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TA RESOURCE

Becoming a Medicaid Provider of Peer Support: A Guide for Family-Run Organizations

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ABOUT THE NATIONAL TECHNICAL ASSISTANCE NETWORK FOR CHILDREN'S BEHAVIORAL HEALTH

The National Technical Assistance Network for Children's Behavioral Health (TA Network) operates the National Training and Technical Assistance Center for Child, Youth, and Family Mental Health (NTTAC), funded by the Substance Abuse and Mental Health Services Administration, Child, Adolescent and Family Branch. The TA Network partners with states, tribes, territories, and communities to develop the most effective and sustainable systems of care possible with and for the benefit of children and youth with behavioral health needs and their families. The TA Network provides technical assistance and support across the country to state and local agencies, including youth and family leadership organizations.

ABOUT THE FAMILY RUN EXECUTIVE DIRECTOR LEADERSHIP ASSOCIATION (FREDLA)

This resource was produced by FREDLA in its role as a core partner in the National Technical Assistance Network for Children's Behavioral Health and through this partnership, provides training and consultation to family-run organizations and others to improve partnerships with family organizations. FREDLA is dedicated to building the leadership and organizational capacity of state and local family-run organizations focused on the well-being of children and youth with mental health, emotional, or behavioral challenges and their families. FREDLA was incorporated in 2013 and received its non-profit status in 2014. FREDLA currently has a membership of 36 state or local family organizations and has an active 20-member Board of Directors comprised of family leaders.

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Each of these individuals realized the major changes in the landscape for funding parent peer support services and family organizations in general, and wanted to contribute their knowledge and experience to the field. We are most grateful for the investment of their time and expertise to this document, which we hope will be a valuable guide for family organizations about to enter the Medicaid world.

This resource builds on a document produced by the Center for Health Care Strategies and funded by the federal Centers for Medicare and Medicaid Services. The document describes considerations for family-run organizations as they weigh the benefits and challenges of becoming Medicaid providers of family and youth peer support services. Gratitude is due to its authors Jane Kallal, Lisa Conlan Lewis, Dayana Simons, Jessica Lipper, and Sheila Pires.

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Table of Contents

Introduction

This guide is designed to assist family-run organizations (FROs) in becoming Medicaid providers of parent peer support services. It includes a step-by-step process for FROs to follow as they embark on this journey. Each step is illustrated by the experiences of two FROs: The Family Involvement Center in Arizona (FIC) and Tennessee Voices for Children (TVC). These FROs have become Medicaid providers and are well-positioned to identify effective strategies and pitfalls throughout the process. Each is at a different stage of development as a Medicaid provider, thus sharing their insights from different vantage points.

The document reflects information about the FROs at the time the information was collected. Some aspects of their services as Medicaid providers may have changed since that time, as have the organizations themselves and states in which they function. Such changes will inevitably continue and will result in ongoing modifications to each FSO's services and financing. Despite changes, the lessons learned from their experience can provide valuable guidance to other FROs seeking to provide Medicaid-billable parent peer support services

How to Use the Guide

In February 2014, a document was published by the Center for Health Care Strategies and funded by the Centers for Medicare and Medicaid Services (CMS), entitled "Becoming a Medicaid Provider of Family and Youth Peer Support: Considerations for Family Run Organizations," referred to hereafter as the "Considerations document" (Kallal, et al., 2014). This document provides guidance to FROs as they decide whether to become Medicaid providers and includes information needed to weigh the options and to understand the basics about Medicaid, including working with governments, staffing, and billing.

Resource 1: Considerations for Becoming a Medicaid Provider (see Appendix A) includes the readiness tool and pros and cons summary from the CHCS document.

This guide builds on the Considerations document and is designed to provide concrete guidance and resources to FROs that have made the decision to become Medicaid providers and are ready to begin implementation. The information and resources provided in the guide can assist FROs to understand and prepare for providing Medicaid-financed parent peer support. It is structured to allow FROs to use the tool in its entirety or to draw on various sections and resources as they become relevant to their work.

The guide outlines nine steps that must be undertaken to become a Medicaid provider. It should be noted that the process is not linear and that many of these tasks overlap and are completed concurrently.

For each of these steps, the guide provides: 1) a brief description; 2) delineation of the specific tasks to be completed; and 3) examples of how the tasks have been approached by FIC and TVC, the challenges they have faced, and the lessons learned that can inform other FROs. Useful resources from the FROs are included in Appendix A.

Step 1 – Laying the Groundwork
Step 2 – Knowing the State Medicaid Program
Step 3 – Determining the Service Delivery Approach
Step 4 – Obtaining Needed Credentials
Step 5 – Determining Financing and Rates
Step 6 – Building an Administrative Infrastructure
Step 7 – Developing Staff
Step 8 – Initiating Medicaid Services
Step 9 – Planning for Sustainability

Role and Organization of Parent Peer Support Services

According to the National Federation of Families for Children's Mental Health (NFFCMH), parent-to-parent support has been a fundamental element of the children's mental health family movement for more than 20 years (NFFCMH, 2008). Over time, parent peer support has become an integral component of the array of services and support comprising a system of care for children, youth, and young adults with behavioral health challenges and their families. Many states and communities involved in the implementation and expansion of the system of care approach have prioritized parent peer support services as an integral part of their system reform efforts. More recently, the value of youth peer support has been recognized, and these services are increasingly available as part of the service array in states and communities.

States and communities use a wide range of titles for parent peer support providers (PSPs), such as family or parent partners, advocates, mentors, navigators, and support specialists. Despite the variation in terminology, common functions identified by NFFCMH include:

- Providing information, support, and advocacy
- Helping the parent or primary caregiver navigate through systems
- Helping the parent or primary caregiver understand options and make informed decisions
- Promoting productive partnerships between parents and professionals

The NFFCMH defines PSPs as:

"Primary caregivers who have the 'lived experience' of being actively involved in raising a child who experiences emotional, developmental, behavioral, substance use, or mental health challenges. PSPs have experience navigating child-serving systems to access services and supports. PSPs have received specialized training to assist and empower other families who are raising children with similar experiences." (Spencer, Gargan, & Pearson, 2014)

As the use of parent peer support has expanded, the need for national standards was identified to ensure that PSPs have high levels of competency in the skills required for this role. A national Certification Commission for Family Support was created, and a certification program for PSPs was launched in 2012. (See https://www.ffcmh.org/certification) The Commission emphasizes that parent peer support is not a clinical service, but is a peer-to-peer support service. The providers of services are parents who have lived experience in navigating systems and provide support to other parents or primary caregivers as peers based on their common background and history, rather than as experts who have all the answers.

Although the service is generally referred to as "parent peer support," it is intended to support the many individuals who serve as primary caregivers for youth with behavioral health challenges. The national Certification Commission defines a "parent" broadly to include birth parents, foster parents, adoptive parents, family members standing in for an absent parent, or persons chosen by the family or youth to have the role of parent (Certification Commission for Family Support, 2011). **In this guide, the term "parent peer support" is used and is intended to be inclusive of all of types of primary caregivers.**

The Commission describes the focus and scope of parent peer support as follows:

- The focus of the service is on empowering parents and caregivers to parent and advocate for their child/youth with emotional, mental or behavioral health disorders or challenges.
- The scope of the service involves assisting and supporting family members to navigate through multiple agencies and human service systems (e.g., basic needs, health, behavioral health, education, social services, etc.).

- The service is strength-based and established on mutual learning from common lived experience and coaching that:
    - Promotes wellness, trust, and hope
    - Increases communication, informed decision making, and self-determination Identifies and develops advocacy skills
    - Increases access to community resources and the use of formal and natural supports
    - Reduces the isolation that parents or primary caregivers experience and the stigma of emotional, behavioral and mental health disorders

Implementing parent peer support involves multiple elements:

- Employment: Hiring and paying PSPs
- Training: Orientation and ongoing training
- Supervision: Ongoing oversight
- Location: Where PSPs do their work
- Certification: What entity certifies PSPs

Each of these key elements can take place within an FRO, a government agency, a managed care organization (MCO) or behavioral health organization (BHO), or a private provider agency. In some cases there are blended models where different entities have a role in different elements of parent peer support. As a result, there is considerable variation across states and communities as to how these services are organized (Obrachta et al., 2011).

Family peer-to-peer support is a key element in many family-run organizations across the country. It has been regarded as one of the most powerful and motivational tools to help families….overcome the challenges of raising a child with emotional, mental, or behavioral health disorders." (NFFCMH, 2008, p.8, 13)

With this variability, the NFFCMH (2008) raised questions as to whether the location of PSPs within the provider agencies that serve children and families impairs their ability to provide "full and unbiased information" about choices and/or whether it impairs their ability to advocate objectively. The NFFCMH, FREDLA, and FROs across the country believe that parent peer support is best provided when the FRO employs, trains, and supervises PSPs. This is based on the premise that PSPs from independent FROs, with the primary roles of system transformation, support, and advocacy, are in a better position to advocate for parents or primary caregivers. Additionally, FROs emphasize strict fidelity to the definition of parent peer support, whereas other types of organizations may not.

