Alternative or "in Lieu of" Service Description
Child Focused Assertive Community Treatment Team
"Child ACT"

1. **Service Name and Description:**

Service Name: Child ACT for Children and Youth with SED and co-occurring SUD or I/DD
Procedure Code: Code: H0040 HA U5 U1 Encounters: H0040 HA U5 TS

Description:

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

Population	Age Ranges	Projected Numbers	Characteristics
MH diagnosis with and without co-occurring SU or I/DD or autism	12 – 18 19-21 are eligible for Adult ACT Teams	75	• Youth with a primary mental health diagnosis. However, individuals diagnosed with Mental Health conditions and co-occurring Moderate or Mild Intellectual disabilities or Autism will be assessed on a case by case basis. • High risk for out of home residential treatment due to history of multiple hospitalizations, multiple placements in residential treatment, unresponsive to other forms of outpatient or enhanced behavioral health services. • Symptoms at a severity level where PRTF or other intensive residential treatment would be recommended.

3. **Treatment Program Philosophy, Goals and Objectives:**

Treatment Program Philosophy:
Child Focused Assertive Community Treatment (Child ACTT) is a team-based multi-disciplinary approach to serve children in their homes, kinship placements, DSS foster homes, or may begin during transition from a more restrictive residential setting. Similar to the ACTT service for adults, this service uses a community-based team approach to meet the needs of youth with Serious Emotional Disturbance (SED).

This service is used to meet the needs of youth that are high risk for out-of-home residential treatment due to a psychiatric disorder, have a history of multiple hospitalizations or long term hospitalization(s) at a state facility, have a history of multiple episodes of Residential treatment, who are unresponsive to conventional outpatient treatment (outpatient therapy, Intensive In-home services, etc.) after discharge from residential treatment even when evidenced based models were utilized, and/ or symptoms are at a severity where typically Psychiatric Residential treatment would be recommended, but based on team approach and planning for crisis intervention, Child ACTT would be appropriate to implement.

- The service is designed for male and female beneficiaries with a primary mental health diagnosis. However, individuals diagnosed with Mental Health conditions and co-occurring Moderate or Mild Intellectual disabilities or Autism will be assessed on a case by case basis for participation in Child ACTT. • A beneficiary who is appropriate does not benefit from receiving services across multiple, disconnected providers, and may become at greater risk of hospitalization, out of home placement, substance use, victimization, and juvenile justice involvement. The beneficiary needs assertive engagement to develop treatment motivation.
- The team provides person-centered services addressing the breadth of a beneficiary's needs, helping him or her achieve their personal goals.
- The team includes the family/caregiver, as they are a critical component of addressing the identified beneficiary's needs and achieving goals. Thus, a fundamental charge is to be the first-line (and generally sole provider) of all the services that a beneficiary needs. Being the single point of responsibility necessitates a higher frequency and intensity of communitybased contacts and a very low beneficiary-to-staff ratio.
- Services are flexible; teams offer varying levels of care for all beneficiaries and appropriately adjust service levels given an individual beneficiary's changing needs over time.
- Services address needs in multiple life domains, including family life and social relationships, health, housing, substance use, medication support, financial stability, activities of daily living, educational/vocational success, and wellness self-management/relapse prevention.
- Treatment interventions would include evidenced based treatment with the methodologies being specific to the present needs of the member, so this would vary from member to member:
    - Trauma Systems Therapy (underlying agency-wide treatment model)
    - Trauma Focused Cognitive Behavioral Therapy (TF-CBT)
    - Dialectical Behavior Therapy (DBT)
    - Cognitive Behavioral Therapy (CBT)
    - Motivational Interviewing (MI) o Attachment Self-Regulation and Competency (ARC)
    - Wellness Recovery Action Plan (WRAP)
    - Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS)
    - Seven Challenges
    - Other models as determined by youth/family need

Child ACTT services are primarily provided in the community. A fundamental feature of Child ACTT is that services are taken to the member/family in his or her natural environment, rather than having the member/family come into an office or clinic setting to receive services. Services shall be delivered in various natural environments, such as homes, schools, court, homeless shelters, libraries, street locations, and other community settings.

