

## Alternative or “in Lieu of” Service Description

### 1. Service Name and Description:

**Service Name:** Family Centered Treatment®

**Procedure Code:**

H2022-U3-HE	FCT Core (Authorization Required)
H2022-22-Z2	FCT Encounter (Authorization Not Required)
H2022-22-Z1	FCT 3 Month Outcome (Authorization Not Required)
H2022-22 Z3	FCT 6 Month Outcome (Authorization Not Required)

Family Centered Treatment® (FCT) is a comprehensive evidence-based model of intensive in-home treatment for at risk children and adolescents and their families. Designed to promote permanency goals and to reduce length of stay in residential and/or PRTF facilities, FCT treats the youth and his/her family through individualized therapeutic interventions. Children and adolescents eligible for FCT may be facing involvement in the juvenile justice system, out-of-home placements, and/or reunification and may display severe emotional and behavioral challenges due to maltreatment (neglect, abuse), trauma (from domestic violence, sexual abuse, substance abuse), and/or serious mental health disorders. By improving youth and family functioning, FCT provides an alternative to out-of-home placements or, when it is in the youth’s best interest to be placed out of the home, to minimize the length of stay and reduce the risk of readmission. FCT is delivered by an assigned Qualified Professional with a caseload averaging 4-6 individuals/families. FCT is supervised by a certified/trained FCT supervisor, or a FCT supervisor in the process of completing FCT Supervisor Certification

***FCT is a researched, viable alternative to prevent residential placements, hospitalization, correctional facility placement and other community-based services such as Intensive In Home.*** A distinctive aspect of FCT is that it has been developed as a result of frontline Qualified Professionals’ effective practice. FCT is one of few home-based treatment models with extensive experience with youth with severe emotional and behavioral challenges, dependency needs, and mental health diagnosis as well as histories of delinquent behavior, otherwise known as crossover youth. In addition, FCT is extremely cost-effective and stabilizes youth at risk and their families.

FCT is based on eco-structural therapy and emotionally focused therapy. It focuses on addressing the functions of behavior, including system functions that look deeper than behavioral compliance, thus creating sustainable change and decreasing the likelihood of readmission. Based on the understanding that families requiring such services may have experienced trauma, all phases incorporate **trauma-focused treatment**. Other characteristics of the model that set FCT apart are highlighted below.

- An evidence-based model, FCT is an enhancement on many models of treatment used as part of community-based services because it is a systemic model that works intensively and collectively with family members, thereby positively impacting the family system and decreasing the likelihood of further involvement into the system by any family member.

- FCT was designed to be flexible to meet the needs of youth, family, and their community. The Qualified Professional-based model in large part had its formative years of development in North Carolina and has since been successfully established in several other states.
- FCT is provided by FCT Certified or in-training credentialed staff, who must complete the rigorous FCT certification program.
- A distinct and meaningful aspect of FCT is in determining whether a family is truly engaged in treatment or not. Many comparable models typically define engagement as two to three sessions. FCT, however, defines engagement in treatment as the completion of five sessions.
- Transitional indicators are utilized to assist the family in recognizing how they are moving through the treatment process. These indicators are determined by the family's progress and not by designated timeframes. This allows the family system to move through treatment at a pace specific to their needs. It also enables the family to feel empowered in the FCT process.
- Fifteen fidelity measures indicate progression through the phases of FCT treatment.
- A unique feature of FCT is the Giving Back Project. As part of the FCT phases, the family engages in a project that strengthens their ties to the community, builds their self-esteem, and provides an opportunity to bond further and to practice the skills they've learned.

FCT outcomes compare favorably with the best in the field, especially on such key dimensions such as:

- Success in preventing out of home placement
- Reunification
- Engagement rates
- Customer satisfaction and
- Readmission

Specific treatment techniques are integrated from empirically supported behavioral and family therapies including eco-structural and emotionally focused treatment. In addition to focusing on the youth, FCT also engages the family in treatment. FCT Qualified Professionals strengthen the family's problem-solving skills and operant family functioning systems, including how they communicate, handle conflict, meet the needs for closeness, and manage the tasks of daily living that are known to be related to poor outcomes for children/youth. The Qualified Professional, in conjunction with the youth, family, and other stakeholders, develops an individualized treatment plan. Using established psychotherapeutic techniques and intensive family therapy, the Qualified Professional works with the entire family, or a subset of the family, to implement focused interventions and behavioral techniques designed to:

- Enhance problem-solving
- Improve limit-setting
- Develop risk management techniques and safety plans
- Enhance communication
- Build skills to strengthen the family
- Advance therapeutic goals
- Improve ineffective patterns of interaction
- Identify and utilize natural supports and community resources for the youth and parent/caregiver(s) in order to promote sustainability of treatment gains

FCT's personalized interventions are designed to strengthen the family's capacity to improve the youth's functioning in the home and community with a goal of preventing the need for a youth's admission to an inpatient hospital, psychiatric residential treatment facility, or other residential treatment setting.

FCT utilizes a highly thorough and frequent session schedule to promote change for families with intensive needs.

FCT ~~Qualified Professionals~~ is best delivered with a minimum of two multiple-hour sessions per week but flexibility is allowed ~~are expected to provide a minimum of two multiple-hour sessions per week and increase this~~ as indicated by the youth and family’s evolving needs **as documented in the PCP**. Frequent, intensive therapy in the context of the family/home setting facilitates sustainable change via immediate and on-site enactments or coaching to parents, offering support where and when suggestions are most needed. Phone contact and consultation are provided as part of the intervention. In addition, unlike other in-home models, the first and last month of FCT treatment—joining and discharge respectively—~~are not tied to the minimum standard due to~~ reflect the titration up and down of service provision.

With FCT, a Qualified Professional is available 24 hours a day, seven days a week during each phase of FCT to provide additional support and crisis services as indicated.

When/where applicable, best practice standards of in home therapy are paramount. All FCT Qualified Professionals are expected to understand and abide by best practice standards for in home therapy including but not limited to safety of client/family/others & self; coordination of services including medical, on-call and crisis service; quick and timely responses to intake of services; and interventions that are timely, accessible, and not experimental in nature.

**Description:**

**2. Information About Alliance Population to be Served:**

Population	Age Ranges	Projected Numbers	Characteristics
Children with behavioral and/or emotional needs	3-20	2,625 Medicaid funded and State Funded IHS	<p>Characteristics of a family that may be an appropriate referral to FCT include but are not limited to the following (for Medical Necessity requirements, please see Utilization Management section below):</p> <ul style="list-style-type: none"> <li>• Significant family functioning issues</li> <li>• a step down from a higher level of care</li> <li>• there has been DSS involvement in the last year</li> <li>• there has been Juvenile Justice involvement in the last 6 months</li> <li>• there has been a behavioral health Emergency Room visit and/or hospitalization in the last 6 months</li> <li>• there have been multiple school suspensions within the past year</li> <li>• there have been crisis intervention in the last 6 months to include (but not exclusive</li> </ul>

			<p>of) law enforcement involvement, crisis line calls, mobile crisis service, emergency crisis bed stay</p> <ul style="list-style-type: none"> <li>• physical abuse</li> <li>• verbal abuse</li> <li>• sexual abuse</li> <li>• physical neglect</li> <li>• emotional neglect</li> <li>• parent or caretaker that abuses substances</li> <li>• parent or caretaker that is the victim of domestic violence</li> <li>• parent or caretaker that has a mental health diagnosis</li> <li>• the loss of a parent or caretaker to divorce, abandonment or death</li> <li>• a parent or caretaker that is incarcerated</li> <li>• a traumatic event that is significantly impacting the stability of the family or members of the family unit</li> </ul>
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**3. Treatment Program Philosophy, Goals and Objectives:**

**Treatment Program Philosophy:**

**Family Centered Treatment® Philosophy**

The evidence-based model Family Centered Treatment® (FCT©) is founded in the belief that families seemingly stuck in a downward spiral can make positive, lasting changes. Resilience theory holds that children and families have the capacity to function well in the face of significant life challenges. Because of this belief, all aspects of treatment value the youth and family’s voice in the process and employ strength-based approaches that focus on hope rather than on deficits, challenges, and barriers. The intention is to promote permanency goals while preserving the dignity of youth and families within their culture and community.

FCT’s origins derive from Qualified Professionals’ efforts to find practical, commonsense solutions for families faced with forced removal of their children from the home or dissolution of the family, due to both external and internal stressors and circumstances. FCT is an alternative model grounded in the use of sound and research-based treatment. Personalized techniques are integrated from empirically supported behavioral and family therapies and services are provided frequently, with FCT Qualified Professionals available 24/7 to support the youth and family when needed. Addressing needs while observing strengths and patterns of interaction as they are happening allows skilled Qualified Professionals to help families create change in the core components of family functioning.

Another guiding principle of FCT is that it is family centered. While the referred client is integral to the treatment process, FCT is a family system model of home-based treatment, and treatment can and does occur with other members when their behaviors or roles are critical to the progress of the referred family member (client). All phases of FCT involve the family intensively in treatment. During the assessment phase, the family defines their “family constellation,” and those members are invited to participate in the structural family assessment and subsequent treatment activities as directed. Other individuals who may have key roles in the youth’s wellbeing (e.g., caregivers, stakeholders, psychiatrists, etc.) are also viewed as critical to the success of FCT and are, at minimum, informed of treatment progress. They can be more integrally involved based on the family’s need.

In addition, FCT places emphasis on the value of support systems—both during and after treatment. FCT develops a system of community resources and natural supports based on the youth and family’s needs and preferences to enhance the individualized treatment plan by providing opportunities for further skill development. Building a network of support will also promote sustainable outcomes by providing the youth and family with resources to utilize after discharge.

### **Objectives and Goals:**

The overarching objective of providing FCT to families is to keep children safe and thriving in their home environment. Specifically, the objective of FCT is to provide an alternative to out-of-home placements, minimize the length of stay in out-of-home placements, and reduce the risk of additional out-of-home placements by improving child/youth and family functioning. To achieve this, targeted goals for FCT include:

- Decrease in crisis episodes and inpatient stays
- Decrease in the length of stay in inpatient, crisis facilities, PRTF, and other residential placements
- Decrease in emergency room visits
- Successfully engage families in treatment (target = 85% of families)
- Maintain low readmission rate (target = less than 10% of clients will require future FCT services minimally six months post discharge because of an increase in sustainability and stability due to focus on family functioning)
- Reduce or eliminate symptoms, including antisocial, aggressive, violent behaviors or those symptoms related to trauma or abuse/neglect
- Achieve permanency goals (target = 80% of clients will either remain in their home, reunite with their family, live independently or have a planned placement upon discharge)
- Improve and sustain developmentally appropriate functioning in specified life domains
- Enable family stability via preservation of or development of a family placement
- Enable the necessary changes in the critical areas of family functioning that are the underlying causes for the risk of family dissolution
- Reduce hurtful and harmful behaviors affecting family functioning
- Develop an emotional and functioning balance in the family so that the family system can cope effectively with any individual members’ intrinsic or unresolvable challenges
- Enable changes in referred client behavior to include family system involvement so that changes are not dependent upon the Qualified Professional

- Enable discovery and effective use of the intrinsic strengths necessary for sustaining the changes made and enabling stability

**4. Expected Outcome as identified by the Family Centered Treatment Foundations:**

Decrease in trauma symptomology

Improved family functioning

Improved functioning in the home, school and community settings

Increased utilization of learned coping skills and social skills

Increased utilization of natural supports in the community

Increased capacity to monitor and manage the individual's behavior

**Expected Outcomes Measured by Alliance Health:**

- Decrease in crisis episodes and inpatient stays
- Decrease in the length of stay in inpatient, crisis facilities, PRTFs and other Residential Placements
- Decrease In Emergency Room Visits
- 85% of families will successfully engage in treatment
- Less than 10% of clients will need future FCT services minimally 6 months post discharge because of an increase in sustainability and stability due to focus on family functioning
- 80% of clients will either remain in their home, reunite with their family, live independently or have a planned placement upon discharge

**5. Utilization Management:**

**Entrance Criteria**

**The beneficiary is eligible for this service when all of the following are met:**

- a. there is a mental health or substance use disorder diagnosis (as defined by the DSM-5, or any subsequent editions of this reference material), other than a sole diagnosis of intellectual and developmental disability;
- b. the beneficiary has a caregiver who is willing to participate with service providers for the duration of the treatment
- c. there is significant family functioning issues (to include areas such as Problem Solving, Communication, Role Performance, Affective Responsiveness and Involvement, and Behavioral Control) that have been assessed and indicate that the beneficiary would benefit from family systems work );

- d. based on the current comprehensive clinical assessment, this service is indicated and outpatient treatment services were considered or previously attempted, but were found to be inappropriate or not effective;
- e. the beneficiary has current symptoms or behaviors indicating the need for a crisis intervention as evidenced by suicidal or homicidal ideation, physical aggression toward others, self-injurious behavior, serious risk taking behavior (running away, sexual aggression, sexually reactive behavior, or substance use);
- f. the beneficiary's symptoms and behaviors are unmanageable at home, school, or in other community settings due to the deterioration of the beneficiary's mental health or substance use disorder condition, requiring intensive, coordinated clinical interventions;
- g. the beneficiary is at imminent risk of out-of-home placement based on the beneficiary's current mental health or substance use disorder clinical symptomatology, or is currently in an out-of-home placement and a return home is imminent; and
- h. there is no evidence to support that alternative interventions would be equally or more effective, based on North Carolina community practice standards (Best Practice Guidelines of the American Academy of Child and Adolescent Psychiatry, American Psychiatric Association, American Society of Addiction Medicine).

#### **Entrance Process**

The process for a beneficiary to enter this service includes:

- a comprehensive clinical assessment that demonstrates medical necessity shall be completed prior to provision of this service. If a substantially equivalent assessment is available, reflects the current level of functioning, and contains all the required elements as outlined in community practice standards as well as in all applicable federal and state requirements, it may be used as part of the current comprehensive clinical assessment.
- Relevant diagnostic information shall be obtained and included in the PCP.
- For Medicaid FCT services, a signed service order shall be completed by a physician, licensed psychologist, physician assistant, or nurse Qualified Professional according to his or her scope of practice. Each service order shall be signed and dated by the authorizing professional and shall indicate the *date* on which the service was ordered. A service order shall be in place *prior to* or on the day that the service is initially provided in order to bill Medicaid for the service. The service order shall be based on a comprehensive clinical assessment of the beneficiary's needs.

Prior authorization by the Medicaid approved vendor is required for Medicaid funded FCT services on or before the first day of service. To request the initial authorization, submit the required clinical information to the Medicaid approved vendor for review.

### **Continued Stay Criteria**

The beneficiary is eligible to continue this service if the desired outcome or level of functioning has not been restored, improved, or sustained over the time frame outlined in the beneficiary's PCP; or the beneficiary continues to be at risk for out-of-home placement, based on current clinical assessment, history, and the tenuous nature of the functional gains.

#### **AND**

One of the following applies:

- a. The beneficiary/family is making satisfactory progress toward meeting goals and there is documentation that supports that continuation of this service will be effective in addressing the goals outlined in the PCP;
- b. The beneficiary/family is making some progress, but the specific interventions in the PCP need to be modified so that greater gains, which are consistent with the beneficiary's premorbid level of functioning, are possible; or
- c. The beneficiary/family fails to make progress, or demonstrates regression, in meeting goals through the interventions outlined in the PCP. The beneficiary's diagnosis should be reassessed to identify any unrecognized co-occurring disorders, and interventions or treatment recommendations shall be revised based on the findings. This includes consideration of alternative or additional services.

### **Discharge Criteria**

The beneficiary meets the criteria for discharge if support systems for the family have been put into place, and any one of the following applies:

- a. The beneficiary has achieved goals and is no longer in need of FCT services;
- b. The beneficiary's level of functioning has improved with respect to the goals outlined in the PCP, inclusive of a transition plan to step down to a lower level of care;
- c. The beneficiary is not making progress or is regressing, and all reasonable strategies and interventions have been exhausted, indicating a need for more intensive services;
- d. The beneficiary or legally responsible person no longer wishes to receive FCT services; or
- e. The beneficiary, based on presentation and failure to show improvement despite modifications in the PCP, requires a more appropriate best practice treatment modality based on North Carolina community practice standards (for example, National Institute of Drug Abuse, American Psychiatric Association).

### **Service Exclusions**

Family Centered Treatment cannot be provided during the same authorization period as Intensive In-Home, MST, Intercept, Outpatient Plus and Outpatient Therapy Services.



## **EPSDT Special Provision**

### **Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age**

#### 42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiary under 21 years of age if the service is medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed Qualified Professional). This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary's physician, therapist, or other licensed Qualified Professional; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product or procedure:

- 1) That is unsafe, ineffective, or experimental or investigational.
- 2) That is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

#### EPSDT and Prior Approval Requirements

- 1) If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does NOT eliminate the requirement for prior approval.
- 2) IMPORTANT ADDITIONAL INFORMATION about EPSDT and prior approval is found in the *NCTracks Provider Claims and Billing Assistance Guide*, and on the EPSDT provider page. The Web addresses are specified below.