Peer support services are financed by states and communities using different financing streams, and often with a combination of funding strategies. Grants from the Substance Abuse and Mental Health Services Administration (SAMHSA) have been used extensively to initiate parent peer support services. Commonly referred to as "system of care grants", these funds are provided through SAMSHA's Children's Mental Health Initiative (CMHI). State mental health general revenue funds and Mental Health Block Grant funds are often used for parent and youth peer support services. In addition, financing from other child-serving agencies, such as child welfare or juvenile justice, may be used to provide parent peer support services to families involved in those systems, and, in a few cases, private insurance covers these services.

The most rapidly growing source of funds for peer support services is Medicaid. These services are being added to state Medicaid plans and/or offered through various waivers. Obtaining Medicaid

reimbursement for peer support services is relatively easy if the provider agencies are already certified Medicaid providers. However, FROs must go through the complex process of becoming Medicaid providers in order to receive Medicaid reimbursement for parent peer support.

The NFFCMH reported that, as of 2014, 32 states included peer support services in their state Medicaid plans (Spencer, Gargan, & Pearson, 2014). However, many states only cover peer support services for adult consumers. In 2013, a joint bulletin was issued by CMS and SAMHSA detailing home- and community-based services for children's behavioral health that can be covered by Medicaid. Peer support for both parents or primary caregivers and youth are included, providing a basis for states to add these as covered services (CMS-SAMHSA, 2013).

Introduction to the Family-Run Organizations

The two organizations highlighted in this toolkit have been leaders in becoming Medicaid providers of parent peer support services. They are at different stages of implementation: Arizona Family Involvement Center (FIC)'s pioneering work began in 2005 and Tennessee Voices for Children (TVC) implemented Medicaid-financed services in 2014. The experience of these FROs provides valuable guidance from their particular vantage points to other organizations that are pursuing Medicaid financing.

- **FIC** is located in Maricopa County, Arizona, which is the largest and most populous county in the state and includes Phoenix, and also has programs in other areas, including Prescott Valley, Flagstaff, and Tucson. It is an FRO founded in 2002 to serve as a partner in developing the system of care for children with emotional and behavioral health needs in the state. As an FRO, 51 percent of the board and 90 percent of FIC's employees have personal life experience raising children with emotional, physical, and behavioral health challenges. FIC provides a wide range of services including training classes, support groups, and parent-to-parent support. FIC is a non-profit, 501(c)(3) organization (i.e., certified by the Internal Revenue Service as tax exempt). The organization currently has 44-50 employees and an overall budget of more than $3 million. FIC is affiliated with the NFFCMH, National Alliance for Mental Illness (NAMI), and FREDLA. FIC refers its PSPs as "parent support partners."
- **TVC** was founded in 1986 by Tipper Gore and was formally organized in 1990 as a statewide coalition of individuals, agencies, and organizations working together to promote children's health and education services. TVC has progressed over time to become a statewide source of referral, support, and advocacy for families and the systems that serve them. As an FRO, 54% of TVC's staff are family members. The organization is the statewide Tennessee chapter of the NFFCMH and has worked to promote a coordinated system of care for children with mental health challenges. TVC is a not-for-profit organization with 501(c)(3) status and operates three offices across the state (Nashville, Knoxville, and Memphis). TVC currently has 47 staff members and a budget of over $3 million. TVC refers to its PSPs as "family support specialists."

Steps to Becoming a Medicaid Provider

Step 1: Lay the Groundwork

As FROs embark on the process of becoming Medicaid providers, Step 1 involves careful consideration of the potential impact of this shift and the development of strategies to address anticipated issues. Laying the groundwork also involves establishing the relationships that are critical to functioning as a Medicaid provider.

Tasks:

1. ***Assess the Potential Impact on the Organization Becoming a Medicaid Provider***
    - *Impact on the mission and culture of the FRO*
    - *Impact on the advocacy role and "authenticity" of the FRO*
    - *Impact on how the organization is perceived by families and others*
2. ***Build Relationships and Connections***
    - *State agencies: Medicaid, behavioral health, and other child-serving agencies*
    - *Managed care organizations (MCOs) and behavioral health organizations (BHOs)*
    - *Provider agencies*

Impact on the Organization

FROs must consider whether becoming a Medicaid provider will create a culture shift for the organization and what the impact might be. The Considerations document poses questions including:

- Will the organization's primary identity shift from that of an FRO to a provider organization?
- Does becoming a Medicaid provider change how families [and others] view the organization?

> *"We spent a lot of time internally talking about the shift before diving into conversations externally. There was internal fear that being a provider would mean a loss of our advocacy stance, and a concern that we would be seen as clinical providers. In reality, the house wasn't built yet, and we had an opportunity to inform and influence how it would be set up. This IS advocacy." (TVC)*

The first task is to address these questions by assessing the potential impact on the FRO — its mission, role, and activities — as well as how the organization is viewed by families and other stakeholders. Since a primary role of FROs is to advocate for individual families and at the policy level, it is essential to anticipate how being a provider of Medicaid-covered services may affect advocacy activities. As noted in the Considerations document, "When a family organization becomes a provider, it runs the risk of being perceived as having become part of the 'system' and losing its credibility as an advocate for families." This assessment should result in strategies to ensure that organizations can maintain their mission, identity, and authenticity while, at the same time, adapting to the changes in policies, services, funding and administration that invariably occur as Medicaid providers.

> *FIC has evolved with all the new aspects of being a Medicaid provider, as well as attempting to retain and grow the other key functions and mission of what an FRO is to families, communities, and states." (FIC)*

FIC recognized the potential impact on the role of the organization and has made concerted efforts to separate and protect its advocacy functions at all levels of system of care development. FIC has been able to accomplish this by securing separate contacts with regional behavioral health authorities (RBHAs), providers, and state agencies. TVC had extensive internal conversations about this issue and the fear that the organization would be seen as clinical providers rather than as advocates. After reaching consensus internally about staying true to its mission, external outreach was used intentionally to discuss the transition.

Arizona Family Involvement Center

When FIC was moving in the direction of becoming a Medicaid provider, the organization was confident that it could still be an advocate and system of care advisor. Based on its relationships with key state leaders and its history of system-level involvement, the organization did not feel that this role would be threatened. In fact, not becoming a Medicaid provider would have limited FIC's capacity to connect and support larger numbers of families needing services by decreasing its ability to remain sustainable. Becoming a Medicaid provider has not impacted the way families see FIC's mission and programs. However, at least initially, many providers viewed FIC as a competitor for services rather than a partner for providing non-clinical services that focus on the needs of the parent or primary caregiver and on strengthening the family.

Tennessee Voices for Children

There was concern in TVC about what the shift to becoming a Medicaid provider would mean for the organization and its culture. Considerable time was spent internally discussing how it might impact the culture and what people on the outside would think. In particular, there was discussion to address the fear of the loss of advocacy as a central purpose of TVC, whether they would be seen as providing clinical services rather than peer support, and whether they were going to be told by Medicaid and the MCOs how to do their job. The organization diagrammed all that was known and unknown about becoming a Medicaid provider. It took time for staff to understand the change in thinking occurring in the state agencies and MCOs about making sure that children and families get what they need. In overcoming reservations, TVC realized that it had an opportunity to influence how Medicaid-financed parent peer support services would be implemented based on its experience about what works, which is true advocacy. Support and buy-in from staff was essential prior to taking this step and communicating externally about the plans.

TVC proceeded to meet personally with state agencies, providers, and organizations over a period of months to discuss why peer support is so important and how the move to becoming a Medicaid provider would enable more families to receive the service. TVC also worked to maintain positive relationships with provider agencies that were developing parent peer support services within their own organizations and offered them training through the TVC certification training program. Throughout this transition, TVC has remained true to its model, and its work informed the standards adopted by the state. The organization's advocacy role has not been impacted.

Relationships and Connections

An important part of laying the groundwork involves relationship building with those agencies that will play a role in financing, regulating, and monitoring the parent peer support services.

Establishing connections and productive working relationships at the outset will allow FROs to have input into a range of decisions that have a significant impact on the viability and effectiveness of parent peer support services.

FROs should begin by identifying the key players in the state or community:

- ***Medicaid and Behavioral Health Agencies:*** The state Medicaid agency is critical. In a number of states, the state behavioral health authority administers the behavioral health services provided through Medicaid. Collaborative relationships with both state Medicaid and behavioral health agencies are essential. MCOs and BHOs: I those states with Medicaid managed care, MCOs and BHOs may be the entities that contract with providers and, as such, play a pivotal role in procuring parent peer support services from FROs. States may have more than one MCO or BHO, and communication and partnerships with them will provide a vehicle for resolving contractual and service delivery issues.
- ***Care Management Entities (CMEs):*** CMEs are increasingly being created by states to serve as the "locus of accountability" for defined populations of youth with complex challenges and their families who are involved in multiple systems. CMEs are responsible for improving the quality and cost of care for these high-need populations. Since many of the families served by CMEs will need parent peer support, partnerships are needed to ensure that families receive these services.
- ***Provider Agencies:*** Providers are also key partners. Typically, provider agencies make referrals for the parent peer support services, and PSPs will also need to collaborate closely with providers that are working with children and families to ensure that services are well-aligned and coordinated.

"We didn't anticipate the impact of leadership changes in state agencies or change in RBHA contactors. These changes can put family-run organizations back at ground zero and requires efforts to rebuild collaborative relationships." (FIC)

FROs should be proactive in identifying and reaching out to the key players. Organizations may start by requesting meetings with the Medicaid agency, behavioral health agency, MCO or BHO, and providers. This creates an opportunity for them to learn about the programs and services offered by the FRO, along with its funding, accomplishments, and challenges.

Actively participating on committees also creates opportunities as it offers a path to mutually productive relationships and serves a dual purpose — it keeps FROs up to date on developments and provides an opportunity to offer input and shape policy. It is important to ensure that knowledgeable family leaders represent the FRO and consistently attend committee meetings, so that key partners come to know them and identify them with the organization.

For example, FIC's strong relationship with the state's behavioral health agency allowed family voice to be considered in decisions made not only about parent peer support but about the entire children's system of care. Through long-standing collaborative relationships with the state to develop systems of care, TVC had the opportunity to provide input as to how parent peer support would be provided. FIC noted the importance of rebuilding these relationships when there are changes in leaders in state agencies and when management and administrative structures change, such as MCOs, BHOs, or CMEs. Both of the organizations emphasized the importance of open communication, collaboration, and joint problem solving in order to address challenges that arise on an ongoing basis.

Arizona Family Involvement Center

From the earliest stages, FIC's director and a large cadre of parents and primary caregivers were closely involved in the planning process for the children's mental health system of care. Serving on multiple committees allowed FIC and affiliated parent leaders to establish relationships with the state's behavioral health agency, which manages Medicaid behavioral health services. Through this process, partnerships were strengthened and solidified, and family voice became an integral part of all decision making. FIC's director and other parents were also involved in meetings with providers and with the organizations that were selected as RBHAs, which function as MCOs. FIC emphasized that relationships with state policy makers and the RBHAs are both critical. This has not always been easy, as over the past 10 years there have been multiple changes in leadership in state agencies, as well as changes in RBHA contracts and in provider structures. FIC has worked to cultivate new collaborative relationships, provide historical perspectives, and advocate for increased understanding of the benefits of parent peer support services.

> *"It was an extraordinary opportunity for not only FIC parent staff, but also for other parent representatives to be at so many tables in the design and roll-out of the children's system of care and to learn about the Medicaid system first hand." (Arizona FIC)*

Tennessee Voices for Children

Early in its history, TVC worked closely with the Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS) to build trust and create a partnership that would allow the organization to have a strong voice on the needs of children with mental health issues and their families. This has been evident in TVC's participation in over 100 coalitions, committees, councils, and collaborative groups across the state since its inception. TVC was a partner with TDMHSAS for five federal system of care demonstration grants, a system of care expansion grant, and a healthy transitions grant, which is also based in system of care values and principles. TVC is a member of the state's legislatively mandated Council on Children's Mental Health, which includes the state Medicaid agency. In addition to its close working relationship with TDMHSAS, TVC leaders formed a positive relationship with the behavioral health component of the state Medicaid program (referred to as TennCare), and have maintained a strong independent relationship over time. The resulting partnerships led to strong support as TVC sought to diversify its funding by becoming a Medicaid provider, and has allowed TVC to play an influential role in determining how parent pee

Step 2: Know the State Medicaid Program

Step 2 involves becoming familiar with the state's Medicaid program. As noted in the Considerations document, FROs must learn whether or not it is a managed care program, how behavioral health services are administered, how peer support is covered, and whether potential changes in the Medicaid program may affect parent peer support.

Tasks:

1. ***Determine the structure of the state's Medicaid Program***
    - *Managed care or fee-for-service (FFS) or both*
    - *How behavioral health services are administered*
    - *Structures used for the program, e.g., administrative services organizations (ASOs), MCOs that manage both physical and behavioral health, BHOs that manage only behavioral health services, CMEs that manage care and cost for high-need children, and Health Homes created under the Affordable Care Act (ACA) that provide physical and behavioral health services for populations with "chronic" health care needs, etc.*
2. ***Determine if and how peer support is covered***
    - *State Medicaid Plan service*
    - *Medicaid waiver service*
    - *Medicaid administrative dollars*
    - *Other mechanisms, e.g., child welfare funds or other child-serving agencies*
    - *Combination of approaches*
3. ***Identify potential changes***
    - *Explore possible changes to the state's Medicaid program that may be occurring or are under consideration with potential implications for peer support (e.g., health reform implementation, waivers, redesign initiatives, managed care implementation)*
    - *Provide input into state regulatory, policy, or other changes when possible*

Structure of State's Medicaid Program

The structure of the state's Medicaid program, and the state's use of managed care, sets the parameters for providing parent peer support services by:

- Defining the service
- Establishing parameters (e.g., how many hours of service are allowable per day/week/month)
- Determining eligibility to provide the service

- Identifying what entity will contract with the FRO
- Describing how oversight and monitoring will occur
- Designating how the organization will bill for services and if reimbursement will be based on FFS or another arrangement

Medicaid programs operate differently in each state. For example, some states use a managed care approach whereby an MCO or BHO contracts for and manages providers and services, while in others, the state Medicaid agency administers and manages the program directly. Then, there are further states, which use both approaches simultaneously. The approach used determines the contractual and billing processes for parent peer support services:

- The FRO may function as an independent provider or under a contract with the state Medicaid agency, state behavioral health agency, or an MCO or BHO.
- In some states, providers (including FROs) bill Medicaid directly for the services provided. In others, MCOs, BHOs, or ASOs handle the administrative functions of the Medicaid system, including claims processing.

Because of these variations, it is important to learn how the Medicaid program is structured in the state and how parent peer support services will be administered. FIC and TVC leveraged their relationships to learn about the organization of the Medicaid program in their respective states and to understand how their organizations would fit into the system.

Arizona Family Involvement Center

Medicaid services in Arizona are financed through an 1115 Managed Care Waiver. The Division of Behavioral Health Services (DBHS) of the Arizona Department of Health Services (ADHS) manages a behavioral health carve-out and contracts with three regional authorities that serve as MCOs (the RBHAs), covering three geographic regions throughout the state. DBHS also contracts with two Tribal Behavioral Health Authorities. RBHAs receive capitation payments for Medicaid services, as well as state resources to provide services to non-Medicaid populations and to pay for services not covered by Medicaid. It is the RBHAs that, in turn, contract with FIC for parent peer support services.

FIC's director and other parent leaders were closely involved in planning the children's mental health system of care that was created as a result of the settlement of a class action lawsuit filed on behalf of Medicaid-eligible youth in need of behavioral health services (known as the Jason K or JK lawsuit). This provided a strong knowledge base about the state's Medicaid program and how FIC would function as a provider. Participation in the process provided information on the structure of the Medicaid system, plans, descriptions, covered services, medical necessity criteria, and billing requirements.

Tennessee Voices for Children

TennCare is one of the oldest Medicaid managed care programs in the country. Established in 1994, the program operates under an 1115 Managed Care Waiver and is an integrated, full-risk, managed care program that serves the entire state's Medicaid population. Medicaid services are managed by the "Bureau of TennCare," including behavioral health services. TennCare contracts with three MCOs for both physical and behavioral health services, all of which are statewide. The MCOs contract with behavioral health providers including TVC that are paid either through case rates or FFS. The state's behavioral health authority (TDMHSAS) collaborates with TennCare and the MCOs in many aspects of behavioral health services. A joint pilot program composed of representatives from TennCare, the MCOs, TVC, behavioral health providers, and TDMHSAS was initiated in 2013 in one region to implement the system of care approach for Medicaid children's behavioral health services using the Wraparound process and adding services, such as care coordination, parent peer support, and home-based treatment.

TVC board members and advisors have served in key positions in the state system and have experience with the Medicaid program. A working relationship with one of the MCOs helped TVC to learn how TennCare functions and led to an appreciation by the MCO of the important role of parent peer support. Through these relationships, TV developed considerable knowledge about the Medicaid system and has had opportunities to provide input on how peer support services are incorporated into the benefit package.

Coverage of Peer Support

Coverage of peer support varies across states (Simons & Mahadevan, 2012). Some states may include parent peer support as a covered service in their state Medicaid plans, while others cover and finance these services through a Medicaid waiver or SPA.

- ***State Plan Amendment (SPA)*** — A Medicaid state plan is an agreement between a state and the federal government describing how the state abides by federal rules, and thus is able to claim federal matching funds for its Medicaid program. The state plan delineates the groups of individuals to be covered, services to be provided, methodologies for providers to be reimbursed, and the administrative process. SPAs allow the specified services to be provided to anyone meeting eligibility criteria. Created under the ACA, 1915(i) SPAs allow states to provide home- and community-based services to specific populations including children and youth with serious behavioral health conditions, and can be used to add peer support as a covered service.

  Under their Medicaid plans, states may add peer support as a "benefit" with its own service code for billing, or revise the definitions of other services already in their plans to include peer support (e.g., family support and case management). When a state is planning to change or update its Medicaid policies, covered services, or operational approach, they must send SPAs with this new information to CMS for review and approval. In Tennessee, peer support was added to the state plan.

- ***Medicaid Waivers*** — Medicaid waivers also provide vehicles for financing peer support, as they allow coverage of an array of home- and community-based services that are not included in the state plan. A number of different waivers can be used to cover parent peer support. In Arizona, parent peer support was added as a covered service based on the settlement of the class action lawsuit through its 1115 Managed Care Waiver. Click here for more information about Medicaid waivers.

Arizona Family Involvement Center

Parent peer support became a covered Medicaid service in Arizona's state plan as a result of the JK settlement agreement, along with the child and family team (Wraparound) approach to planning and delivering services and an array of home- and community-based services and supports guided by system of care principles. At the time, peer support was a new concept, and the service was developed concurrently with the implementation of the system of care, with parent voice required by the settlement agreement. A two-year demonstration project began in 2000 in two regions of the state (Maricopa County and Northern Arizona). During the demonstration project, state funding was utilized for parent peer support, and this service was established as an important component of the services available to families, with the recommendation that it be introduced at the beginning of service delivery. Following the pilot, the state proceeded with a full-scale system of care implementation. FIC became a Medicaid provider of peer support in 2005.

Tennessee Voices for Children

Parent peer support was added as a service officially covered by Medicaid in 2014. Previously, TVC had a contract with one MCO to provide parent peer support, which was billed under a code for home- and community-based treatment. TVC also had experience with another MCO under Single Case Agreements. This prior experience was a factor in the decision of the state Medicaid program to include parent peer support in its array of covered services. There was evidence of its effectiveness, and MCOs were already buying the service even before it had its own official definition and service code. This early work provided an opportunity to test and refine the approach to parent peer support. The joint mental health–Medicaid pilot gave legs to the effort to include parent peer support as a covered service.

Potential Changes

The landscape for the organization and financing of behavioral health services for children and adolescents is rapidly shifting. Among the changes occurring in states are changes related to national health reform, with implementation of the various provisions of the ACA, and large-scale Medicaid redesign initiatives that include the adoption of managed care strategies. As FROs learn about their state Medicaid programs, it is important to identify potential changes and anticipate how they may affect the delivery of parent peer support services and their role as providers. An example is the opportunity offered in Arizona to incorporate peer support in a Medicaid system that integrates physical and behavioral health care.

Arizona Family Involvement Center

The Arizona Medicaid system is moving towards integrating physical and behavioral health care. FIC is participating in the initial discussions about integrated care and is preparing for the application this service delivery model to children. In 2013, FIC, under a RBHA grant, partnered in a demonstration of integrated health services for families of children with significant physical and behavioral health needs and provided parent peer support and education services. Additionally, FIC recently began serving children with chronic health conditions and special needs through a contract with another MCO focusing on this population.

In 2014, a pilot was initiated to implement an integrated health model for adults with a serious mental illness, with plans for a statewide implementation for adults in 2015. FIC's contract with the RBHA in Northern Arizona supports peer support services to both the children's and adult systems. This is giving FIC the opportunity to develop its PSP workforce within the integrated care model to prepare for the future.

Tennessee Voices for Children

The 2013 pilot, initiated in one region of the state, is a joint effort of the state mental health and Medicaid agencies. A collaborative workgroup was created including these state agencies, the three MCOs, and six CMHCs serving the area. TVC has participated as a member of the workgroup and provides parent peer support services to families served through the pilot. The most significant potential change in the Medicaid program is the potential for statewide adoption of the system of care approach for Medicaid-financed children's behavioral health services statewide, which would dramatically increase the demand for parent peer support.

Step 3: Determine the Service Delivery Approach

Step 3 focuses on determining how parent peer support services will be provided. The tasks involve determining the definition of parent peer support that will be used and the practice approach that will guide service delivery.

Tasks:

1. ***Determine the state's parent peer support definition***
    - *Review the state's definition of parent peer support*
    - *Determine if the definition of peer support fits for parent peer support as distinguished from peer support for adult consumers*
    - *Partner with the state, if possible, to develop a definition or to revise an existing definition*
    - *Identify potential changes or limits in peer support services that may be experienced by becoming a Medicaid provider*
2. ***Determine the practice model for parent peer support***
    - *Examine potential models of parent peer support*
    - *Define the model of parent peer support to be implemented, if possible*

Definition of Parent Peer Support

Definitions of parent peer support differ across state Medicaid programs, although most share similar components:

- Provided by a person with lived experience as a parent or primary caregiver
- Assistance to parents or primary caregivers to navigate through the service planning and delivery process
- Advocacy, support, and mentoring to parents or primary caregivers
- Linking parents or primary caregivers with formal and informal services and supports
- Empowering parents or primary caregivers as advocates for their children and families

Parent peer support is a service whereby providers (PSPs) use their lived experience, coupled with specialized training, to assist, empower, support, advocate, mentor, and coach parents or primary caregivers raising children who experience emotional, behavioral, substance use, and other challenges.

The joint bulletin issued by CMS and SAMHSA in 2013 detailed home- and community-based services that can be covered by Medicaid. Peer support is included in the bulletin and is defined as below.

> *Parent and youth peer support services include:*
>
> 1. *Developing and linking with formal and informal supports*
> 2. *Instilling confidence*
> 3. *Assisting in the development of goals*
> 4. *Serving as an advocate, mentor, or facilitator for resolution of issues*
> 5. *Teaching skills necessary to improve coping abilities*
>
> *The providers of peer support are family members or youth with "lived experience" who have personally faced the challenges of coping with serious mental health conditions, either as a consumer or caregiver. These peers provide support, education, skills training, and advocacy in ways that are both accessible and acceptable to families and youth. (CMS-SAMHSA, 2013, p.4)*

When becoming Medicaid providers, FROs must consider the definition of parent peer support used in their respective states. It may differ from the definition used by the organization and may require organizations to adapt their definitions. Further, some states have multiple service codes that can be used to bill for parent peer support and, therefore, have multiple definitions that may be applicable to the services provided by FROs.

If parent peer support services are new to the state, there may be an opportunity for the organization to have input into the definition. FIC had significant input in the initial development of the definition, and more recently has been able to suggest modifiers that will allow the state to determine how much family support is being provided by the parent workforce versus other behavioral health staff who can also provide and bill for parent peer support. TVC also provided considerable input on the definition and guidance for parent peer support services, based on its prior experience in delivering this service.

Arizona Family Involvement Center

The definition of parent peer support was created along with the development of the new system of care resulting from the JK lawsuit. The FIC founder and other parents had input on the definition based on their involvement in the settlement process that included working with all state child-serving agencies, as well as Arizona's Medicaid agency. The Covered Behavioral Health Services Guide provides definitions for all services covered by Medicaid. FIC uses four primary codes to bill for parent peer support services and each are defined below:

- Self-help/peer services
- Home care training family services (aka Family support)
- Case management
- Behavioral health promotion

1. *Self-Help/Peer Services*

Defined as involving assistance with:

- More effectively utilizing the service delivery system (e.g., assistance in developing plans of care, identifying needs, accessing supports, partnering with professionals, overcoming service barriers)
- Understanding and coping with the stressors of the person's disability (e.g., support groups, coaching, role modeling, and mentoring)

A benefit of this code is it allows for billing of services provided both individually and in groups. FIC uses the code when facilitating support groups and providing parent education services.

2. *Family Support*

Referred to in the guide as "home care training – family (family support)," the service is defined as:

Face-to-face interaction with family member(s) directed toward restoration, enhancement, or maintenance of the family's functioning to increase the family's ability to effectively interact and care for the person in the home and community. It may involve activities such as:

- Assisting the family to adjust to the person's disability
- Developing skills to effectively interact and/or guide the person
- Understanding the causes and treatment of behavioral health issues
- Understanding and effectively using the system
- Planning long-term care for the person and the family

The definition for family support does not specify that it must be provided by a person with lived experience. Although the basic definitions cannot be changed from what is included in the Covered Services Guide, consideration is being given to adding modifiers to the family support code. One such modifier is to add language addressing peer support provided by credentialed PSPs with lived experience to differentiate this from family support provided by other types of staff. FIC uses the code for family support to bill, which is reimbursed at a higher rate than the rate for peer support. Adding this modifier would allow tracking of how much family support is provided by parent peers versus other staff.

3. *Case Management*

Defined as a supportive service provided to enhance treatment goals and effectiveness:

- Assistance in maintaining, monitoring, and modifying covered services

- Brief telephone or face-to-face interactions with a person, family, or other involved party for the purpose of maintaining or enhancing a person's functioning
- Communication and coordination of care with the person's family; behavioral and general medical and dental health care providers; community resources; and other involved supports including educational, social, judicial, community, and other state agencies
- Coordination of services related to continuity of care between levels (e.g., inpatient to outpatient care) and across multiple services
- Outreach and follow-up of crisis contacts and missed appointments
- Participation in staffing, case conferences, or meetings with or without the person and their family participating
- Other activities as needed

4. *Behavioral Health Prevention/Promotion Education and Medication Training and Support Services (Health Promotion)*

Education and training refers to single or multiple sessions provided to an individual or a group of individuals and/or their families related to the enrolled person's treatment plan. Education and training sessions are usually presented using a standardized curriculum with the purpose of increasing an individual's behavioral knowledge of a health-related topic such as the nature of an illness, relapse and symptom management, medication management, stress management, safe sex practices, HIV education, parenting skills, and healthy lifestyles (e.g., diet, exercise). FIC has parent trainers who are credentialed and have the expertise to provide and bill for behavioral health promotion services, enabling the organization to provide training and education from a parent perspective to parents and primary caregivers.

Tennessee Voices for Children

TVC was able to provide guidance on the definition and expectations for parent peer support. Family support services are defined as:

Services that are used to assist other caregivers of children or youth diagnosed with emotional, behavioral, or co-occurring disorders, and are provided by persons who are Certified Family Support Specialists (CFSSs). A CFSS is a person who has previously self-identified as the caregiver of a child or youth with an emotional, behavioral, or co-occurring disorder and who has successfully navigated child- serving systems to access treatment and resources necessary to build resiliency and foster success in the home, school, and community. This individual has successfully completed training recognized by TDMHSAS on how to assist other caregivers in fostering resiliency in their child.

These direct caregiver-to-caregiver support services include assistance in managing their child's illness and fostering resiliency and hope in the recovery process, including:

- Developing formal and informal supports
- Assisting in the development of strengths-based family and individual goals
- Serving as an advocate, mentor, or facilitator for resolution of issues that a caregiver is unable to resolve on his or her own
- Providing education on system navigation and skills necessary to maintain children with emotional, behavioral or co-occurring disorders in their home environment

Rather than telling us how to deliver parent peer support services, the state and MCOs looked to us for guidance in determining expectations for the role and developing the service in partnership. This opportunity to sit at the table all together is reflective of a system of care. (TVC)

Practice Model

The practice model for parent peer support services is often dictated by the definition and approach specified by the state Medicaid program. A practice model considers both organizational and direct service components that prescribe how services will be provided to parents, including:

- Whether parent peer support services can only be provided by individuals with lived experience
- Whether peer support should be provided by an independent FRO rather than through a service provider agency
- What is included and excluded in the role of the PSP
- The preferred caseload size and duration of services
- How the PSP relates to service planning teams, care managers, clinicians, and other providers
- What education levels, experience, competencies, certification, and supervision are required for PSPs

Two aspects of the practice model that FROs have paid particular attention to are:

1. The requirement that these services be provided only by persons with lived experience
2. The value of providing peer support by independent FROs

Both of these are part of the practice approaches of all three FROs. There is a strong belief that this represents a more effective and authentic practice model, and that fidelity to this approach is critical. The practice model for parent peer support can also be impacted by the "medical necessity" criteria used to determine if services can be billed to Medicaid, which vary widely across states and MCOs.

> *"FROs should understand that becoming a Medicaid provider can shift an organization's service delivery approach from whatever it takes to whatever you can bill for." (Jane Walker, FREDLA)*

FIC emphasized the importance of maintaining integrity to the model of parent peer support when becoming a Medicaid provider, even in the face of the prescriptiveness of Medicaid financing. Ideally, some type of work group with FROs, the state Medicaid and behavioral health agencies, and MCOs would be created to plan how services will be delivered in order to ensure authentic peer support services that are feasible in terms of both service delivery and financing.

Resource 2: Practice Model (See Appendix A) includes a logic model and flow chart depicting FIC's approach to parent peer support.

Arizona Family Involvement Center

According to FIC, there can be greater flexibility in how peer support services are delivered when financed through other sources, while Medicaid contracts are more prescriptive. The practice model adopted by FIC across all funding sources is that parent peer support must be provided by a parent or primary caregiver with lived experience. Within the Medicaid system, the PSP is considered integral to the Wraparound approach and must be included in the individualized service plan. FIC's practice model also includes providing peer support as an independent or stand-alone service when requested by parents.

> *"Although there are enough families to go around, the practice model for PSPs can easily change when family-run organizations are not providing the service and developing the workforce." (FIC)*

Some aspects of FIC's practice model changed when it became a Medicaid provider. For example, the practice model changed from parent-initiated requests for peer support to primarily receiving referrals from providers implementing the Wraparound approach. This has resulted in parents having to wait to receive peer support services. In addition, the timeframe for FIC peer support and education services was shortened significantly.

FIC's practice model is also based on the premise that parent peer support is best provided by an FRO. According to FIC, it is important to emphasize the connection between parent peer support and the FRO's ability to educate and organize parents to promote system improvement — something other types of provider agencies are not able to do as well. FIC developed a logic model for the array of parent support services that reflects its practice approach, along with a tool that provides information about the parent/caregivers' situations to ensure the right fit of support options to meet their needs.

> *"Family-run organizations must be vocal about what they need to work as Medicaid providers effectively and stay true to their own models of parent peer support." (FIC)*

Tennessee Voices for Children

Fundamental to TVC's practice model is that parent peer support is best delivered by FROs that have an advocacy mission aligned with the family's needs. This allows a neutral party to engage the family in services and help them to voice their own needs, while at the same time collaborating with providers. Lived experience is also central and is included in certification requirements.

Caseloads for PSPs range from 10-15 families (depending on what other services are included for the family), and families are typically seen twice a week. In some instances, the PSPs have acted in a dual role as care coordinator and PSP, serving as facilitators of Wraparound child and family team meetings in addition to providing parent peer support. TVC feels that these roles are distinct and should be separated. Currently, the practice model is shifting from fulfilling this dual role, and PSPs are working in close collaboration with a care coordinator who serves as the Wraparound facilitator. With the separation of these functions, PSPs can concentrate on their primary role of parent peer support.

Step 4: Obtain Needed Credentials or Licenses for the Organization

Becoming a Medicaid provider typically requires that provider organizations and agencies meet a set of criteria in order to obtain the needed credentials or licenses. Step 4 involves determining, applying for, and obtaining licenses or other relevant credentials for the FRO.

Tasks:

1. ***Determine the credentials or licenses that are required for the FRO***
    - *Review and analyze requirements for the FRO to become a Medicaid provider*
    - *Determine what, if any, certification, license, or accreditation is required*
    - *Implement any changes or improvements needed to meet requirements for certification or licensure*
2. ***Submit the necessary applications and materials***
    - *Prepare and submit documentation for licensing*

Credentialing and Licensing

Licensing requirements are unique to each state. They can be as simple as just enrolling as a Medicaid provider or as difficult as obtaining a facilities license, which entails extensive application, documentation and inspection processes. In some instances, required credentials or licenses come from multiple state agencies or third-party organizations, forcing FROs to navigate complex, sometimes conflicting rules.

It is also possible that requirements change over time. FIC was initially able to participate as a newly created type of community agency that could provide Medicaid services by meeting a small set of criteria.

"Becoming a licensed facility can alter the environment of a family-run organization in terms of maintaining a welcoming environment. There can be more restrictive requirements that are barriers to delivering care in the true spirit of systems of care and parent-to- parent support." (FIC)

Subsequently, however, FIC made a strategic decision to become an outpatient clinic, which resulted in a rigorous process to obtain a facilities license. Some of the licensing requirements in states may not be good fits for FROs and, as in FIC's example, may not be entirely consistent with the system of care approach. FIC noted that some of the requirements may apply to the entire organization, not just to the Medicaid services. Thus, it is essential for FROs to determine what licenses are needed and what is involved in meeting the specific requirements. This information will allow organizations to explore strategies for obtaining credentials while, at the same time, protecting all or parts of the organizations from adverse impacts. TVC was fortunate enough not to need any new licenses to become a Medicaid provider based on its long-standing license as an outpatient mental health facility.

Resource 3: Family-Run Organization Credentials (See Appendix A) includes the requirements to become a Medicaid provider in Tennessee.

Arizona Family Involvement Center

In 2004, the state created the new provider contract category of "Community Service Agencies (CSAs)," primarily to enable family-run and other community-driven organizations to provide peer support and bill Medicaid. When FIC was a CSA, a license was not required. Instead, all that was required was state certification that the organization met particular criteria in order to provide peer support. The CSA structure ultimately proved ineffective due to restrictions on some billing codes or not having the billing codes that would allow the agencies to provide the required continuum of services. FIC and many of the CSAs chose to become a "direct support provider" of home- and community-based services and a "licensed outpatient clinic," requiring that the organization obtain a "facilities" license through the state's Bureau of Medical Facilities. The requirements for a facilities license are designed to protect client safety, and many do not fit with a FRO that hosts a multitude of community activities to increase social connectedness between parents and increase their natural supports. FIC has had to add extra staff support to its parenting classes and has had to incorporate additional time into the first session to complete the paperwork connected with licensure, including confirming identity through a driver's license or photo ID.

FIC found that licensing resulted in some demonstrable changes to the environment. One example is that all volunteers must have fingerprint clearance cards in order to provide support, and support groups cannot be held in community locations such as churches or schools. It was noted that some of the requirements seem to go against the essence of the system of care approach, and that at times, the organization felt like it was "running a hospital." Based on the potential impact, FIC recommends that FROs thoroughly understand all licensing and credentialing requirements and intentionally preserve a part of the organization that is not subject to some of these requirements. The current RBHA is working to incorporate greater flexibility, and FIC is part of a large group of service providers that are meeting regularly with the RBHA to address some of these barriers.

Tennessee Voices for Children

TVC has been licensed by TDMHSAS as an outpatient mental health facility since 2003. This licensure was needed when the organization sought new opportunities to provide services and needed the required credentials. No additional licensure was needed to become a Medicaid provider. Some of the required credentials led to the need for resource investments — for example bringing the facility up to code for equipment such as fire extinguishers and first aid. Others relate to governance, policies and procedures, financial management, personnel, client records and client rights. While it is sometimes cumbersome to comply with all the requirements, TVC feels that the credentials strengthen the organization and its accountability.

"Being in compliance with the licensure requirements is tedious, but it strengthens our operations and provides healthy oversight and accountability." (TVC)

Step 5: Determine Financing and Rates

Step 5 addresses the contractual and financial aspects of being a Medicaid provider. This step is perhaps the most difficult and complex for FROs but is critical, since financing can "make or break" the parent peer support services provided by FROs. Some organizations hire outside consultants to assist with this step, such as an accountant to help project costs and revenues or an attorney to review contracts. The specific tasks include contracting methods, billing rates and processes, and resources for start-up expenses.

Tasks:

1. ***Determine the state's contracting and payment methods for parent peer support***
    - *Determine the state's contracting approach with the organization, e.g., contract directly with state Medicaid agency or subcontract with a provider agency, MCO, or BHO*
    - *Determine the payment mode, e.g., fee-for-service (FFS), case rate, daily rate, block purchase or a combination of approaches*
    - *Determine the typical turnaround time to receive payment once billing is submitted*
2. ***Determine the Medicaid rates, billing codes and time increments for billing***
    - *Determine the state's rates and billing codes for parent peer support*
    - *Determine what is included and not included in rates*
    - *Determine the billing increments, e.g., per 15 minutes, day, week or episode of care*
    - *Determine any limits on billing per family, e.g., maximum number of hours per day, per week or per month*
    - *Estimate the organization's total costs of providing parent peer support*

- *Identify financing to cover expenses not covered by Medicaid, e.g., administrative costs, staff time for documentation, training and supervision, vacation/holidays, travel*
- *Determine the process, if any, for requesting rate adjustments based on actual costs*

3. ***Identify funding for start-up costs and cash reserves***

- *Estimate start-up costs and identify funding for start-up expenses*
- *Determine needed reserves for cash flow purposes*
- *Develop and implement a plan for building needed reserves*

Contracting and Payment Method

"If there is an opportunity to get block funding, then the family-run organization won't have to cover big up-front costs to get going." (FIC)

Based on the structure of the state's Medicaid system, the FRO may contract directly with the state Medicaid agency or may operate with a subcontract from a provider agency, MCO or BHO. Virtually all aspects of providing and administering peer support services are shaped by contract provisions, prompting FIC to caution organizations to be sure that they understand all of the requirements in the contract. Legal help may be needed for a thorough review and analysis of a contract. A complication is created when the FRO has multiple contracts with different MCOs for peer support. TVC has separate contracts with the state's three MCOs, each requiring different procedures. Complications were created for FIC when, for a time, "provider network organizations" were created as a layer between providers and the RBHAs that function as MCOs. FROs should determine if they will have multiple Medicaid contracts and plan strategies for tracking their differing requirements and processes for monitoring, billing, and other functions.

Another critical factor affecting the financial viability of parent peer support services is the way in which the organizations are paid:

Block payments provide 1/12 of the total contract amount each month over the year.

FIC is funded in this way and uses encounter data to determine if all of these funds were earned or if they must refund some amount. An advantage to block funding is that organizations are protected to some degree from cash flow problems, particularly during the start-up phase.

Fee-for-Service (FFS) is a more common form of payment.

TVC is paid on this basis. This payment method fluctuates with the case flow and may be higher at times or lower when there are fewer cases. Even when the number of cases temporarily dips, organizations must continue to pay staff. This can create a cash flow problem for FROs, and having sufficient reserves to carry the organization through these times is critical.

FROs are not likely to have an influence on the payment method, and should put the administrative processes in place to handle the payment method in their respective states.

Tennessee Voices for Children

TVC is paid on a FFS basis through separate contracts with each of the three MCOs in the state. Claims are submitted at the end of each month, and full payment is made thereafter. Currently both per day/per diem and unit rates are used depending on the authorized service. TVC has managed well with the FFS billing method so far, but will need to streamline the process as the volume of families increases. In some cases, claims must be resubmitted if they do not go through properly, but the organization has not experienced financial hardship as a result of late payments. However, the contracted rates with some of the MCOs are not currently covering costs, and TVC is negotiating these rates. The process is slow to reach resolution, but with the level of commitment from the MCOs, TVC feels certain that a fair rate can be achieved for both parties.

Arizona Family Involvement Center

Currently, a block funding process is the most common model used in Arizona whereby FIC receives 1/12 of its contract amount each month. Service encounters are then tracked over the course of the year as claims are submitted, with the assumption that the services will equal 100% of the contract amount. As the year progresses, monthly billing summaries are aligned with the amount of revenue to see if the organization is "encountering" at the level needed. If encountering is running short for two or three months, then revenue is deferred on financial reporting. If FIC over-encounters above the total contact amount, the organization does not get paid for the overage. However, if FIC under-encounters and does not provide services equal to the total contract amount, then the RBHA may require that excess reimbursement to be paid back. Although block funding is more beneficial for FROs, the current RBHA is transitioning over the next three years from block funding to FFS for all providers.

Medicaid Rates

"If lower rates are accepted, the family organization must find ways to rethink service delivery and staff assignments to make ends meet." (TVC)

State Medicaid agencies, or their contracted managed care entities, determine the types of services that are reimbursable, designate billing codes for these services and set the payment rates.

Units of Service: Billing is typically handled in increments or "units of service." These may be time units, such as 15-minute or 30-minute units. Further, the Medicaid agency or managed care entity will establish parameters on the amount of services, for example, the maximum number of units of a service that can be billed in one day or one month. In Arizona, a limit is that the family support billing code can only be used for face-to-face contacts; for telephonic support services, FIC must bill using the code for case management. In Arizona, the RBHAs are allowed to pay higher rates than the state-established payment rates, and FIC's RBHAs in Maricopa County and northern Arizona have done so. TVC submitted rate proposals to each MCO and payment rates were then negotiated. One of the three MCOs offered rates that were too low, resulting in a protracted negotiation process and a "single case agreement" to allow TVC to provide some parent peer support services in the interim. Payment rates and limits are critical factors for FROs in that they determine if parent peer support services are financially viable for FROs.

Non-Billable Activities: In addition to setting rates, Medicaid agencies specify which activities for peer support are included in the rates and which are not billable. Non-billable activities frequently include time spent in training, supervision, documentation and travel. In some states, telephone contacts may

"It's essential for FROs to keep abreast of rate changes. Also, the impact on families and FROs should be considered when the state or MCO is changing billing codes or rates." (FIC)

not be billable. The assumption is that rates will be sufficient to cover the costs that are not directly billed, but this often is not the case. FROs must implement strategies to cover costs that are excluded.

Most FROs will not have the opportunity for input in the Medicaid agency's rate setting process. However, with careful documentation of the actual costs of providing parent peer support, they may be able to request rate increases from the Medicaid agency or MCO. FIC requested and received rate increases, and TVC went through a detailed process to estimate its costs in order to propose rates to the MCOs. Although negotiated rates ultimately were not as high, the organization has documentation for future proposals and rate increase requests. FROs must be prepared to made adjustments in their approach and staffing based on the adequacy of payment rates.

Resource 4: Contracts and Rate Setting (See Appendix A) includes a guide to rate setting, a sample scope of work from FIC, and sample encounter rates from FIC.

Arizona Family Involvement Center

FIC has had limited opportunity to provide input for rate setting for parent peer support and related codes. Rates are determined by individual RBHAs with guidance from the state Medicaid program and DBHS that manages the behavioral health carve-out. Information about the average salaries of staff providing the service, educational levels and other requirements for the job are factored into the rate-setting process, along with actuarial data. A concern of family- and peer-run organizations is how life experience can be factored into rate setting, as many PSPs may not have degrees or related professional work experience, but have significant life experience, along with knowledge and skills to help other parents.

RBHAs have the option to pay higher rates for services than the state-produced Medicaid rate, but are not allowed to pay less than the state rate. When FIC became a Medicaid provider, it started with a contract for $400,000. It was estimated that the organization could achieve sufficient "encounters" to bill the $400,000 with six PSPs, while also allowing for a program director and a part-time clinical director.

FIC's plan was to offer both parent-to- parent support services in the home and in the community, as well as parent education and support groups at their center and training facility. Knowing the reimbursement rates already established by the state, the organization calculated that it could make these encounter goals with a caseload of 12-15 families per PSP. Initially, the goal was for staff to encounter for 60% - 65% of their time. Currently, the service delivery process is more complex, and PSPs are encountering at about 50%; this is attributed to staff working with families for shorter periods of time, driving more, and not getting as many referrals for high-need families.

In some states, other provider agencies may be paid more than FROs for providing the same service. FIC was able to advocate for reimbursement rates of specific service codes, such as family support and peer support at the same rate that is paid to other providers. FIC, like other providers, is able to request rate increases through the RBHAs based on their cost of doing business. The Maricopa RHBA recently raised rates for all services by 12%.

Tennessee Voices for Children

When it was announced that parent peer support was being added as a covered service, TVC submitted a proposal to each MCO, including rate proposals. The rates that TVC proposed were derived by the organization based on costs including salary, benefits, occupancy, phone, insurance and other indirect costs. TVC had an opportunity to negotiate rates with each MCO. Not all of the rates offered are adequate to cover costs. However, the organization determined that it would be best to demonstrate the actual costs to provide services and use this as a basis for future negotiation. The contracts do offer the possibility of rate adjustments, and TVC is aware of other providers that have successfully renegotiated their rates.

In order to work within the Medicaid rate structure, TVC has had to adjust the practice model by paying attention to what is billable. For example, if collateral contacts are made with the family present, it can be billable time, but without the face-to-face involvement of the family, some of these contacts are not billable. Staff members have had to learn how to organize their time and service delivery strategy in order to maximize billable time.

Start-Up Costs and Cash Reserves

"The family organization has to make sure that the reimbursement rate is viable and that support is available for start-up costs. It's important to have a clear understanding of all of the costs." (Jane Walker, FREDLA)

There is often a gap between gearing up to provide parent peer support services under Medicaid and receiving the first reimbursements. Start-up costs can involve putting an administrative infrastructure in place, purchasing hardware and software, hiring and training staff, and developing a client base in order to start billing. Without funding for start-up or sufficient cash reserves to get through this initial period, the sustainability of the FRO could be jeopardized. Thus, FROs must estimate their start-up costs and identify a strategy and funding sources to cover these costs. TVC had few start-up costs, since most of the infrastructure for peer support was established previously, and cash reserves were sufficient to cover any lag in payment. However, many FROs may find this challenging.

Once billing is up and running, the time until the organization is reimbursed will vary anywhere from 30 to over 90 days, depending on the state. It is important for FROs to understand the typical turnaround for payment in their states and plan accordingly. They must ensure that they have sufficient cash reserves to weather the billing cycle, as well as payment delays or shortfalls. Some organizations find it helpful to obtain a line of credit with a bank that so they can draw funds temporarily when cash flow is tight. This can be an effective strategy to ensure that payroll and bills are paid on time while waiting for reimbursement. However, a line of credit requires careful management of funds so an organization does not continue to use the line of credit without paying it back and, thereby, builds up a debt that it cannot repay.

"Ensure that the anticipated amount of Medicaid reimbursement will support the infrastructure needed to make the services viable." (FIC)

Tennessee Voices for Children

TVC was a well-established organization at the time that it became a Medicaid provider and had enough capital to cover start-up costs and to handle any gaps or lags in payments. There were fewer start-up costs than other FROs incur, since TVC already had many infrastructure elements in place. An electronic health records system was in place that required minimal upgrading, and TVC did not have to hire and train many new PSPs. Rather, staff members who were providing parent peer support under time-limited grants began billing Medicaid as a natural progression as part of the sustainability plan. In fact, a goal of federal system of care grants is to transition over time to Medicaid financing for services and supports, and since TVC was already the source of training for PSPs statewide, there was minimal expense for training any new staff that were needed.

Step 6: Build an Administrative Infrastructure

Step 6 addresses infrastructure building. FROs typically focus on developing programs more than on developing infrastructure. This occurs because the mission is helping families, and also because funders often do not pay for infrastructure. When becoming a Medicaid provider, having an adequate infrastructure is essential as Medicaid has stringent billing and documentation requirements that must be met before they will pay for services.

Tasks:

1. ***Develop necessary billing and financial management capacity***
    - *Determine staffing needs for financial management, billing and documentation*
    - *Determine administrative staff capacity needed for compliance with federal, state, and/or payer data collection, storage and reporting requirements*
    - *Identify funding for additional administrative staff positions or for outsourcing*
2. ***Develop a process for required documentation by staff***
    - *Determine the documentation needed by PSPs to meet Medicaid billing requirements*
    - *Plan and implement, or modify, a process for documentation*
    - *Conduct staff training and ongoing monitoring of staff documentation*
3. ***Determine technology needs***
    - *Identify necessary technology for billing and reporting functions*
    - *Identify and implement, or modify, a Management Information System (MIS) capable of meeting administrative and documentation requirements*
    - *Identify and implement electronic health records (EHRs)*
4. ***Develop a process to prepare for required audits***
    - *Determine the auditing requirements and process that the organization may be subject to*
    - *Ensure that the required documentation and administrative processes include the necessary data to prepare for audits*
5. ***Implement quality assurance (QA) and outcome measurement processes***
    - *Determine QA requirements and required methods or tools*
    - *Design and implement an assessment of parent peer support services at specific intervals and a continuous quality improvement (CQI) process*
6. ***Obtain required insurance for FSO operations***
    - *Determine requirements for business/liability insurance*
    - *Procure needed insurance*

Billing and Financial Management Capacity

A critical task when becoming a Medicaid provider is developing the infrastructure needed for the many administrative functions that are required. Most FROs will not have previously had this capacity and will have to build their administrative infrastructure at the outset. FROs often find this to be one of the most challenging aspects of the process.

The first major task involves determining the needs for staff with expertise in handling billing, claims management, financial management, accounting, and compliance monitoring. FROs may choose to hire staff for these roles that are in-house employees, or may choose to outsource these functions through contracts with firms that have experience and expertise in this area.

Initially, FIC hired an individual for billing, but ultimately determined that it was more cost-effective for the organization to outsource this work to a firm that handles billing, claims adjustments and data compliance monitoring to prepare for audits. FIC emphasized the importance of ensuring that the resources in Medicaid contracts are sufficient to support the necessary financial and billing infrastructure and that it is ideal to have someone with financial management expertise be involved in the early planning phases of becoming a Medicaid provider. TVC uses several internal staff for administrative tasks, with the goal of consolidating the functions with one dedicated staff member in the future.

Arizona Family Involvement Center

For the first year, FIC hired an individual who had billing experience in a larger agency to handle claims submission. Based on the complexity of the work, the time spent to meet all the processing requirements and the frequent need to adjust the billing process due to system and contracting changes, FIC decided to outsource billing and now contracts with a firm that specializes in this function. The cost for the contract is based on a percentage of the billing, currently approximately 4% of the claims that are actually adjudicated. The firm helps FIC prepare for audits and attends audits, noting any problems and working with FIC to implement any changes needed to improve the process.

FIC recommends that an individual with financial management and accounting expertise be involved in the planning phase of becoming a Medicaid provider. This person's expertise can be used to review a potential Medicaid contract and help to determine the administrative infrastructure needed.

Tennessee Voices for Children

TVC currently uses internal staff to handle administrative functions including billing and documentation. Although it is considered ideal if all of the aspects of the billing process are consolidated and handled by one dedicated individual, currently the tasks are split. The director of programs compiles all of the necessary contact information and documentation for claims, which is then given to the finance director who submits claims and manages the process until the payment is received, including following up on any disallowed claims or claims that must be resubmitted due to missing information or errors. When a higher volume of Medicaid clients is achieved, the organization will consider hiring a dedicated staff member for these tasks. In addition, the billing forms are now on paper so reports from the EHR system are extracted and transferred to paper to submit claims. A long-term goal is to entirely move to an electronic billing system.

Documentation by Staff

"The documentation requirements make FROs do the work better. PSPs have to look at why they're doing what they're doing and if they're moving towards a goal." (Jane Walker, FREDLA)

The documentation required of staff is detailed and can be challenging. Typically, service plans with specific goals, progress notes for each encounter, and summaries at various intervals are required. Documentation of medical necessity is typically required, as well as detailed reporting of encounters — what services were provided, for what duration of time, in what location, etc. Most PSPs have little experience with this level of documentation, and training, supervision, and coaching are needed to help them feel comfortable with the tasks and to ensure that the documentation meets billing and audit requirements. Time for documentation can be an issue, particularly since PSPs spend much of their time out of the office working with families.

FIC tries to meet PSPs where they're at and spends time working with them on an individual basis to teach them how to write good plans and progress notes. With one group of new PSPs, FIC provided intensive training prior to providing services. Templates have been created to guide the PSPs and to make the documentation process as user-friendly as possible. TVC uses both supervisors and a quality officer to monitor documentation and work with PSPs to keep up with their documentation and improve their skills. This underscores the importance of investing in training PSPs to develop documentation skills as incomplete or inaccurate documentation may result in Medicaid denying claims or withholding payment. Despite the level of effort involved, the FROs observed that documentation improves the focus and work of the PSPs, and TVC noted that this type of documentation and accountability accompanies the professionalization of the role of PSPs.

Resource 5: Documentation (See Appendix A) includes examples of support plans, progress notes, monthly summaries, and other documentation from FIC.

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Although some documentation is required for all family members receiving parent peer support through FIC, documentation is more extensive on the Medicaid side of the organization where a support plan with goals and objectives must be completed by the second visit. PSPs are required to develop these support plans, as well as enter progress notes and monthly summaries into EHRs. Since most PSPs have little or no experience with this type of documentation, some find it intimidating. It is important to provide training, coaching and support to help them learn how to do this well and to help them master the system. Recently, FIC adopted a new approach to hiring and developing entry level staff for PSP positions. Rather than recruiting and immediately preparing them for the community-based parent support work, FIC first provided 3 months of intensive training and coaching on all program areas of the agency prior to beginning their work with families. This included training on administrative, billing and documentation functions.

"If it's not documented, it wasn't done!" (FIC)

Tennessee Voices for Children

Staff at TVC had to learn how to provide the documentation required for Medicaid billing. An EHR system is used that staff can access on their agency devices, and they are required to enter information into the EHR within 72 hours after each visit. The organization encourages staff to use "concurrent documentation" if the family agrees, which allows them to enter the required information during their visit with the family. The required information includes:

- Individualized service plan
- Progress notes which include who they met with start and end time, type of visit, and location

New employee training teaches PSPs how to use the system. Agency leaders monitor documentation and work with PSPs to improve this as needed. Initially documentation was challenging to staff, but with training and support, the staff has been able to complete these tasks well.

"Staff understands that this documentation comes with professionalizing the role of the PSP and being a Medicaid provider." (TVC)

"One of the major shifts is getting staff and management comfortable with watching reports constantly. Reporting and tracking are critical and have to be a part of managing the work and monitoring the budget." (TVC)

Technology

Good MIS and EHR systems can facilitate all of the administrative functions that come with being a Medicaid provider and reduce the burden on staff. FROs must determine whether current MIS and EHR systems will be able to adequately meet the reporting and billing requirements for Medicaid or if new hardware and/or software is needed. Both Medicaid and MCOs are increasingly requiring EHRs for reporting and auditing purposes. Additionally, the organizations must determine if new or modified data collection, management and storage processes are needed. Developing technological capacity may require a significant investment of resources in terms of costs, staffing, and training.

Both organizations noted that paper records and billing systems are difficult and make the documentation and billing process more complex and labor-intensive. An FRO can work with a software developer to create its own customized system, or can purchase and adapt a system already developed for similar purposes. FIC modified a web-based system, which includes both HER and billing functions, used by another agency for its needs. TVC also customized an existing system, but it only includes EHRs — billing is done on paper. The organization is exploring resources to implement an electronic billing system.

Arizona Family Involvement Center

FIC emphasized that choosing an EHR system is important for FROs. Using paper records and notes is burdensome for staff, and EHRs facilitate both staff documentation and billing. FICNet is the system used for Medicaid documentation and billing purposes, as well as for payroll, performance tracking and quality improvement. Adapted from a system designed for another agency, FICNet was customized specifically for the organization. The system is web-based, so PSPs can access the system remotely from their laptops, smart phones and tablets. Although staff may not be tech savvy, the system is user-friendly, and staff receives training and ongoing support as needed. If areas of the system are identified as difficult for staff, FIC works to improve the system and make it as error free as possible, as all services provided by FIC must be documented.

FICNet is organized into modules, and there are different levels of access and ability to modify, specific to an employee's role. Staff enters their service plans, the types of services they provided, start and end times so the system can calculate the units of services (e.g., 15 minute intervals), progress notes, etc. and submit these in real time. Codes are provided for much of the data entered, and staff can use "cheat sheets" to help them identify and enter the correct codes. Progress notes must be tied to the objectives in the support plan and the requirements for the billing codes, and FIC provides staff with sentence starters to help them structure these progress notes correctly. Non-billable tasks are also entered by staff — driving, documentation, supervision, etc. Many types of reports can be generated, including productivity reports showing the percent of billable time for staff members and reports to track the number of supervision hours received by staff to ensure that they meet supervision requirements.

Staff members also enter the hours they worked, vacation and sick days, etc., and their timesheets automatically go to their supervisors for approval and are then used for payroll purposes.

Approved billing codes vary according to the different contracts that FIC has for services, and the system can track this to reduce the complexity of having multiple contracts that allow billing for different codes. FICNet is also structured to help staff meet the requirements for Medicaid billing. For example, the next review dates for plans and diagnoses are flagged, and reports are run to identify upcoming expirations. This ensures that PSPs know they must work with the case manager to update these, since Medicaid will not pay claims without current information. In addition, the system helps staff address often complex Medicaid regulations, including that a service plan cannot pre-date an assessment, and a signature must be obtained within 72 hours. These details are tracked and reviewed by staff in medical records, so services are not found to be out of compliance in Medicaid audits and claims aren't denied. Because of these requirements, FIC emphasized the importance of having strong, detail-oriented staff for medical records functions. The information in FICNet goes directly to the contracted vendor that handles claims processing to review, batch and notify FIC of anything that needs correcting before submitting bills to Medicaid. The system also generates summaries of encounters for time intervals, such as for a week, and produces ongoing reports on encounters.

FICNet also checks client enrollment in Medicaid quarterly. Families may fall off Medicaid, and this allows the organization to be aware of this and help the family re-enroll when possible. If after 30 days the families cannot be re-enrolled, they are transitioned to other services rather than those that are Medicaid-billable. In these instances, FIC is not able to continue providing intensive, in-home services that are financed by Medicaid, but may be able to provide some support.

Tennessee Voices for Children

TVC has had an EHR system in place since 2000, so it did not need to invest in new hardware nor software. The system was customized to TVC's needs and is flexible enough so modules can be added as the need arises. TVC would like to add an electronic billing component to the system, since the organization now does paper billing for Medicaid. The organization is exploring foundation funding to build an electronic billing system and upgrade the EHR system.

Medicaid Audits

Medicaid requires meticulous attention to billing and payment. In order to ensure that all requirements are met, Medicaid providers are subject to audits at regular intervals. These audits may focus on documentation, medical necessity criteria, and proper service authorization, billing codes, units of services, overpayments and evidence of fraud or abuse. If noncompliance or irregularities are found with respect to any claim, payment can be denied and/or providers may be subject to penalties and paying back funds. The federal CMS has the authority to audit providers, but audits may also be performed by the state Medicaid agency, MCO or BHO that contracts with the FRO for parent peer support.

Auditors conduct file reviews and look for key documents, such as signed and dated consent forms and complete documentation for every service billed. For example, if the FRO billed for six visits with one family, each visit must be documented. Medicaid may require a plan of care, and the documentation for visits may need to relate to goals in the plan. FROs should ensure they have staff and processes in place to monitor compliance internally to be ready for audits and minimize the likelihood of adverse findings. Most organizations must also have annual financial audits.

Arizona Family Involvement Center

FIC is subject to data validation audits from the RBHA that are conducted to ensure that services are authorized properly, that authorized services are provided, and that there is no evidence of fraud and abuse. Over the time that FIC has been billing Medicaid, only paperwork errors have been found (mainly on the referral packages sent by agencies), and the organization has never received a penalty. The process has underscored the importance of working closely with referring agencies to ensure that they are aware of Medicaid billing guidelines, improve referral packages, and update services plans as required. Annual financial audits are also required by the RBHA.

Tennessee Voices for Children

There is a clause requiring contract audits in TVC's contract with the MCO, stating that the MCO can audit at any point in time to determine the appropriateness of covered services, etc. Since TVC was a fully contracted Medicaid provider for less than a full year at the time of this review, the organization had not yet undergone an audit. However, TVC had experienced a site visit with one MCO.

Quality Assurance and Outcome Measurement

Contracts with Medicaid or MCOs may require providers to implement QA and outcome measurement processes over and above compliance audits. Even if these are not requirements, FROs may choose to implement QA and outcome assessment procedures that provide valuable information for assessing the delivery of parent peer support services and for making improvements. These may include process

measures including whether families are seen the required number of times per week, or whether progress notes are entered within the specified timeframe. Outcome measures may assess the impact of parent peer support services on families to document the effectiveness of the services.

FIC has used surveys to determine the impact of parent peer support on a range of indicators and is developing a new outcome measurement system. TVC's Chief Quality Officer is responsible for QA, focusing on individual PSPs and across teams, programs, and the organization as a whole to identify strengths and areas needing attention.

Arizona Family Involvement Center

FIC has tried some assessment approaches, such as a "thermometer tool" for parents to rate their peer support services, and phone calls by supervisors to assess the quality of services. In addition, parent surveys have been used. A 2012 survey found that:

- 68% of families reported decreased isolation
- 86% reported feeling listened to and heard regarding their families' situation
- 83% reported learning new information, resources, and strategies to help their families
- 77% reported that they have increased the effectiveness of their child and family teams
- 75% reported that they felt more confident in navigating the behavioral health system

The organization is working on a new outcome measurement system for some of its services and is exploring some instruments that might be appropriate.

Currently, FIC uses a Parent Support Tool designed to explore the parent or caregiver's situation in five key areas:

1. Presence of the Family Support System
2. Acceptance of the Family Support System
3. Ability to be Heard by Service Providers
4. Coping with Stress
5. Transitions, Impact and Timing

PSPs complete this tool in collaboration with the family through conversation and come to agreement in scoring the tool and determining the right fit of support options to meet the parent or caregiver's needs. FIC also used the Family Empowerment Scale for a number of pilot projects and the National Family Support and Strengthening Participant Survey for their parent education series.

Tennessee Voices for Children

As of 2014, TVC has a dedicated staff person who directs functions including clinical supervision, staff training, and QA and CQI processes. Although not necessarily required by the MCO contract, the organization has put a number of procedures in place that combine elements of staff supervision and QA:

- Standard supervision form used for monthly meetings with supervisors to monitor measureable responsibilities (e.g., documentation with 72 hours, meeting with families two times per week)
- Establishing and tracking accountability goals
- