It is expected that the individual will be able to benefit from this treatment • This level of care is the least restrictive setting that will produce the desired results in accordance with the needs of the individual
SERVICE EXPECTATIONS	**Assessments** • If an IDI was completed within 12 months prior to admission, and is determined to be clinically relevant, it may serve as the admission IDI. If there has been a gap in treatment of six months or more, or if there is new information available, an IDI addendum must be completed and may serve as the admission IDI • If an Initial Diagnostic Interview (IDI) has not been completed within the 12 months prior to admission, a new IDI or IDI addendum must be completed within 24 hours of the beginning of treatment. The IDI must meet the requirements as noted in the Initial Diagnostic Interview definition in this manual **Support Services** • Provide a therapeutic milieu with active treatment/recovery/rehabilitation activities led by individuals trained in the provision of recovery principles. These activities include skill-building in areas such as community living, personal care, social

	relationships, vocational/educational skills, and use of leisure time. The individual selects activities that meet their goals and needs • Provide referrals to behavioral health and other community resources as needed • Access to support during pre-crisis or crisis situations, with active linkage to more intensive level of care if necessary **Treatment Planning** • An initial treatment plan must be developed within 24 hours of admission to guide each upcoming session with the provider that created the plan • Under clinical supervision, develop an Individualized Treatment, Rehabilitation, and Recovery Plan, including discharge plan, with the individual within 30 days of admission • Review must be completed every 90 days with the individual under the direction of a licensed clinician and must include family, guardians, and/or other natural supports as authorized by the individual **Discharge Planning** • Discharge planning is an ongoing process that occurs throughout the duration of service. A documented discharge plan must be completed as part of the individualized treatment, rehabilitation, and recovery plan • A transition plan must be completed prior to discharge
LENGTH OF SERVICE	Length of service is individualized and based on clinical criteria for admission and continuing stay, as well as the client's ability to demonstrate progress on Individual treatment/recovery goals. The amount, duration, and frequency of the service will be documented in the treatment plan.
STAFFING	**Clinical Supervisor:** Must be one of the following: • Psychiatrist • Psychologist • Provisionally Licensed Psychologist • Advanced Practice Registered Nurse (APRN) • Registered Nurse (RN) • Licensed Independent Mental Health Practitioner (LIMHP) • Licensed Mental Health Practitioner (LMHP) • And must be working in the program to provide clinical supervision, consultation and support to direct care staff and the individuals in the program **Direct Care Staff**: Sufficient to meet staffing ratio • Personal recovery experience preferred for all positions
STAFFING RATIO	1 Staff: No more than 12 Individuals
HOURS OF OPERATION	To ensure access for all individuals, providers should be able to provide services during evening and weekend hours in addition to typical business

	hours, with 24/7 access to crisis intervention services. Weekend and evening hours may be by appointment for established clients, as appropriate, if the provider is not typically open outside of business hours.
CONTINUED STAY REQUIREMENTS	All of the following criteria must be met for continuing treatment at this level of care: • The acuity of the individual's symptoms continues to necessitate treatment at the current level of care based on admission criteria • The individual does not require a more intensive level of services and no less intensive level of care is appropriate • The individual's treatment plan is up to date, with targets that are appropriate and related to improvement in the individual's symptoms and achievement of their goals • The individual is making progress towards rehabilitation goals and they are showing progress towards symptom reduction as demonstrated by objective behavioral measurement of functional improvement or standardized report from the member or guardian of symptom and/or functional improvement • If progress has not been made or symptoms have increased, the treatment plan has been modified to focus on any new symptoms or to address barriers to progress • There is evidence that the treatment team is working towards a transition plan to meet the individual's treatment needs once this level of care is no longer appropriate
DESIRED INDIVIDUAL OUTCOME	• The individual has substantially met the treatment, rehabilitation, and recovery plan goals and objectives • The precipitating condition has stabilized such that there is sustained improvement in the health and psychosocial functioning • The individual's condition can be managed without the professional external supports and interventions at this level of care • The individual has alternative support systems secured to help maintain active recovery and stability in the community • The individual is connected to the next appropriate level of care necessary to treat the condition

Professional Partner Program (PPP)

The Professional Partner Program (PPP) uses the wraparound approach model to serve youth/young adults and their families who are experiencing serious emotional disturbances/mental health challenges and high, complex needs and who are at risk of out-of-home placement or institutionalization. PPP is rooted in a strengths-based perspective that focuses on identifying the underlying needs of the youth and their family and providing access, coordination, and collaboration to community services and supports. Each wraparound team includes the youth/young adult and their family, a Care Coordinator, and formal/informal supports. This service utilizes the wraparound approach to organize services and supports through the four phases of Wraparound: Engagement, Plan Development, Implementation, and Transition.

SERVICE TYPE	Mental health disorder
ALLOWABLE SETTINGS	• Community • Home • Office or Clinic
BILLING INFORMATION	Fee code for this service is: • PPP-MH **Telehealth** This service is allowed via telehealth-see DBH Fee Code Guide.
SERVICE ELIGIBILITY AND ADMISSION REQUIREMENTS	The individual must meet all of the following admission guidelines ***prior*** to being admitted to this service: • Age: The individual (youth/young adult) is between the ages of 3 and 25 years old • The individual (youth/young adult) demonstrates symptomatology consistent with a mental health disorder diagnosis as outlined in the current edition of the Diagnostic and Statistical Manual (DSM) published by the American Psychiatric Association, which requires and can reasonably be expected to respond to therapeutic intervention. (See Eligibility and Admissions in PPP Appendix) ○ If the individual's primary diagnosis is under the DSM's Neurodevelopmental Disorder or Substance-related Disorder category, a documented pattern of deficits must have existed for 12 months or longer, and the individual's functional impairments must primarily be related to the serious mental or emotional disturbance • The individual must also demonstrate significant functional impairments due to their mental/behavioral health diagnosis, which cannot be attributed to intellectual, sensory, or health factors, as evidenced by the score of their CAFAS/PECFAS assessment (See Eligibility and Admissions in PPP Appendix) • The individual is not currently enrolled or working with other providers that are considered a duplication of the PPP services • To meet fidelity for Wraparound services, at least one family member/caregiver support person needs to be identified and oriented to the program as a team member for the youth/young adult • It is expected that the individual will be able to benefit from this treatment • This level of care is the least restrictive setting that will produce the desired results in accordance with the needs of the individual
SERVICE EXPECTATIONS	**After Service Eligibility requirements are fulfilled and an Admission date is set, begin Phase One immediately. (See Eligibility and Admissions in PPP Appendix)**

	Phase One: Family and Team Engagement
	<u>Must occur within 14 days from admission date and must include:</u>
	• Completion of client registration (at admission and then annually), the Protective Factors Survey (PFS), and the Descriptive Information Questionnaire (DIQ) in the Centralized Data System (DBH's data system)
	• Orienting the family and individual to the program and wraparound model
	• Documentation of the IDI, if it was not collected during the eligibility process, but
	  ○ **If an IDI was completed within 12 months prior to admission** and is determined to be clinically relevant, it may serve as the admission IDI. If there has been a gap in care of six months or more, or if new information is available, an IDI addendum must be completed and may serve as the admission IDI
	  ○ **If the individual has not been previously diagnosed** but an acceptable diagnosis is considered likely, the Care Coordinator may use information provided by the youth/family about the individual's bio-psychosocial history as well as a CAFAS/PECFAS score as evidence that a diagnosis is probable. With this documentation, the individual may be accepted into the program, contingent upon an IDI from a licensed professional confirming a diagnosis is received within 60 calendar days of the admission date
	  ○ **If an IDI is not received within 60 calendar days** of the admission date, the individual must be discharged from the program within the following 30 calendar days
	• Gathering information about safety/crises concerns, or crises the youth and family anticipate, and administering a suicide screening tool to determine if concerns require immediate attention
	  ○ If immediate attention is needed, a safety plan (such as the Stanley-Brown) must be developed at that time with the individual and their family. Update and review the safety plan during Phase Two, or as appropriate
	  ○ If immediate attention is not needed, create a proactive crisis/safety plan with antecedents and associated strategies for prevention measures
	• Schedule upcoming meetings and activities, as needed
	• Progress notes to document a record of all contacts and activities, including evidence of meaningful contacts, activity towards specific goals, services purchased, team decisions, and program logistics (See Progress Notes and Meaningful Contact in PPP Appendix)
	• Once Phase One is completed, immediately enter Phase Two
	  • *If unable to complete all items in Phase One within the 14-day timeline, review Transition/Discharge Guidelines in PPP Appendix for next steps*

	Phase Two: Initial Plan of Care <u>Must occur within 14 days of starting Phase Two and must include:</u> • An Interpretative Summary with information collected from the individual, their family, and collateral providers. This summary will address the strengths, needs, abilities, and preferences of the individual and their family, as well as the bio-psychosocial history (including diagnosis, presenting problems, etc.) and family dynamics • An initial Plan of Care to guide the activities of the team until the Plan of Care is formally developed in Phase 3 (see Initial Plan of Care in PPP Appendix) . It must include (but is not limited to): o Identified team members (formal and informal) o A review of the individual and family's strengths, needs, abilities, and preferences (found in the Interpretative Summary) o The individual and their family's presenting need(s) and short-term goals based on presenting needs that the individual and family want to work on first o Documentation of safety/crises concerns, or crises the youth and family anticipate, in the Safety/Crisis Plan (continued from Phase One) • Scheduling the first Team Meeting (to be accomplished during Phase Three) • Progress notes to document a record of all contacts and activities, including evidence of meaningful contacts, activity towards specific goals, services purchased, team decisions, meeting schedules, contact preferences, and program logistics • Once Phase Two is completed, immediately move to Phase Three • *If unable to complete all items in Phase Two within the 14-day timeline, review Transition/Discharge Guidelines in PPP Appendix for next steps* **Phase Three: Plan Implementation** <u>Must occur every 30 days from starting Phase Three (then activities of Phase Three are repeated until POC goals are achieved, and formal wraparound isn't needed) and must include:</u> • Implementation of the Plan of Care (POC) (See Plan of Care in PPP Appendix), evolved from the initial plan of care, including (but not limited to): o Monitoring objectives and making updates accordingly o Documentation of updates, progress, and strategies to achieve POC goals and objectives • The first Team Meeting must occur within 14 days of starting Phase 3 and then occur at least every 30 days. If a meeting is missed, document the reason it did not happen (See Team Meetings in PPP Appendix) • Regular communication and *meaningful contact* between the Care Coordinator and the individual/family to provide support and coordination as evidenced within the file's documentation.

	Communication can be in person, by phone, or via telehealth, but text messaging cannot be the sole source of contact. (See Meaningful Contact in PPP Appendix)
	• Monitoring, providing, and purchasing any services and supports that align with POC goals through flexible funding. (See Flex Funding in PPP Appendix)
	• Responding to the individual/family in times of crisis, including providing emergency team meetings within 72 hours of any crisis
	• Transition/discharge planning is an ongoing process that occurs throughout the duration of service (See Transition/Discharge Planning in PPP Appendix)
	  ○ Planning a formal transition must begin at least 90 days before discharge
	• Progress notes to document a record of all contacts and activities, including evidence of meaningful contacts, activity towards specific goals, services purchased, team decisions, meeting schedules, contact preferences, and program logistics
	• Once Phase Three is complete, immediately move to Phase Four
	  • *If unable to complete all items in Phase Three within the 30-day recurring timeline, review Transition/Discharge Guidelines in PPP Appendix for next steps*.
	
	Phase Four: Transition
	<u>Must occur within 60 days from starting Phase Four and must include:</u>
	• Transition out of wraparound service activities including making recommendations or referrals, as needed
	• Wrapping up and/or completing all POC goals
	• A transition letter with an updated Safety/Crisis Plan for transition into the community must be completed prior to discharge (see Transition/Discharging in PPP Appendix) and a copy provided to the individual/family
	• Progress notes to document a record of all contacts and activities, including evidence of meaningful contacts, activity towards specific goals, services purchased, team decisions, and program logistics

SUPPORTING SERVICES AND DOCUMENTATION (SEE PPP APPENDIX)	• The Wraparound Fidelity Index 4.0 (WFI) measures fidelity to the wraparound model • Clinical supervision between a licensed provider and the Care Coordinator must occur every 90 days or as often as necessary to update progress and/or revise the POC. • Reporting Requirements on outcome measures, monthly financial reports, and flex funding
LENGTH OF SERVICE	As identified by the team members and as determined clinically necessary. Typical stay for programs using a wraparound fidelity model is 12-18 months.

STAFFING	**Program Director** Must have one of the following: • A bachelor's degree in a human service-related field, or equivalent field experience **Care Coordinator** (or Wraparound Care Coordinator) Must have the following: • Completed all training requirements (See PPP Appendix) • Monthly, at a minimum, direct supervision (can be done individually or in a group) to maintain program standards, service delivery, and appropriate care/case planning • Bi-weekly contact with a supervisor or coach to improve staff skills and access to clinical consultation, as appropriate, and must be available to staff in times of wraparound team emergency
STAFFING RATIO	1 Care Coordinator: 10-15 Individuals
HOURS OF OPERATION	To ensure access for all individuals, providers should be able to provide services during evening and weekend hours in addition to typical business hours. Care Coordinators must schedule appointments/meetings at the family's convenience, which may include evening or weekend hours. There is 24/7 access, as identified by the team, for emergencies.
CONTINUED STAY REQUIREMENTS	All of the following criteria must be met for continuing treatment at this level of care: • The acuity of the individual's symptoms continues to necessitate treatment at the current level of care based on admission criteria including the eligibility requirement of the CAFAS/PECFAS score as listed in the PPP Appendix. If the individual does not meet the CAFAS/PECFAS score requirements during re-assessment, the individual must be moved to Phase Four for transition and discharge. • The individual does not require a more intensive level of services, and no less intensive level of care is appropriate • The individual's plan of care is up to date, with targets that are appropriate and related to improvement in the individual's needs and achievement of their goals • The individual is making progress towards the plan's goals, and they are showing progress towards symptom reduction as demonstrated by objective behavioral measurement of functional improvement or standardized report from the member or guardian of symptom and/or functional improvement • If progress has not been made or symptoms have increased, the plan of care has been modified to focus on any new needs or to address barriers to progress • There is evidence that the team is working towards a transition plan to meet the individual's needs once this level of care is no longer appropriate
DESIRED	• The individual has substantially met the plan of care goals and

Individual Outcome	objectives • The precipitating condition has stabilized such that there is sustained improvement in the health and psychosocial functioning • The individual's condition can be managed without the professional external supports and interventions at this level of care • The individual has alternative support systems secured to help maintain active recovery and stability in the community • The individual is connected to the next appropriate level of care

Recovery Support

Recovery Support services promote successful independent community living by helping individuals achieve behavioral health goals, supporting recovery, and connecting the Individual to services that support those goals. Recovery Support links individuals to community resources, identifies and problem-solves barriers that limit independent living, and builds on strengths and interests that support well-being. This service provides crisis relapse prevention, active case management, and referrals to other independent living and behavioral health services to help the Individual maintain self-sufficiency and well-being.

Service type	Mental health, substance use disorder, or both
Allowable Settings	• Community
Billing information	Fee codes for this service are: • Recovery Support-MH • Recovery Support-SUD **Telehealth** This service is allowed via telehealth-see DBH Fee Code Guide.
Admission Requirements	The individual must meet all of the following admission guidelines to be admitted to this service: • The individual demonstrates symptomatology consistent with a primary diagnosis, as outlined in the current edition of the Diagnostic and Statistical Manual (DSM) of Mental Disorders published by the American Psychiatric Association, which requires and can reasonably be expected to respond to therapeutic intervention. • Demonstrated inability to sustain independent housing and living without professional support • History of multiple treatment episodes and/or recent episode(s) with a history of poor treatment adherence or outcome • Requires assistance in obtaining and coordinating treatment, rehabilitation, and social services • It is expected that the individual will be able to benefit from this treatment • This level of care is the least restrictive setting that will produce the desired results in accordance with the needs of the individual

SERVICE EXPECTATIONS	**Assessments:** • If an IDI was completed within 12 months prior to admission, and is determined to be clinically relevant, it may serve as the admission IDI. If there has been a gap in treatment of six months or more, or if there is new information available, an IDI addendum must be completed and may serve as the admission IDI • If an Initial Diagnostic Interview (IDI) has not been completed within the 12 months prior to admission, a new IDI or IDI addendum must be completed within 24 hours of the beginning of treatment. The IDI must meet the requirements as noted in the Initial Diagnostic Interview definition in this manual **Support Services** • Connection to community resources for behavioral health and independent community living needs • Advocacy, problem solving, active intervention for stabilization, prevention of increased impairment, and psychoeducation for illness management • Face-to-face contact one time per month, at a minimum **Treatment Planning** • An initial treatment plan must be developed within 24 hours of admission and include a crisis and/or relapse prevention plan that addresses mental health and/or substance use goals • Under clinical supervision, develop an individualized treatment, rehabilitation, and recovery plan, including a discharge plan, with the individual within 30 days of admission • Review must be completed with the individual under the direction of the treatment team every 120 days, or as clinically indicated. **Discharge Planning** • Discharge planning is an ongoing process that occurs throughout the duration of service. A documented discharge plan must be completed as part of the individualized treatment, rehabilitation, and recovery plan • A transition plan must be completed prior to discharge.
LENGTH OF SERVICE	Length of service is individualized and based on clinical criteria for admission and continuing stay, as well as the client's ability to demonstrate progress on Individual treatment/recovery goals. The treatment plan will document the amount, duration, and frequency of services.
STAFFING	**Recovery Worker:** Must have one of the following: • High school diploma or equivalent; 2 years lived experience or 2 years direct care experience in the human services field; knowledge of community resources, trauma-informed care principles, recovery and rehabilitation principles • Peer Support certification preferred

	Additional Requirements • Supervision by a licensed clinician
STAFFING RATIO	1 Recovery Support Worker: 50 Individuals
HOURS OF OPERATION	To ensure access for all individuals, providers should be able to provide services during evening and weekend hours in addition to typical business hours with 24/7 access to crisis intervention services. Weekend and evening hours may be by appointment as appropriate for established clients if the provider is not typically open outside of business hours.
CONTINUED STAY REQUIREMENTS	All of the following criteria must be met for continuing treatment at this level of care: • The acuity of the individual's symptoms continues to necessitate treatment at the current level of care based on admission criteria • The individual does not require a more intensive level of services and no less intensive level of care is appropriate • The individual's treatment plan is up to date, with targets that are appropriate and related to improvement in the individual's symptoms and achievement of their goals. • The individual is making progress towards rehabilitation goals, and they are showing progress towards symptom reduction as demonstrated by objective behavioral measurement of functional improvement or standardized report from the member or guardian of symptom and/or functional improvement. • If progress has not been made or symptoms have increased, the treatment plan has been modified to focus on any new symptoms or to address barriers to progress. • There is evidence that the treatment team is working towards a transition plan to meet the individual's treatment needs once this level of care is no longer appropriate.
DESIRED INDIVIDUAL OUTCOME	• The individual has substantially met the treatment, rehabilitation, and recovery plan goals and objectives • The precipitating condition has stabilized such that there is sustained improvement in the health and psychosocial functioning • The individual's condition can be managed without the professional external supports and interventions at this level of care • The individual has alternative support systems secured to help maintain active recovery and stability in the community • The individual is connected to the next appropriate level of care necessary to treat the condition

Supported Employment-Extended Services

Supported Employment-Extended Services is provided after an individual has met their goal of stable competitive employment and transitioned from Vocational Rehabilitation's Supported Employment services, while still requiring/benefiting from recovery and rehabilitation supports

to maintain community-based employment. This service is for individuals with significant disabilities that constitute, or result in, a substantial barrier in retaining employment. Services align with the individual's strengths, abilities, interests, and informed choice. The service functions similarly to job stabilization, allowing the level of intensity and frequency of contacts and interventions to be gradually reduced.

SERVICE TYPE	Mental health, substance use disorder, or both
ALLOWABLE SETTINGS	• Community (including job sites, neutral setting away from workplace, clinic, or office)
BILLING INFORMATION	Fee codes for this service are: • Supported Employment Extended Services-MH • Supported Employment Extended Services-SUD If service is rendered in a CCBHC: • SEESinCCBHC-MH • SEESinCCBHC-SUD **Telehealth** This service is allowed via telehealth-see DBH Fee Code Guide.
ADMISSION REQUIREMENTS	The individual must meet all of the following admission guidelines to be admitted to this service: • The individual demonstrates symptomatology consistent with a primary diagnosis, as outlined in the current edition of the Diagnostic and Statistical Manual (DSM) of Mental Disorders published by the American Psychiatric Association, which requires and can reasonably be expected to respond to therapeutic intervention. • Presence of functional deficits in two of three functional areas: ○ Instrumental activities of daily living: inability to be employed or an ability to be employed only with extensive supports; or deterioration or decompensation resulting in inability to establish or pursue educational goals within normal time frame or without extensive supports; or inability to consistently and independently carry out home management tasks ○ Social functioning: repeated inappropriate or inadequate social behavior or ability to behave appropriately only with extensive supports; or consistent participation in adult activities only with extensive supports or when involvement is mostly limited to special activities established for persons with mental illness; or history of dangerousness to self/others ○ Activities of Daily Living: Inability to consistently perform the range of practical daily living tasks required for basic adult functioning as evidenced by functional limitations in at least three of the 5 following areas: • Grooming, hygiene, washing clothes, meeting nutritional needs • Care of personal business affairs

	• Transportation and care of residence • Procurement of medical, legal, and housing services • Recognition and avoidance of common dangers or hazards to self and possessions • The individual has achieved stabilized employment through Vocational Rehabilitation (VR) Supported Employment Services and has provided the following information: **a**. Employment information (name of employer, address, and direct supervisor; employee title, start date, average hours worked weekly, current wage, benefits) **b**. Individual's progress towards competitive job stabilization **c**. Description of job fading **d**. Current natural supports • The individual has a desire to maintain competitive stable employment • It is expected that the individual will be able to benefit from this treatment • This level of care is the least restrictive setting that will produce the desired results in accordance with the needs of the individual
SERVICE EXPECTATIONS	**Assessments:** • Perform brief screening of the intensity of the situation **Support Services** • Face-to-face contact with the individual after admission and regular contact based on an individual's needs • On-site and off-site job support and job skill development, when requested by the individual and/or their employer • Coordination and participation with treatment plan goals • Documentation will include coordination with employers, other services and treatment providers, including medical providers, linkage to services and identified internal/external supports • Oversight and regular monitoring for opportunities of advancement, per individual interest • Referrals to crisis assistance must be available 24 hours a day, 7 days a week **Treatment Planning** • An initial treatment plan must be developed, including hours and wages worked, a relapse prevention plan, a crisis prevention plan, and a discharge plan, with the individual within 30 days of admission • Under clinical supervision, the individualized treatment, rehabilitation, and recovery plan must be reviewed every 90 days, or as needed. **Discharge Planning** • Discharge planning is an ongoing process that occurs throughout the duration of service. A documented discharge plan must be completed as part of the individualized Treatment, Rehabilitation, and Recovery Plan

	• A transition plan must be completed prior to discharge.
LENGTH OF SERVICE	Length of service is individualized and based on clinical criteria for admission and continuing stay. The anticipated duration of the service must be documented in the treatment, recovery, rehabilitation plan
STAFFING	**Program Director:** Must have the following: • Three years of experience in vocationally related service, vocational-related degree preferred, or a Program Director of other rehabilitation service **Supported Employment Specialist:** Must have one of the following: • High school diploma with a minimum of 2 years of experience in the field and training, preferably by a nationally accredited training program, with evaluation of course competency. Supported Employment Specialists must be capable of performing all phases of vocational services (engagement, assessment, job development, job placement, job coaching, and follow-along supports) **Additional Requirements** • All program staff must be trained in the Individual Place and Support (IPS) model
STAFFING RATIO	1 Employment Specialist: 25 Individuals
HOURS OF OPERATION	To ensure access for all individuals, providers should be able to provide services during evening and weekend hours in addition to typical business hours, with 24/7 access to crisis intervention services. Weekend and evening hours may be by appointment as appropriate for established clients if the provider is not typically open outside of business hours.
CONTINUED STAY REQUIREMENTS	All of the following criteria must be met for continuing treatment at this level of care: • The acuity of the individual's symptoms continues to necessitate treatment at the current level of care based on admission criteria • The individual does not require a more intensive level of services and no less intensive level of care is appropriate • The individual's treatment plan is up to date, with targets that are appropriate and related to improvement in the individual's symptoms and achievement of their goals. • The individual is making progress towards rehabilitation goals and they are showing progress towards symptom reduction as demonstrated by objective behavioral measurement of functional improvement or standardized report from the member or guardian of symptom and/or functional improvement. • If progress has not been made or symptoms are increased, the treatment plan has been modified to focus on any new symptoms or to address barriers to progress.

	• There is evidence that the treatment team is working towards a transition plan to meet the individual's treatment needs once this level of care is no longer appropriate.
DESIRED INDIVIDUAL OUTCOME	• The individual has substantially met the treatment, rehabilitation, and recovery plan goals and objectives • The precipitating condition has stabilized such that there is sustained improvement in the health and psychosocial functioning • The individual's condition can be managed without the professional external supports and interventions at this level of care • The individual has alternative support systems secured to help maintain active recovery and stability in the community • The individual is connected to the next appropriate level of care necessary to treat the condition • The Individual is competitively employed and maintaining a job of choice

SOAR

SSI/SSDI Outreach, Access, and Recovery (SOAR) is a dedicated service program committed to assisting individuals who are experiencing homelessness, or at risk of homelessness, and have a severe mental illness (SMI), medical impairment, or a co-occurring substance use disorder. SOAR providers help individuals access disability benefits, including Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI).

SERVICE TYPE	Mental health, substance use disorder, or both
ALLOWABLE SETTINGS	• Facility • Community • Office or Clinic
BILLING INFORMATION	Fee codes for this service are: • SOAR-MH • SOAR-SUD **Telehealth** This service is allowed via telehealth-see DBH Fee Code Guide.

ADMISSION REQUIREMENTS	The individual must meet all of the following admission guidelines to be admitted to this service:
	• This service is for individuals experiencing homelessness or who are at risk of homelessness. Individuals experiencing homelessness are defined as:
	  ○ An individual or family who lacks fixed, regular, and adequate nighttime residence (i.e., living in emergency shelters, transitional housing, places not meant for habitation, **OR**
	  ○ An individual or family who will immediately lose their primary nighttime residence (within 14 days), provided that no

	subsequent housing has been identified and the individual/family lacks support networks or resources needed to obtain housing, **OR** ○ Unaccompanied youth under 25 years of age, or families with children and youth who qualify under Federal statutes, have not had a lease or ownership interest in a housing unit in the last 60 or more days, have had two or more moves in the last 60 days, and who are likely to continue to be unstably housed because of disability or multiple barriers to employment, **OR** ○ An individual or family who is fleeing or attempting to flee domestic violence, has no other residence, and lacks the resources or support networks to obtain other permanent housing. ○ At Risk of Homelessness is defined as: ○ An annual income below 30% of the median family income for the area, as determined by Housing Urban Development, **AND** ○ Do not have sufficient resources or support networks, immediately available to prevent them from moving to an emergency shelter or place not meant for habitation, **AND** ○ Exhibit one or more risk factors of homelessness, including recent housing instability or exiting a publicly funded institution or system of care such as foster care or a mental health facility. • SOAR is appropriate for individuals being served by the Department of Veterans Affairs (VA), Supportive Services for Veteran Families (SSVF), Department of Housing and Urban Development-VA Supportive Housing, Housing First, and other Permanent Supportive Housing for those who have recently been experiencing homelessness.
SERVICE EXPECTATIONS	**SOAR critical components** • Serving as the individual's representative by completing the SSA-1696: Appointment of Representative form, receiving notices mailed to the individual, communicating directly with SSA and DDS to provide information, and obtaining records from the individual's application file. • Solicit clinical and medical records from providers and assist the individual in gathering and providing relevant and sufficient documentation for the application • Use the Medical Summary Report (MSR) to provide an overview of the applicant's life story and how they came to be in their current circumstances. This is a succinct, comprehensive summary of the applicant's medical treatment history, and describes any functional impairments that stem from mental or physical health conditions and affect their ability to work. • Each MSR must be reviewed by a supervisor or a SOAR-trained mentor prior to submission, as applicable. • Follow Nebraska's Standard SOAR Process for Completing SSI/SSDI

	Applications, including using the SOAR Functional Assessment Statement (FAST) Medical Summary Report (MSR).
	
	Support Services
	• Facilitates the completion of the intake process, including all required paperwork
	• Assists the individual in gathering all materials for the Social Security Administration (SSA) and Disability Determination Services (DDS) application process
	• Support the individual in establishing a Protective Filing Date (PFD) for the Online Disability Benefits Application
	• Complete application packets and submit all required documentation within 60 days after establishing the PFD
	• Complete an SSI/SSDI application, including all required forms with the individual
	• Submit the Online Disability Benefits Application, then submit a completed Paper Application packet within required timelines
	• Complete the following, as needed:
	  ○ SSA Appeals Process
	  ○ SOAR Referral Tool
	  ○ Work Activity Report
	  ○ Claimant's Appointment of Representative
	  ○ Functional Report
	  ○ Consent of Release of Information
	
	Discharge Planning
	• Discharge planning is an ongoing process that occurs throughout the duration of service and must be completed prior to discharge.

LENGTH OF SERVICE	At least 45 days, pends appeal process
STAFFING	**SOAR Providers** • Completed the Nebraska SOAR course on a yearly basis OR; • Complete the Nebraska SOAR Recertification with an updated Certification of Completion **Additional Requirements** All program staff must complete training and become certified through the Nebraska SOAR certification program. Providers must recertify their certification when appropriate.
STAFFING RATIO	1 SOAR provider: 5-10 active cases
HOURS OF OPERATION	Typical business hours
CONTINUED STAY REQUIREMENTS	All of the following criteria must be met for continuing treatment at this level of care: • Application is being collected or pending

DESIRED INDIVIDUAL OUTCOME	• The individual has completed the SOAR application and has confirmation on the outcomes of their application.

Professional Partner Program (PPP) Appendix

PPP is a behavioral health, wraparound service for individuals aged 3-25 years old and their families who are experiencing serious mental or emotional disturbances and who have a diagnosable mental, behavioral, or emotional disorder. This program uses the evidence-based Wraparound model to develop a planning and implementation process that creates a unique, individualized set of services and natural supports to meet the needs of the individual and their family. The program emphasizes the meaningful involvement of parents, family members, and youth to build advisory and policy-development capacity, including in developing and implementing quality monitoring and program evaluation practices.

Eligibility and Admissions

PPP is specifically designed to serve youth at risk of hospitalization or out-of-home placement; therefore, eligibility must be determined before the individual, and their family are admitted to this service. The eligibility and admissions steps are:

1. When a referral is received, PPP staff will screen the individual to determine if the individual is an appropriate fit for this service.
    - If yes, then proceed to the next requirement
    - If no, then refer the individual to another service immediately

2. PPP staff will determine if the individual meets eligibility requirements (listed in the Admission Criteria section of the service definition), including:
    - Age requirement
    - Documentation of behavioral health symptomatology in the form of an Initial Diagnostic Interview (IDI) to be placed in the individual's file.
        - **If an IDI was completed within 12 months prior to admission** and is determined to be clinically relevant, it may serve as the admission IDI. If there has been a gap in care of six months or more, or if new information is available, an IDI addendum must be completed and may serve as the admission IDI
        - **If the individual has not been previously diagnosed** but an acceptable diagnosis is considered likely, the Care Coordinator may use information provided by the youth/family about the individual's bio-psychosocial history as well as a CAFAS/PECFAS score as evidence that a diagnosis is probable. With this documentation, the individual may be accepted into the program, contingent upon an IDI from a licensed professional confirming a diagnosis is received within **60 calendar days of the admission date**
        - **If an IDI is not received within 60 calendar days** of the admission date,

the individual must be discharged from the program within 30 calendar days from that determination.

- Functional deficits
- Family member/caregiver involvement
- Lack of duplication of services
- Appropriateness of level of care and likelihood to benefit from service

    - If all requirements are met, or can be reasonably assumed, proceed to the next requirement.
    - If all requirements are not met, refer the individual to another service immediately.

3. PPP staff will assess the individual using the Child and Adolescent Functional Assessment Scale (CAFAS) and Preschool or Early Childhood Functional Assessment (PECFAS). These tools will assess the individual's degree of functional impairment across several subscales (School/Work Role Performance, Home Role Performance, Community Role Performance, Behavior Toward Others, Moods/Emotions, Self-Harmful Behavior, and Substance Use Thinking). <u>For eligibility purposes, the following score requirements apply:</u>

    - CAFAS score of 80 or greater and moderate/severe in two subscales OR
    - PECFAS score of 70 or greater and moderate/severe score in two subscales OR
    - Moderate/severe score in at least two subscales (moderate is considered at 20 or above).

    - If the CAFAS/PECFAS score requirements are met, and all other requirements have been met, proceed to the next requirement.
    - If the individual does not meet the minimum score on the CASAS/PECFAS during this eligibility period but it is likely that the individual is appropriate for this level of care, the Care Coordinator must complete an Exception Waiver Form within 7 business days of determining the need for a waiver exception. Or PPP staff can choose to refer the individual to another service immediately.

    The Exception Waiver form can be emailed to DBH (DHHS.DBHNetworkOperations@nebraska.gov) and will be reviewed in the order received, with review completed within 7 business days of receipt. After reviewing, DBH staff will contact the provider with a response to their waiver request via email or phone.

4. PPP staff will set an "Admission Date" for the individual and their family. The *admission date* is the day the individual/family entered/started PPP services, and Phase One activities must begin that day. Enter the Admission Date in the CDS system to reflect the start of a billable month for this service.

- Families with multiple individuals who individually meet the admissions criteria may be considered separate "clients" for the purpose of client load sizes.

The Wraparound Model

The Wraparound service model provides a team-based, family-centered approach to individualized support to help youth remain safely in their homes and connected to their communities. Individuals and their families receive a customized blend of traditional and non-traditional services with a tiered system of phases and individualized plans of care. The Nebraska Professional Partners Program embodies the wraparound approach to service delivery and consists of 10 Principles:

1. **Family voice and choice**: families are active in every level of the wraparound process.
2. **Team-based**: wraparound is a team-based process with everyone working together to develop, implement, and evaluate an individualized plan.
3. **Natural supports**: services and supports reflect a balance of formal and informal community and family supports.
4. **Collaboration**: the team coordinates services and supports, creating a seamless flow of interventions and resources.
5. **Community-based**: services and supports are based in the individual/family's community.
6. **Culturally competent**: the team remains respectful of the family's unique beliefs, traditions, identity, and perspectives.
7. **Individualized**: the team creates a specific plan to meet the family's goals and a crisis/safety plan to manage potential emergencies.
8. **Unconditional Care**: the team is committed to working alongside the family every step of the way and adopts a "whatever it takes" approach.
9. **Continuation of care**: services and supports are provided unconditionally.
10. **Outcome-based**: specific, measurable outcomes to monitor the individual and family's progress towards goals.

The Phases of the Wraparound Fidelity Model

Phase One: Family and Team Engagement (must occur within 14 days of admission)

- Orient the family and individual to the program and the wraparound model
- Ensure urgent needs and safety concerns are addressed, then create a crisis/safety plan (or a preventative plan)
- Facilitate conversations around care planning and engagement with the individual, their family, and other identified team members

Phase Two: Initial Plan of Care (must occur within 14 days of entering Phase Two)

- Prioritize needs and brainstorm strategies for success
- Establish ground rules and create a team mission for all team meetings
- Develop the initial Plan of Care and prioritize goals based on needs
- Schedule first Team Meeting to take place in Phase Three
- Review crisis/safety plan including emergency contacts and update accordingly

Phase Three: Plan Implementation (must occur every 30 days; then activities of phase are repeated until POC goals are achieved and formal wraparound isn't needed)

- Implement the POC and monitor objectives and strategies to achieve outcomes
- Review and update the POC to reflect progress towards each goal and continued interventions identified
- Maintain and build team trust and rapport
- Document the necessary program logistics, including meeting schedules, preferred methods of communication, and other activities

Phase Four: Transition (must occur within 60 days of entering Phase Four)

- Plan a purposeful transition out of services for the individual/family, including a post-transition crisis management plan
- Complete a transition letter that documents the team's work and celebrates successes
- Follow up with the family and provide support, if necessary.

Wraparound Fidelity Index (WFI) Tool

The Wraparound care coordination model is a research- and evidence-based process that seeks to improve the lives of children and their families with complex needs. The Wraparound Fidelity Index (WFI) tool measures the relationship between service processes and program outcomes, quality improvement, and fidelity to the model. It is based on the four phases of wraparound care: Engagement, Plan Development, Implementation, and Transition.

PPP uses the Wraparound Fidelity Index, Short Form (WFI-EZ) tool to gather data on the program's overall fidelity, key element fidelity scores, satisfaction, and outcomes. The WFI-EZ is a brief self-report survey that can be administered online, via paper, or through an interview and takes about 10 minutes to complete. The WFI-EZ has four types of respondents: parents/caregivers, youth (11 years of age or older), team members, and Care Coordinators. These interviews should be presented to each participant as a confidential opportunity for families and individuals to share their voice and make effective change.

WFI-EZ Implementation

The individual/family should have received wraparound for at least 30 days before the first interview. If you cannot administer the tool within those 30 days, administer it within 3-6 months after Phase One activities begin. Interview the individual and their family within a 1- to 2-week period of each other. Care Coordinators must administer the WFI tool every 6 months after the initial completion. (See PPP Reporting Schedule)

Care Coordinators and all staff administering the WFI tool must be trained to understand what it means to assess "fidelity" in wraparound programs. Interviewers should be trained on the interviewer role, the administration process, entering and managing WFI data (including WFI ID#s), collecting consent forms, and the tool's scoring process. All Care Coordinators will specify a process for regularly distributing and collecting the WFI-EZ, including scheduling, administration, and scoring. Data collection can be translated into summary reports, fidelity monitoring, and quality assurance plans.

Team Meetings

Team Meetings are an important part of the wraparound process to ensure strong support and engagement. For the individual/family's first team meeting, the team will develop ground rules and the family's mission. The individual/family will prioritize their needs, and the team can brainstorm strategies, services, and supports to meet each selected need. The Care Coordinator will lead the team meeting and document all team decisions in the team meeting notes and, if appropriate, in the plan of care.

The first team meeting will take about 90 minutes and can sometimes be split into two team meetings. In these situations, the team meetings should be scheduled within one week of each other. After the first team meeting, each team meeting can be used to assess the effectiveness of the POC. Based on these discussions and discoveries, the Care Coordinator will update or revise the POC in writing.

Meaningful Contact

For the purpose of this service definition, the term "*meaningful contact*" is defined as an interaction between the Care Coordinator and/or other formal and informal supports that is expected to further the accomplishment of the goals for the individual/family as identified in the POC (such as a family visit or team meeting). Meaningful contacts must take place in person, via face-to-face telehealth, or by phone, and the Care Coordinator is responsible for making all reasonable efforts to schedule and conduct these interactions.

Documentation Requirements

Crisis/Safety Planning

Crisis/Safety planning, or preventative safety/crisis planning, is a standard component of this level of care and wraparound services. A good crisis/safety plan identifies what could go wrong and how people should respond. All plans should include who will inform whom, when to make contact, and emergency/crisis contact information. Give a copy of the crisis/safety plan to everyone on the team and review and/or update it at every team meeting, as needed.

In the event of a crisis, the Care Coordinator must schedule an emergency team meeting within 72 hours of the crisis. At the emergency team meeting, review and update the crisis/safety plan accordingly. A sample Safety/Crisis plan can be found in the Forms section of this appendix.

Interpretive Summary

The interpretive summary contains information that has been gathered from the intake paperwork, the individual/family, and other collateral providers. This document summarizes the individual and their family's strengths, needs, abilities, and preferences, and biopsychosocial history (including diagnosis, presenting problem) and other relevant information about the family's dynamics.

Initial Plan of Care

The initial Plan of Care (POC) is an individualized, preliminary plan that addresses the short-term, prioritized goals established during Phase Two of the program. The initial POC shall be in effect until the Plan of Care has been formally developed during Phase Three.

Plan of Care (POC)

The Plan of Care (POC) is a working document that reflects information gathered during Phase One and Two (i.e., the initial POC) and is updated throughout the duration of the program.

The POC must be developed with the individual and their family and may include input from formal or informal supports. It will address the individual's and their family's needs (reasons behind the individual's behaviors) and must align with the results of IDI, CAFAS/PECFES, and any other assessments performed. Regularly review the individual's progress and revise goals as

outlined in the service definition. POC goals must align with the reason the individual was referred to the program, be individualized, and person-centered. The individual and their family's involvement in developing the POC should match their age, ability, and strengths.

The Plan of Care must (but is not limited to):

- Be oriented to and apply the principles of the wraparound process, including but not limited to inclusion, direct and active participation, and a meaningful life in the community of one's choosing
- Incorporate and be consistent with best practices
- Include the individual's individualized goals and expected outcomes in their own words, if possible
- Contain prioritized objectives that are measurable and time-limited
- Describe objectives or interventions that are trauma-informed, person-centered, and strength-based
- Identify staff responsible for implementing the objectives or interventions
- Specify the planned amount, frequency, and duration of each objective or intervention
- Delineate the specific criteria to be met for discharge or transition to a lower level of care (See Transition and/or Discharge Planning)
- Documentation from suicide screening tool(s) including a component to avoid crises or admission to a higher level of care using principles of recovery and wellness, including 24/7 crisis resources. May include the safety or crisis plan.
- Document that the POC is completed within the time frame specified in the service definition
- Document that the plan has been developed, reviewed, updated, and revised with the direct and active involvement of the individual and their parents or guardians, as appropriate and authorized by the individual. If documentation shows that the individual is not achieving their goals, timely revision of the plan must be documented
- Include the signature of the individual or guardian, or both, to indicate agreement with the plan. If the individual served is under the age of 18, the plan must be signed by a parent or guardian
- Be approved and signed by the licensed clinician or supervisor if provisionally licensed

PPP Team Meeting Notes

Team meeting notes provide a written narrative of the collaboration, engagement, and work happening with the individual/family and their team. These notes should document which phase of wraparound the individual/family is currently in, progress toward POC goals, barriers or setbacks in achieving individualized POC goals, and all team discussions. All documentation should reflect how each team member was involved in creating goals to meet the needs of the individual (and family), utilizing strengths and abilities to achieve goals, and any decision-making between the individual and their team members.

PPP Progress Notes

Each progress/contact note must contain a chronological record of all activities provided to the individual, the date performed, the duration of the activity (including session start and end times), and the staff member who conducted the session. Progress notes must document implementation of the individual's POC. Progress notes must be completed within the time frame specified in the program's policies and procedures and document all actions/activities provided or attempted.

Progress notes must:

- Include the date, place, and modality of the services
- Substantiate the activity provided through narrative description, including a summary of interventions delivered or attempted
- Include an accurate start and end time
- Indicate how the activity provided, or attempted, relates specifically to goals and priorities identified in the POC
- Document the individual's (and their family/supports) participation in the activity, and revision of goals and objectives/interventions, as needed
- Periodically, the progress note should document collaborative review of progress measures and their patterns over time, directly with individuals to ensure care remains aligned with their goals, supports shared decision-making, and promotes meaningful progress toward improved well-being.

Transition and/or Discharge Requirements

Transition and/or Discharge Planning

Transition and discharge planning is an ongoing process that occurs throughout the wraparound process. A documented discharge plan must be completed as part of the Plan of Care (POC) and should be collaboratively developed by the team. Once the team agrees the individual and family are ready for discharge, planning for formal transition should begin at least 90 days before the formal discharge. During the transition process, the team will/may identify and prioritize new goals or needs for a successful transition. The goal of the transition process is to successfully connect the individual/family to supports and services within the community. The discharge plan must be documented in the individual's POC and include the supervising clinician's signature and the date of signature.

The discharge plan must:

- Be provided within the time frame specified in the program's policies and procedures, which considers the prompt transfer of clinical records and information to ensure continuity of care

- Document the individual's progress in relation to the Plan of Care, addressing all goals identified by the individual/family and how strengths have been utilized
- Describe the reason(s) for discharge

Transition Letter

A transition letter must be completed prior to the formal discharge date and will summarize the work done throughout the program. The transition letter should highlight the family's strengths and successes, what has been helpful or worked for the family, a summary of CAFAS/PECFAS scores, the discharge plan including aftercare and referral information, and an updated crisis/safety plan. The POC and transition letter must be given directly to the family and/or mailed to the family within 30 days of the formal discharge.

Discharge Process

Once the individual has been discharged from PPP, the Care Coordinator (or another team member) has 15 days to discharge the individual from CDS. The reason for the individual's discharge needs to be documented in CDS also. The month of the individual's discharge can be billed **if** a meaningful contact took place during that calendar month.

If the individual/family is indirectly refusing to participate, the Care Coordinator must attempt to contact the individual and family up to 30 days as evidenced by frequent phone calls, home visits, and/or letters. If these attempts yield no contact, the Care Coordinator must discharge the individual from the program. The individual will be considered discharged from the program as of the date indicated on the Professional Partners Program Discharge Form.

The individual must be discharged if: Goals cannot be met within the level of care, the individual is no longer eligible for PPP based on the admission criteria, the individual/family is directly or indirectly refusing services, or the youth/family becomes Medicaid eligible and obtains or is referred to services and/or supports that have reduced the need for wraparound services (such as PPP).

Staff Training Requirements

Care Coordinators

Must have:

- Background checks completed
- Have a minimum of a bachelor's degree in a human service-related field or equivalent field experience
- A minimum of 4 contact hours of orientation/training in topics that may include, but are not limited to:

  - program policies and procedures
  - wraparound process and fidelity procedures
  - goal setting and objective writing
  - suicide screening/prevention, tools, and crisis intervention techniques
  - boundaries and ethics
  - youth behavioral health

- A minimum of 40 hours of core training and shadowing experience including, but not limited to:
  - the wraparound process, fidelity procedures, and the WFI tool
  - screening/enrollment/discharge procedures
  - confidentiality and ethics
  - youth mental health/ substance use
  - CAFAS/PECFAS and other tool utilization
  - POC development
  - crisis/safety planning
  - family-centered practice

- At least 12 continuing education hours completed every 2 years from the start date of employment. Topics may include, but are not limited to:
  - cultural competency
  - diagnostic health/therapeutic interventions for youth
  - wraparound, trauma
  - evidence-based practices
  - IEP process
- Documentation of completed trainings (available upon request)

Reporting Requirements

PPP providers will submit programmatic and service outcomes for both the program and the individuals and families served. PPP providers will submit data for the Descriptive Information Questionnaire (DIQ), CAFAS/PECAFAS, Protective Factors Survey (PFS), Suicide Behaviors Questionnaire Revised (SBQ-R), and Wraparound Fidelity Index (WFI) into the CDS. PPP providers must submit this data by the 30th of the month following the fiscal year quarter (see PPP Reporting Schedule).

PPP Reporting Schedule

Time Frame	Assessment to Use	Assessment Measures	Where to input assessment data

During Eligibility & Admissions	CAFAS/PECFAS	Assesses functional limitations and directs POC	CDS & EHR
During Phase One	DIQ	General information about individual & family	CDS & EHR
	PFS	Assesses family's protective factors	CDS & EHR
	SBQ-R	Assesses level of risk for suicide	CDS & EHR
During Phase Two	None	N/A	N/A
During Phase Three	WFI-EZ	Measures fidelity to the Wraparound model	CDS & EHR
Every 6 months from Admission Date	CAFAS/PECFAS	Assesses functional limitations	CDS & EHR
	WFI-EZ	Measures fidelity to the Wraparound model	CDS & EHR
	PFS	Assesses family protective factors	CDS & EHR
At Discharge	CAFAS/PECFAS		CDS & EHR
	PFS		CDS & EHR
Annually (and as needed)	SBQ-R		CDS & EHR

PPP Monthly Wraparound Financial Report

A Monthly Wraparound Financial Report must be submitted to DBH and provide a record of how any flexible funds are directly supporting the behavioral health, safety, and well-being of the individual/family. The monthly financial report will account for program operations, fund expenditures and income, and indicate the specific goals/objectives in the POC that purchases are supported for each individual/family. Document further funding details in individual progress notes and/or team meetings.

PPP providers should have a process for monitoring expenditures for: 1) each individual and family (individually), and 2) all individuals and families served through the PPP. The Program shall have a process for managing service delivery to stay within the overall budget, and it shall

monitor and evaluate the use of all funds for cost-effectiveness and, most importantly, to improve individual outcomes.

The due date for each Monthly Wraparound Financial Report is 30 days after the end of each reporting period, with a 10-day grace period (e.g., the August report is due by September 30th but must be in by October 10th). Send these reports directly to the Division of Behavioral Health Network Team, who will review and approve all reports and maintain the data within DBH. DBH maintains the right to further inquire and deny any financial report or section therein if not deemed to meet the program criteria.

Month	**Monthly Wrap-Up Financial Report Due Date**
July	September 10th
August	October 10th
September	November 10th
October	December 10th
November	January 10th
December	February 10th
January	March 10th
February	April 10th
March	May 10th
April	June 10th
May	July 10th
June	August 10th

Program Financial Protocol

PPP Flex Funding Guidelines and Requirements

Each PPP Program must comply with all current protocols, policies, and/or regulations regarding allowable and unallowable costs. *All* flex funds must directly benefit the behavioral health,

safety, and well-being of the admitted individual and be indicated in the POC and other associated reporting. The entire team must approve all formal and/or informal services and supports purchased, and they must be clearly indicated as directly supporting a POC goal.

If private insurance is present, it will be considered the primary payor. All payor sources, private and public, will be exhausted before using PPP flexible funding to reimburse those services or subsidize insurance payments, including Medicaid. Public funds provided in the PPP shall cover only those services not covered by private insurance or other funding sources such as:

- Initial Diagnostic Interviews and/or Addendums
- Substance Use Disorder Assessments and/or Addendums
- Mental Health and/or Substance Use Outpatient Therapy
- Psychotropic Medications prescribed to the individual
- Crisis prevention services
- Mental Health and/or Substance Use Respite services
- Interpretation services and supports
- Team Celebration Expenses (a successful discharge, meeting a goal on behavioral contract)
- Specialized transitional living services
- Vocation-related and education-related skills training, education, and support services
- Recreational programs and services
- Health services
- Parental education and skills training services and supports
- Legal services
- Housing (including rent and maintenance)
- Utilities (including telephone service, calling cards, heating costs, etc.)
- Transportation services for therapeutic services or related events (PPP cannot transport an individual unless the PPP ensures it is in compliance with State requirements for transporting consumers).
- General economic support for basic needs which cannot be adequately described by the other service categories.

PPP Billing Process and Guidelines

The PPP provider agrees to comply with their DBH Contract and the payment request, payment process, and financial data reporting for the Professional Partner System (specified below). DHHS will require repayment of funds used to pay for any service not identified by the Plan of Care or found to be reimbursable by another payor source, such as family private insurance or Medicaid.

The provider may bill DBH for the initial CAFAS/PECFAS assessment completed during the

eligibility and admissions process. Reimbursement for the initial CAFAS/PECFAS tool will be based on a flat, fixed rate and will include the cost of the tool and the PPP staff's time to use it. This cost will be allowed once per individual, per encounter, and will be reimbursed after completion and submission of documentation to DBH through the EBS/CDS.

A billable month of service starts on the Admission Date of starting the program, which should be the same day that Phase One activities begin. Each billable month must include at least one (1) *meaningful contact* between the individual/family and members of the team that is therapeutic and meaningful in nature. Meaningful contacts must take place in person, via face-to-face telehealth, or by phone, and the Care Coordinator is responsible for making all reasonable efforts to schedule and conduct these interactions.

If the Care Coordinator does not make meaningful contact with the individual and family during the billing month, the PPP Program should not bill for the service. Keep detailed documentation supporting all outreach attempts, scheduled meetings, cancellations, and collateral contact.

PPP Monthly Financial Reporting Form Guide

Funding Service Categories

Treatment Category

- Initial Diagnostic Interview or Assessment
  - Mental Health and/or Substance Use
- Youth Outpatient Therapy (Mental Health and/or Substance Use)
  - Group Outpatient Therapy (Mental Health and/or Substance Use)
- Family therapy (Mental Health and/or Substance Use)
- Intensive Family Preservation (IFP)
- Psychotropic medications
- Day treatment
- Inpatient residential

Community Services and Supports

- Crisis prevention
- Respite services
  - Mental Health and/or Substance Use
- Interpretation services and supports
- Specialized transitional living services
- Home-Based services
- PPP Team Expenses (i.e. celebrations, supplies for meetings)

Youth Services and Supports

- Crisis prevention
- Respite services
  - Mental Health and/or Substance Use
- Mentoring
- Independent Living
- Supported Employment and Educational Services
- Tutoring
- Recreational programs and services
- Behavioral contracts
- Legal services
- Health services

Family and Economic Services and Supports

- Respite services
- Parental education and skills training services and supports (i.e. Parent Empowerment)
- Family Peer Mentoring
- Money Management
- Day Care
- Legal services
- Housing (including rent and maintenance)
- Utilities (including telephone service, calling cards, heating costs, etc.)
- Transportation services for therapeutic services or related events (PPP cannot transport an individual unless the PPP ensures it is in compliance with State requirements for transporting consumers).
- General economic support for basic needs which cannot be adequately described by the other service categories.

PPP Monthly Wraparound Financial Report Form
(Updated 2026)

Date:	Program:
Completed By (please print):	Signature:
Expenditure Category	**Monthly Cost**
Personnel Services	
Operating Costs	
Travel	
Other	
Total Expenditures	

Treatment	MH	SUD	Costs
Ex: Assessment			
Other:			
Total Treatment Costs			

Community Supports	Costs
Ex: Crisis Prevention	
Other Community Supports:	
Youth Supports	
Ex: mentoring	
Other Youth Support:	
Family & Economic Supports	
Ex: Housing	
Other Family/Economic Supports:	
Total Non-Therapeutic Costs	
Total Wraparound Costs	

PPP Annual Report Template

Overview of the Professional Partner Program

Eligibility Criteria

Adherence to the Wraparound Model

Youth Served in Fiscal Year

Total Number Served

Characteristics of Youths Discharged in Fiscal Year

Youth Psychiatric Diagnoses

Youth Problem Behaviors

Youth Risk Factors

Average Length of Stay

Age at Discharge

Gender

Race

Medicaid Eligibility

Family Characteristics of Youth Discharged in Fiscal Year

Family Risk Factors

Number of Dependents

Outcomes of Fiscal Year

CAFAS Results

PECFAS Results

Summary of Fiscal Year

References

PPP Exception Waiver Form for Admission

Documentation of the following information, including this cover page, should be submitted electronically to the DBH Network team (DHHS.DBHNetworkOperations@nebraska.gov) for further review.

Date_____
Region _____
PPP Supervisor _____
Date of eligibility screening_____

1. Descriptive Information Questionnaire.

2. Evidence that the individual has met the following admission criteria: DSM diagnoses, financial eligibility, functional impairment as evidenced by the CAFAS/PEFAS score, including subscales, and Child Behavioral Checklist Score (if applicable)

3. Please explain in detail why the exception process has been initiated.

4. Is the individual at significant risk of any of the following, if so why?

    - Being placed out of the home or in a more restrictive level of care, or becoming a state ward specifically in order to access behavioral health services

    - Dropping or staying out of school or vocation

    - Committing a criminal offense; becoming homeless

5. Why is this program the most appropriate level of service?

6. What is the recommended Plan of Care?

7. Other assessment results or documentation, as needed

Once all documentation is submitted, requests will be answered within 3 (three) business days by the Network Team at DBH.

General Service Limitations

Non-Covered Services

Services not covered include, but are not limited to:

1. Biofeedback services
2. Treatment that is primarily supportive, social or educational in nature
3. Art, play, or music therapy when provided as the primary modality of treatment

Services must meet the following requirements:

- For rehabilitation services provided at a work site, the rehabilitation service must not be job tasks oriented.
- Any services or components of services which the basic nature is to supplant housekeeping, homemaking, or basic services for the convenience of a person receiving covered services (including housekeeping, shopping, childcare, and laundry services) are not covered.
- Services shall not be provided in an Institution for Mental Disease (IMD).
- Room and board is excluded from any services or rates provided in a residential setting.
- Transportation of children is not included in rehabilitation services or rates.
- Education services are not included in or eligible for payment by Nebraska Medicaid, and do not apply toward the hours of minimum treatment activities for any service in this section. Practitioners providing services to youth must be familiar with each youth's IEP and coordinate with the youth and the youth's school to achieve the IEP. Education services may not be the primary reason for rehabilitation admission or treatment. Academic education services, when required by law, must be available.

Specific Service Limitations

Certified Peer Support Services

To provide Certified Peer Support services via telehealth, there must be at least one documented in-person visit with the individual being served at least once every 30 days.

Certified Peer Support is an ancillary service and must be provided in conjunction with one or more behavioral health services provided by a licensed clinician. The individual must have at least one clinical encounter (e.g. psychotherapy, medication management) with a licensed clinician for every 60 days of peer support.

DRAFT

Detoxification Services

Payment for alcohol and chemical detoxification in a hospital setting is limited to medically necessary treatment, subject to utilization review. This period includes an average detoxification period of two to three days, with occasional needs of up to five days when the beneficiary's condition dictates. A detoxification program for a particular beneficiary may exceed five days and be covered if determined medically necessary by Nebraska Medicaid and the Division of Behavioral Health. Services when the detoxification needs of the beneficiary no longer require an inpatient hospital setting are not covered.

Payment for Psychiatric Services

Payment is made for the day of admission, but not the day of discharge.

For DBH-covered psychiatric services, review DBH billing codes.

Payment for Psychiatric Adult Inpatient Subacute Hospital Services

Payments for psychiatric adult inpatient subacute hospital services are made on a per diem basis. The subacute inpatient hospital per diem rate is not a tiered rate. Payment is an all-inclusive per diem, except for physician services.

For DBH-covered psychiatric services, review DBH billing codes.

Prior Authorizations

For services provided to beneficiaries enrolled in a managed care program, providers of mental health, substance use disorder, must follow prior authorization requirements of the applicable managed care plan or DHHS Division of Behavioral Health services requirements and the requirements outlined in this document.

DBH-Only Medical and Therapeutic Leave

Medical Leave Days: Beds in Psychiatric Residential Rehabilitation, Therapeutic Community, Intermediate Residential and Dual Disorder Residential Treatment and Secure Residential programs can be held up to 10 consecutive days per episode when an individual is hospitalized for a period of medical/psychiatric stabilization and expected to return to the facility.

DRAFT

Individuals in ACT are allowed up to 10 consecutive days per episode when an individual is hospitalized for a period of medical/psychiatric stabilization and the ACT team is actively involved in the planning for return to the community and the individual is expected to return to ACT.

Documentation of the need for stabilization is reflected in the treatment plan and file. The program will be reimbursed at the full program rate per day. This reimbursement is only available if the treatment placement is not used by another individual. More than 3 episodes in a calendar year will result in a Level of Care review. Leaves in excess of 10 consecutive days must be approved by the Division of Behavioral Health or its designee and documented in the Centralized Data System (CDS).

Therapeutic Leave Days: Beds in Psychiatric Residential Rehabilitation, Secure Residential, Therapeutic Community, Intermediate Residential, Dual Diagnosis, and Halfway House programs can be held up to 21 days annually (from the date of admission) when an individual is on therapeutic leave for the purposes of testing ability to function at and transition to a lesser level of care. This reimbursement is only available if the treatment bed is not used by another individual.

Individuals discharging from Assertive Community Treatment (ACT) may be allowed a 30-day period of transition when discharging and moving to a lower level of service (outpatient therapy, medication management, community support mental health, community support substance use disorder, or day rehabilitation).

The treatment plan must indicate the therapeutic rationale and leave period. The individual's record must document the outcome of the therapeutic leave and the need for continued residential level of care. The Division will reimburse at the full program rate per day. Leave in excess of established time frames (21 days or 30 days for ACT per annum) must be approved by the Division of Behavioral Health or its designee and documented in the CDS.

DRAFT

DBH Service Fee Code Guide

DBH-Only Service Name	DBH Billing Code	Audio-Visual Telehealth	Phone Telehealth	For adults, youth, or both
24-Hour Crisis Line	○ 24-Hour Crisis Line-MH ○ 24-Hour Crisis Line-SUD *If billing for a CCBHC, see	X	X	Both
Mobile Crisis Response. *Formerly Crisis Response (MH or SUD)*	○ Mobile Crisis Response-MH ○ Mobile Crisis Response-SUD *If billing for a CCBHC, see	X	X	Both
Emergency Community Support	○ Emergency Community Support-MH ○ Emergency Community Support-SUD	X	X	Both
Hospital Diversion	○ Hospital Diversion-MH ○ Hospital Diversion-SUD			Adults
Respite *(formerly Mental Health Respite)*	○ Respite-MH ○ Respite-SUD			Both
Client Assistance Program (CAP)	○ CAP-MH ○ CAP-SUD	X		Both
Intensive Community Services	○ Intensive Community Services-MH ○ Intensive Community Service-SUD	X		Adults
Therapeutic Consultation (Adult or Youth & Adolescent)	○ Therapeutic Consultation	X	X	Both
Coordinated Specialty Care	○ Coordinated Specialty Care-MH *If billing for a CCBHC, see			Both (Ages 14-35)
Day Support	○ Day Support-MH			Adults
Recovery Support	○ Recovery Support-MH ○ Recovery Support-SUD	X	X	Adults
Supported Employment-Extended Services	○ Supported Employment-Extended Services-MH ○ Supported Employment-Extended Services-SUD	X	X	Adults
SOAR	○ SOAR-MH ○ SOAR-SUD	X		Both
Professional Partner Program	○ PPP-MH	X * see service definition		Both (Ages 3-25)

DRAFT

DBH & MLTC Shared Service Name	DBH Billing Code *For MLTC Codes-See MLTC Fee Schedule *If billing for a CCBHC, see	Telehealth		For adults or youth
Crisis Psychotherapy	○ Crisis Psychotherapy-MH ○ Crisis Psychotherapy-SUD	X	X	Both
Crisis Stabilization	○ Crisis Stabilization-MH ○ Crisis Stabilization-SUD			Both
Emergency Psychiatric Observation	○ Emergency Psychiatric Observation-MH ○ Emergency Psychiatric Observation-SUD			Both
Supervised Detoxification *(formerly Social Detox)*	○ Supervised Detoxification-SUD			Both
Initial Diagnostic Interview (IDI) *(formerly Mental Health Assessment)*	○ Initial Diagnostic Interview	X		Both
Initial Diagnostic Interview Addendum *(formerly Mental Health Assessment)*	○ Initial Diagnostic Interview Addendum	X		Both
Psychological Evaluation and Testing	○ Psychological Testing	X	X	Both
Substance Use Disorder Assessment (formerly Assessment-SUD)	○ Substance Use Disorder Assessment	X		Both
Substance Use Disorder Assessment Addendum	○ Substance Use Disorder Assessment Addendum	X		Both
Assertive Community Treatment	○ Assertive Community Treatment-MH			Adults
Certified Peer Support Services (formerly Peer Support)	○ Certified Peer Support Services (MH or SUD)	X *see Service Definition		Adults
Community Support	○ Community Support-MH ○ Community Support-SUD	X		Adults
Medication Management	○ Medication Management-MH ○ Medication Management-SUD	X		Both
Multisystemic Therapy (MST)	○ Multisystemic Therapy	X		Both
Opioid Treatment Program (OTP)	○ Opioid Treatment Program (OTP)-SUD	X	X	Adult
Individual Psychotherapy *(formerly Outpatient Psychotherapy)*	○ Individual Psychotherapy -MH ○ Individual Psychotherapy -SUD	X	X	Both
Family Psychotherapy	○ Family Psychotherapy-MH ○ Family Psychotherapy-SUD	X	X	Both
Group Psychotherapy	○ Group Psychotherapy-MH	X		Both

DRAFT

	○ Group Psychotherapy-SUD			
Day Rehabilitation	○ Day Rehabilitation-MH			Adults
Day Treatment	○ Day Treatment-MH			Adults
Intensive Outpatient (IOP)	○ Individual Psychotherapy-MH or SUD **For IOP Group Treatment:** ○ Group Therapy-MH or SUD *No more than 3 hours of combined Group Therapy may be billed per day	X		Both
Psychiatric Residential Rehabilitation	○ Psychiatric Residential Rehabilitation-MH			21 years of age or older
Psychiatric Residential Treatment Facility (PRTF)	○ Psych Res Treat-MH			20 years of age or younger
Secure Psychiatric Residential Treatment (formerly Secure Residential)	○ Secure Residential -MH ○ Secure Residential R&B-MH			21 years of age or older
Adult SUD Clinically Managed Low-Intensity Residential Treatment (ASAM 3.1) *(formerly ASAM 3.1 Halfway House)*	○ ASAM 3.1-Clinically Managed Low-Intensity Residential			21 years of age or older
Adult SUD Therapeutic Community- ASAM 3.1 *(formerly ASAM 3.3 Therapeutic Community)*	○ ASAM 3.1-Adult Therapeutic Community			21 years of age or older
Adult SUD Intermediate Therapeutic Residential Treatment- ASAM 3.1 *(formerly ASAM 3.3 Intermediate Residential)*	○ ASAM 3.1-Adult SUD Intermediate Therapeutic Residential, Co-Occurring Capable			21 years of age or older
Adult SUD Co-Occurring Enhanced Residential- ASAM 3.5 *(formerly ASAM 3.5 Short Term Residential)*	○ ASAM 3.5-Adult SUD Short Term Residential			21 years of age or older
Adult SUD Dual-Disorder Residential Treatment- ASAM 3.5 *(formerly ASAM 3.5 Dual Disorder Residential)*	○ ASAM 3.5-Adult SUD Dual Diagnosis			21 years of age or older
Inpatient Psychiatric Hospitalization *(formerly Acute or Sub-Acute Inpatient)*	○ Acute Inpatient Hospitalization-MH			21 years of age or older

DRAFT

	○ Sub-Acute Inpatient Hospitalization-MH			
Medically Monitored Inpatient Withdrawal – ASAM 3.7	○ Medically Monitored Inpatient Withdrawal-SUD			21 years of age or older

DRAFT