*NCTracks Provider Claims and Billing Assistance Guide:*

<https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html>

EPSDT provider page: <http://www.ncdhhs.gov/dma/epsdt/>

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or

procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problem.

**A. Staffing Qualifications, Credentialing Process, and Levels of Supervision Administrative and Clinical) Required:  
Provider Requirements**

FCT providers must meet the provider qualification policies, procedures and standards established by the NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS), the requirements of 10A N.C.A.C 27G and NC G.S. 122C, and any competencies specified by the NC Division of Medical Assistance (DMA). Provider must be accredited through a national accrediting body or achieve national accreditation within 1 year of contract with the MCO.

In addition, the provider agency must maintain FCT licensure through the FCT Foundation, and all staff must maintain the required certification, which includes all recertification requirements and field observations. The FCT Foundation monitors and tracks staff training and certification development. Upon successful passing grade completion of the three training components including the Wheels of Change on line audio/visual training course, field based practice of the required FCT core skills and field based performance evaluation to assess competency, FCT Foundation will issue certification as an FCT clinician to the staff member.

Provider organizations are required to maintain all other FCT Foundation licensure standards as outlined in a licensure agreement.

Provider organizations must:

- Demonstrate the ability to submit FCT fidelity and adherence documentation for all families in receipt of FCT
- Ensure that a minimum threshold, as set by FCTF Board given stage of implementation, of all active and discharged FCT families have fidelity documentation completed and submitted for *last phase of treatment completed*.
- Ensure that a minimum threshold, as set by FCTF Board given stage of implementation, of all active and discharged FCT families have adherence/dosage documentation completed and submitted for the *last phase of treatment completed*.

**Staffing Requirements**

- Staff must ~~be licensed or associate licensed~~ be credentialed as a Qualified Professional.
- All staff, ~~licensed and associate licensed~~, must be fully certified in FCT within twelve months of their initial hire via the official FCT certification program, Wheels of Change®. Certification is granted through the Family Centered Treatment Foundation (FCT Foundation) when staff pass and show competence in required components.

- All staff must demonstrate field-based competency in 16 core skills related to the FCT model to complete the full FCT certification process. These field based competencies are completed during direct observations of the Qualified Professional's sessions with clients by a certified FCT Trainer.
- All staff must complete a minimum of 10 hours per year of Continuing Education. This is monitored by the Clinical Director.
- All staff must be recertified in FCT every 2 years.

### **Supervision:**

FCT understands that for effective services to implement and perform to scale, effective supervision is essential. Through rigorous training and oversight, FCT supervisors provide critical key clinical oversight to their teams and with guidance through the FCT Foundation. Both peer and individual supervision is provided as part of the FCT model.

FCT Supervisors must be Associate or fully licensed behavioral health clinicians practicing within the scope of their license.

FCT Supervisors provide supervision of Qualified Professionals and regional office staff. FCT Supervisors are selected based upon credential qualifications, experience, leadership skills, family systems orientation, and team leadership skills.

FCT Qualified Professionals receive multiple hours of supervision per week. This is a combination of peer supervision, individual supervision, as well as field and on call supervision support. FCT expectations dictate that Qualified Professionals should receive no less than two (2) hours of supervision per week, ~~but often average five (5) combination hours or more.~~ Peer supervision occurs in FCT teams which meet no less than weekly for clinical case supervision and oversight. The FCT Supervisor, designated licensed staff members, or other FCT Directors/Trainers provide individual supervision or consult. The FCT Supervisor is available for on-call to each employee and may refer the employee to other FCT Directors/Trainers for consultation. Each supervision session, whether provided in the field, office, or on the phone (on-call), is recorded by the FCT Qualified Professional on a supervision form indicating direction given. The form is signed by the Qualified Professional and person providing the supervision and is then entered into the Qualified Professional's personnel file.

Use of the national recognized best practices family system's case review process (family mapping, intervention, goals and strategies; aka John Edward's MIGS) is utilized and strategies determined are reviewed during the next team meeting. Weekly team meetings are comprised of FCT Supervisor, staff who are FCT certified or are in the process of certification, and the FCT Trainer, where applicable. The mixture of expertise, licensure, certification, and experience at each team meeting provides continuity of care, alternative perspectives on treatment, allows for specialty expertise to be brought in at critical junctures AND focuses highly on effective Qualified Professional *use of self* (process that examines what the Qualified Professionals are bringing into the treatment process themselves). Supervision notes, team

meeting minutes and case reviews are tracked and monitored for adherence to the model via the FCT Clinical Practice Team.

It is required that FCT Supervisors ~~undergo their own~~ have completed the FCT Supervision Certification, or are enrolled in the FCT Supervisors course and have a minimum of two years of service delivery of FCT or Licensed/Associated Licensed and a Certified Supervisor in FCT, or are credentialed as a Licensed Professional and enrolled in the FCT Supervisors course.

### **FCT Management and Supervisory Training:**

FCT's management and supervisory components are integral to the model fidelity and client outcomes that are achieved. Therefore, all direct supervisors of frontline staff are required to complete the FCT Supervisory Certification Course which includes an experiential practice-based component. The requirements for the FCT Management and Supervisory Course also include the successful completion of the online training curriculum as well as the assignments associated with each unit. There are eight units in the online curriculum and FCT Supervisor Certification is overseen by the FCT Foundation.

The FCT Supervision curriculum consists of learning key concepts on how to guide staff in delivering each phase of treatment effectively. There are supervisory documents that help guide the process to ensure that supervisors are adhering to and producing high fidelity to the model.

When applicable, FCT Trainers work weekly with FCT Qualified Professionals to ensure adherence to the fidelity of the model and assure quality services with field observation. In addition, the trainers model the skill and provide practice experiences to teach and coach Qualified Professionals. They also observe Qualified Professionals in the field or via videotape to assess competency in the core required FCT skills. FCT Trainers are expected to undergo a specific process, overseen by the FCT Foundation, to verify Trainer status.

### **Family Centered Treatment® Training:**

The FCT certification program, including Wheels of Change®, ensures that each FCT Qualified Professional is trained in the principles of youth-guided, family-driven empowerment and can identify and assess child abuse/neglect, domestic violence, and substance abuse issues, as well as how to assist families affected by past trauma in times of crisis. Wheels of Change® (WOC) is a component of a structured certification process that utilizes the five aspects of training modalities: teaching, observing, performing the required task or skill, being observed with checklists to assess competence, and evaluation. Successful completion results in certification in FCT by the FCT Foundation.

FCT Qualified Professionals undertake and successfully complete an intensive competency-based, standardized training/certification process. This knowledge-based portion of the certification process includes testing of knowledge, audio visual learning, discussion boards, and videos of core skills in practice. FCT staff are trained in direct mental health services, long- and short-term mental health interventions designed to maintain family stability, individual and family assessments, Community-Based Partnerships, Cultural Competency, individual, family, and group counseling, individualized service planning, 24-hour crisis intervention and stabilization, skills training, service coordination and

monitoring, referrals to community resources, follow-up tracking, and coordination with local stakeholders.

**Trauma Focused Training:**

Because all families are assessed for trauma at the onset of services, all FCT Qualified Professionals must maintain a level of competency in this area. In order to demonstrate the skills necessary to assess trauma, staff must undergo comprehensive trauma-based training. These skills include recognizing the presence of trauma through interactions and assessment tools and developing personalized interventions to address trauma as identified. The subjects covered in the guided online Trauma Based Training component of the WOC program units include:

- i. Essential Elements of Trauma Treatment (Why do we utilize Trauma Treatment?)
- ii. Trauma Assessments, FCT Trauma Treatment and Creating a New Narrative
- iii. Practical Tools and Implementation

Field-based practice of the required core skills and supervision occurs simultaneously as trainees take the online course.

Additionally, it is best practice to cite and address trauma and trauma impact in safety plans, when/where applicable.

**B. Unit of Service:**

Services	rate	unit of service
FCT Service (length of treatment based on family progress)	\$2,800.00	30 Days
Outcome Payment 3 months Post Discharge	\$600.00	
Outcome Payment 6 months Post Discharge	\$600.00	

**C. Anticipated Units of Service per Person:**

FCT's anticipated length of stay is six months.

Outcome payments three and six months are eligible for FCT recipients who are discharged from episode duration of one to six months.

Eligibility for Outcome Payments dependent upon the following criteria:

- No inpatient, Facility Based Crisis admissions
- No residential Level II or higher from discharge (planned or unplanned)
- No return to FCT, admission to IIH, MST or Intercept or comparable Adult Services

**D. Targeted Length of Service:**

- a. National target standards are 6 months, with the national average at 6.4 months (n=>2,000 families)
- b. It is important to note that in scenarios where reunification or 'unknown' reunification is the objective the national benchmarks for 6 months of service differs. When permanency or reunification is in question additional time to work with the family/caregivers/child is often warranted, extending the treatment time to 9-11 months. The rationale for this is several fold:
  - i. Additional time is often needed to assess safety and permanency needs in the early months
  - ii. Frequently systems (courts) exceed 6 months to make a ruling surrounding permanency
  - iii. The underlying complex dynamics of the systems involved: extreme distrust of the agencies and resistance to intervention and treatment require much longer treatment times for developing trust necessary for effective engagement and adjustments that often occur to the permanency plan.

**E. Describe why this service is needed and is different than any State Plan or alternative service already defined. If implemented in other states, describe successful outcomes.**

Family Centered Treatment® (FCT©) has been a structured, manualized model since 2004, and the model achieved evidence-based status in 2010. FCT is an alternative model to IIH that is grounded in the use of treatment components that are sound and research-based. FCT is comprehensive and designed to address the causes of family system breakdown. The model not only focuses on changing negative behaviors—it also emphasizes the value of positive change so that families are more likely to sustain improvements in family functioning after treatment. FCT Qualified Professionals are available to families 24/7. Attending to strengths, needs, and patterns of interaction while they are happening allows skilled Qualified Professionals to help families create change in the core components of family functioning.

**10. Cost-Benefit Analysis: Document the cost-effectiveness of this alternative service versus the State Plan services available.**

- In 2013 68% of clients served had a least 1 sibling in the home throughout service delivery, multiplying the impact of Family Centered Treatment. None of the siblings had previous history with FCT service delivery.
- January to December 2014, 2625 persons were served in IIHS with an average case cost of \$17,105. This represents a \$2843 savings per individual served. Only 47% of youth were reported to have responded positively to IIHS treatment. This cost has reduced in 2016 to \$16,184. If the percentage of youth responding positively to treatment (as predicted by the model) increased to 60% (outcome target of 80%), FCT returns the investment of 1,200.
- Currently comparing the cost of IIHS, PRTF and Level II TFC, targets of reduction of service and/or increase in outcome, FCT represents significant savings if one six month episode

retains youth at lower levels of care. Total cost of FCT six months post episode will be \$18,000. If FCT can shorten a PRTF stay by 60 days, the episode cost neutral at 18,000. Shortening a Level II Family (TFC) stay by 90 days (140 total), is a savings per youth of \$10,036. In addition, TFC serves approximately 370 youth per day. By reducing our census by one youth, we more than cover the cost of FCT. In addition, by offering FCT earlier in residential stays as a step down plan, Alliance can significantly reduce the overall cost per child in residential stays.

In FY 17 Alliance paid 13.1 million dollars to the five largest PRTF network providers, for an average of 44,333 bed days. If the number of bed days can be reduced by 10,000 and FCT can result in increasing community tenure, 166 youth at \$18,000 each can be served in FCT at no increase in cost.

**Description of comparable State Plan Service Payment Arrangements (include type, amount, frequency, etc.)**

Service	Procedure Code	Unit Definition	Units of Service	Cost of Service
IIHS	H2022	Per Diem	68	\$16,184
PRTF	0911	Per Diem	180	\$54,000
Level II TFC	S5145	Per Diem	250	\$22,810

**Description of Alternative Service Payment Arrangements (include type, amount, frequency, etc.)**

Service	Procedure Code	Unit Definition	Units of Service	Cost of Service
FCT	H2022 U3 HE	Per Month	6	\$16,800
FCT- Outcome	H2022-Z1 and Z3	Per 3 months	2 maximum	\$1200

**Description of Process for Reporting Encounter Data (include record type, codes to be used, etc.)**

Data will be uploaded to the state by the MCO. Monthly payment, outcome payments and encounter data is kept for all services.

**Description of Monitoring Activities :**

FCT Foundation oversees and consistently performs program evaluation through data analysis (data is given to FCT Foundation on a quarterly basis for evaluation). Alliance intends to receive copies of the external fidelity reviews regularly. Alliance will conduct post service review to ensure eligibility for outcome payments as they are requested.