Objectives and Goals:

- Reduce out of home placements
- Reduce use of the Emergency Department
- Increase Family resiliency
- Increase member self-determination and self-advocacy

4. **Expected Outcomes:**
   It is expected that beneficiaries will reduce the amount of time spent in residential settings and become more integrated within their own community. In addition, the following outcomes are expected:
   a. Beneficiary satisfaction
   b. Increased adherence to treatment/service plan
   c. Vocational/educational gains
   d. Increased stay in their community residence with family or natural supports
   e. Increased natural supports
   f. Increased engagement in positive supportive activities
5. **Utilization Management:**
   Unit of Service: 1 Unit per week
   Anticipated Units of Service per Person: 26 units
   A comprehensive clinical assessment (CCA) that demonstrates medical necessity must 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 a part of the current CCA. Relevant diagnostic information must be obtained and included in the Person-Centered Plan (PCP)

Entrance Criteria

Children 12-18 years with major depressive disorders, psychotic disorders, anxiety disorders, disruptive behavior disorders and bipolar disorder because these illnesses more often cause long term psychiatric disability. Beneficiaries with other psychiatric illnesses are eligible dependent on the level of the long-term disability, co-occurring disorders, and complex trauma. Beneficiaries with a primary diagnosis of a substance use disorder, intellectual developmental disabilities, traumatic brain injury, or an autism spectrum disorder are not the intended beneficiary group and would be considered for Child ACTT on a case by case basis.

Child ACTT teams shall document written admission criteria that reflect the following medical necessity criteria required for admission:

a. has a current Mental Health and Diagnostic and Statistical Manual (DSM) 5 (or its successor) diagnosis consistent with reflecting the need for treatment and the covered treatment must be medically necessary for meeting the specific preventive, diagnostic, therapeutic, and rehabilitative needs of the beneficiary.
   AND

b. has significant functional impairment as demonstrated by at least one of the following conditions:

   1. Significant difficulty consistently performing the range of routine tasks required for basic child/adolescent functioning in the community (for example, demonstrating safety skills, self- regulation, and basic social interaction) or persistent or recurrent difficulty performing daily living tasks except with significant support or assistance from others such as friends, family, or relatives;
   2. Significant difficulty maintaining consistent educational/vocational performance at a self-sustaining level (such as regular attendance, regular participation without expulsion or repeated suspension)

Continued Stay Criteria

Medicaid shall cover a continued stay if the desired outcome or level of functioning for the beneficiary or family has not been restored, improved, or sustained over the time frame outlined in the beneficiary's PCP or the beneficiary or family continues to be at risk for relapse based on current clinical assessment, history, or the tenuous nature of the functional gains;
AND
One of the following applies:

a. The beneficiary or family has achieved current PCP goals and additional goals are indicated as evidenced by documented symptoms;
b. The beneficiary or 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;
c. The beneficiary or 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 pre-morbid or potential level of functioning, are possible;
d. The beneficiary or family fails to make progress or demonstrates regression in meeting goals through the interventions outlined in the PCP. (In this case, the beneficiary's diagnosis must be reassessed to identify any unrecognized cooccurring disorders, and treatment recommendations should be revised based on the findings); or
e. If the beneficiary is functioning effectively with this service and discharge would otherwise be indicated, The Child ACTT team services must be maintained when it can be reasonably anticipated that regression is likely to occur if the service is withdrawn.

The decision must be based on either of the following:
1. The beneficiary has a documented history of regression in the absence of Child ACTT team services, or attempts to titrate team services downward have resulted in regression; or
2. There is an epidemiologically sound expectation that symptoms will persist and that ongoing outreach treatment interventions are needed to sustain functional gains.

Discharge Criteria

Beneficiary shall meet at least one of the following:
a. The beneficiary and team determine that ACT-Y services are no longer needed based on the attainment of goals as identified in the person-centered plan and a less intensive level of care would adequately address current goals;
b. The beneficiary moves out of the catchment area and the ACT-Y has facilitated the referral to either a new ACT-Y provider or other appropriate mental health service in the new place of primary private residence and has assisted the beneficiary in the transition process;
c. The beneficiary and, if appropriate, the legally responsible person, choose to withdraw from services and documented attempts by the program to re-engage the beneficiary with the service have not been successful; or
d. The beneficiary and family have not demonstrated significant improvement following reassessment and several adjustments to the treatment plan over at least three months and:

1. Alternative treatment or providers have been identified that are deemed necessary and are expected to result in greater improvement; or
2. The beneficiary's behavior has worsened, such that continued treatment is not anticipated to result in sustainable change; or 3. More intensive levels of care are indicated.
Child ACTT team services may be billed for up to 30 days in accordance with the Person

Centered Plan for beneficiaries who are transitioning to or from Intensive In Home, Day Treatment, Residential Levels II-IV, TASK, or MST.

Service Exclusions

This is intended to be a bundled comprehensive service that meets all treatment needs of the member so other services other than previously referenced during a transition period are excluded from Co-Occurrence. Inpatient, Facility Based Crisis, and Emergency Department Services can still be accessed as medically necessary for crisis stabilizations. Early Periodic Screening, Diagnosis and Treatment (EPSDT) will still be considered on as necessary on an individual member basis.

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 practitioner). 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 practitioner; 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

Child ACTT is a team-based multi-disciplinary approach to serve children in their homes, kinships placements, DSS foster homes, or may begin during transition from a more restrictive residential setting but typically would not exceed 30 days, although may be extended as needed if discharge plans are adjusted. It is the expectation that the majority of services are provided in the home or other community settings, typically 80-90% of the contacts will be in these settings.

While the composition of the team is established, the team members providing the direct interventions to the child and family may be varied based on the needs of the individual. The team will have daily meetings to prioritize activities, share information, and discuss individual members. The team will be available to respond 24/7 for crisis de-escalation and assessment, inclusive of availability by phone within 15 minutes and face to face within no more than 2 hours. This will include face-to-face assessment by a clinician, or nurse if this is determined to be needed for the individual.

The psychiatric provider will be available minimally by phone 24/7 for consultation and treatment recommendations. The team will assess the overall needs of the family to ensure that all necessary treatment and supports are in place for entire family system.

Program Size:
a. Small teams: serve a maximum of 40 beneficiaries, with 1 team member per 8 or fewer beneficiaries (must have at least 5 staff if team is full)
b. Mid-Size Teams: serve a maximum of 63 beneficiaries with 1 team member per 9 or fewer beneficiaries (must have at least 7 staff if team is full)
Note: Movement on and off the teams may result in temporary breaches of caseload. Therefore, teams shall be expected to maintain an annual average not to exceed limits above.

- Child ACTT services must be delivered by staff employed by a MH/DD/SA provider organization that meet the provider qualification policies, procedures, and standards established by the Division of Mental Health, Developmental Disabilities and Substance Abuse Services and the requirements of 10A NCAC 27G unless provided by a federally recognized Tribal provider or

Indian Health Service (IHS) provider. Those providers must demonstrate substantial equivalency as established in 25 USC 1621t and 1647a.

- These policies and procedures set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services.
- Provider organizations must demonstrate that they meet these standards by being a member of the Alliance provider network or an IHS/tribal provider
- The organization must be established as a legally recognized entity in the United States and qualified/registered to do business as a corporate entity in the State of North Carolina or authorized by federal or tribal law or regulation.
- Additionally, within one year of enrollment as a provider with NC Medicaid, the organization shall achieve national accreditation with one of the accrediting bodies approved by the N.C. Department of Health and Human Services (DHHS) or meet substantial equivalency as allowed by 25 USC 1621t and 1647a.

Staffing Requirements

All employees must meet the minimum education, experience and licensure criteria established for their position as required in rules or service definitions, whichever is most restrictive. Child ACTT is delivered by a team comprised of the following positions:

Position	Minimum Staffing	Staff Qualifications
Team Leader This position is to be occupied by only one person. (MANDATORY)	1 FTE	The team leader shall be a licensed mental health professional holding any of the following licenses: licensed psychologist, licensed psychological associate, licensed clinical social worker, licensed professional counselor, licensed marriage and family therapist, licensed psychiatric nurse practitioner, clinical nurse specialist certified as an advanced practice psychiatric clinical nurse specialist. The team leader shall have three years of clinical experience with children with serious emotional disturbance, with a minimum of 2 years post-graduate school experience.
Psychiatric Care Provider (MANDATORY)	**.5 FTE**	Board eligible or certified by the American Board of Psychiatry and Neurology and Licensed to practice in NC and meet the credentialing and qualifications as specified in NCAC 27G .0104(16). Psychiatrist must be a Child and Adolescent psychiatrist. If a psychiatric nurse practitioner is utilized, he/she shall be currently licensed as a NP in NC and meet the requirements as specified in 21 NCAC 36.0800, approval and practice parameters for nurse practitioners, with at least three years

		full-time experience treating children with serious emotional disturbance. If a physician assistant is utilized on the team, he/she shall be currently licensed as a PA in NC and must meet the requirements as specified in 21 NCAC 32S.0200 with at least three years full-time experience treating children with serious emotional disturbance. "Licensed health professionals employed by a tribal health program shall be exempt, if licensed in any State, from the licensing requirements of the State in which the tribal health program performs the services described in the contract or compact of the tribal health program under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.)." This applies to all licensed providers.
Nursing (MANDATORY0	1 **FTE**	A registered nurse(s) (RN) or advanced practice registered nurse (APRN) has a minimum of one year experience working with children with serious emotional disturbance and a working knowledge of psychiatric medication.
Licensed Clinician (MANDATORY)	1 **FTE**	Licensed clinician(s) with at least 1 year of experience working with children with serious emotional disturbance. The licensed clinician shall be a licensed mental health professional holding any of the following licenses: licensed psychologist, licensed psychological associate, licensed clinical social worker, licensed professional counselor, licensed marriage and family therapist, licensed psychiatric nurse practitioner, clinical nurse specialist certified as an advanced practice psychiatric clinical nurse specialist. An associate level licensed professional must be fully licensed within 30 months from the date of hire.
Substance Abuse Specialist (may be utilized to make up the additional 2 FTE (small team) or contribute to the	P**RN**	The team shall include substance abuse expertise if serving youth with primary SUD diagnosis and this is not within the scope of the team lead or other clinicians on the team; individuals providing substance abuse expertise shall meet qualified professional credentials and qualifications

additional staffing for a midsize team)		according to 10A NCAC 27G .0104(19), and have a designation of certified clinical supervisor, licensed clinical addiction specialist, licensed clinical addiction specialist associate, or certified substance abuse counselor.
Peer Specialist - Youth (may be utilized to make up the additional 2 FTE (small team) or contribute to the additional staffing for a midsize team)	**.25 - .5 FTE**	The team includes Peer Specialist(s). Minimum age is 18. To ensure that the experience of the peer specialist is commensurate with those served by team for this position, the individual must have "lived experience" and a personal recovery story specific to child/adolescent SED.
Family Advocate (may be utilized to make up the additional 2 FTE (small team) or contribute to the additional staffing for a mid-size team)	.25- .5 FTE	Each Team has Family Advocate(s) to ensure that the experience of the family advocate is commensurate with those served by the team, for this position, the individual must have "lived experience" and a personal recovery story specific to being a caregiver for an SED child/adolescent.
Case Coordination (may be utilized to make up the additional 2 FTE (small team) or contribute to the additional staffing for a mid-size team)	1 FTE	Team will include case coordination; staff providing this service meet requirements as an associate licensed professional or licensed professional and must have one year of experience with children with serious emotional disturbance. An associate level licensed professional must be fully licensed within 30 months from the date of hire.
Behavioral Specialist (may be utilized to make up the additional 2 FTE (small team) or contribute to the additional staffing for a mid-size team)	.5FTE	Team will include Behavioral Specialist(s). Must qualify as QP or AP. Must have one year of experience working with children with serious emotional disturbance.
Additional Staff		Any additional staffing should reflect the intended program size, number of beneficiaries served, and needs of the team. Areas of expertise and training may include, for example: supportive housing, money management, empirically-supported therapy, family liaison, and forensic and legal issues. If teams are targeting a specific clinical population, it is recommended they hire additional staff reflecting the expertise and training needed for the targeted clinical

		population (example., a second substance abuse counselor for teams serving primarily beneficiaries with co-occurring substance use disorders)

A team will always have a minimum of 5 FTE staff. The team must always maintain a team lead, a nurse, a clinician, and a psychiatric practitioner. The 4th and 5th staff can be a FTE or combination of part time FTEs fulfilling the roles most needed based on the members being served by the team or areas that the existing staff do not have sufficient experience and or expertise in. For example, if the team lead and/or clinician have experience with substance use disorders it may not be necessary to have an additional SUD clinician even if members on the team have this as an identified treatment need. However, if neither of those individuals have this background it may be necessary to have an SUD on the team if the members have this as an identified treatment need. The Case Coordination activities may also be provided by a combination of individuals on the team or may be done by a designated staff member.

The Psychiatric Care Provider is not counted in the minimum FTE but one must always be assigned to a team. Additional staff will be added based on the caseload served by the team or the clinical needs of the members. Not all members being served by the team will interact with all staff, but all will be seen by the Psychiatric Care Provider.

As is typical of an ACTT team, it will be important for the various specialists on the team to ensure cross training of other staff to reinforce strategies, identify unmet needs, etc. For example, the behavioral specialist may be the one developing the specific behavioral strategies, but the other members of the team would also be reinforcing these strategies.

Supervision:
All team members shall receive ongoing clinical and administrative supervision from team leadership, with the team leader as the primary clinical supervisor. Supervision will be based on staff licensure. Non-licensed staff members shall receive scheduled supervision bi-weekly, either in individual or group format; no staff shall go without a supervision session in a given month. As part of the service, a team meeting will occur daily which will also serve as a method for overall supervision of the team facilitated by the team lead or designee in the absence of the team lead.

For licensed professionals: Provider will ensure that all licensed staff complete the required MCO credentialing process and maintain their licensure. Provider organization will complete CAQH, and if needed NCTRACKS, NCID, and NPI and submit credentialing application to MCO.

For unlicensed staff: Provider organization completes primary source verification for education and verifies experience. Final determination of paraprofessional, associate professional, or qualified professional must follow all applicable agencies policies and procedures, NC General Statutes and federal/tribal law and regulations.

The provider organization is responsible for ensuring staff have the knowledge, skills, and abilities required by the population and age to be served.

Staff Training Requirements

Position	Initial – within 120 days of hire	Annual
Team Lead	Crisis Response (3 hours), Person Centered Thinking (12 hours), Introductory Motivational Interviewing (13 hours), System of Care (11 hours), PCP Instructional Elements (3 hours), Alternatives to Restrictive Interventions (8 hours), training in at least one model of care with empirical evidence (duration unknown) 50 Hours Total (plus any specific training required for the treatment modality being used by the team)	Additional 3 hours of training that fits with expertise; annual training as required by the model of care
Psychiatric Care Provider	Person Centered Thinking (12 hours) Alternatives to Restrictive Interventions (8 hours) 20 Hours Total	Continuing Education as required for license
Nursing	Alternatives to Restrictive Interventions (8 Hours) Person Centered Thinking (12 Hours) 20 Hours Total	Continuing Education as required for license.
Licensed Clinician	Crisis Response (3 hours), Person Centered Thinking (12 hours), Introductory Motivational Interviewing (13 hours), System of Care (11 hours), PCP Instructional Elements (3 hours), Alternatives to Restrictive Interventions (8 hours), training in at least one model of care with empirical evidence. 50 Hours Total (plus any specific training required for the treatment modality being used by the team)	Additional 3 hours of training that fits with expertise; annual training as required by the model of care, Alternatives to Restrictive Interventions Refresher
Substance Use Professional	Crisis Response (3 hours), Person Centered Thinking (12 hours), Introductory Motivational Interviewing (13 hours), System of Care (11 hours), PCP Instructional Elements (3 hours), Alternatives to Restrictive Interventions (8 hours), training in at least one model of care with empirical evidence Total 50 Hours (plus any specific training required for the treatment modality being used by the team)	Additional 3 hours of training that fits with expertise; annual training as required by the model of care, Alternatives to Restrictive Interventions Refresher

Peer Specialist - Youth	Peer 2 Peer Training provided by NC Families United (32 hours) 32 Total Hours	Additional 16 hours of Peer 2 Peer training 6 months after hire
Family Advocate	Family Partner 101 provided by NC Families United (24 hours) 24 Total Hours	Over first year: Motivational Interviewing (8 hours), WRAP (16 hours), Child and Family Teams (11 hours), Trauma Informed Care (4 hours). Two electives (hours unknown)
Case Coordinator	Crisis Response (3 hours), Person Centered Thinking (12 hours), Introductory Motivational Interviewing (13 hours), System of Care (11 hours), PCP Instructional Elements (3 hours), Alternatives to Restrictive Interventions (8 hours), training in at least one model of care with empirical evidence 50 Hours Total (plus any specific training required for the treatment modality being used by the team)	Additional 3 hours of training that fits with expertise; annual training as required by the model of care, Alternatives to Restrictive Interventions Refresher
Behavioral Specialist	Crisis Response (3 hours), Person Centered Thinking (12 hours), Introductory Motivational Interviewing (13 hours), System of Care (11 hours), Alternatives to Restrictive Interventions (8 hours), training in at least one model of care with empirical evidence Total Hours 47 (plus any specific training required for the treatment modality being used by the team model)	Additional 3 hours of training that fits with expertise; annual training as required by the model of care, Alternatives to Restrictive Interventions Refresher

Unit of Service:

Services	**rate**	**unit of service**
Child ACT	1030.00	Weekly

B. **Anticipated Units of Service per Person:**
26

C. Targeted Length of Service:
Targeted length of service is 6 months.

D. 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.

This service builds off the evidence-based model of Adult ACT. The same principles, modified to reflect the age of the individual, have shown to reduce hospitalizations and residential placements. This service also aligns with some of the objectives of the Family First and Prevention Act in the Child Welfare/DSS environment, obtaining treatment in the community in non congregate settings when appropriate and preventing multiple placements.

The bundled, comprehensive team approach better supports a gap in care that is often created with multiple providers providing discreet services to individuals with complex needs. This model helps prevent fragmentation in service planning and family supports.

Description of Process for Reporting Encounter Data (include record type, codes to be used, etc.)
Encounters: H0040 HA U5 TS will be filed weekly

Treatment Plan
Each individual receiving Child ACTT services is required to have a Person Centered Plan (PCP) that is fully complete prior to or on the first date of service. The PCP must meet all of the requirements, including an enhanced crisis plan, as outlined in the NC PCP Instruction Manual. The amount, duration, and frequency of the service must be included in the PCP.

Service Documentation
A full service note that meets the requirements per APSM 45-2 is required for each contact or intervention

Description of Monitoring Activities :
Alliance Network management will monitor individuals receiving Child ACT at a minimum annually for compliance. Ongoing monitoring of complaints, incident reports, quality of care reviews, audits etc will occur annually or as needed.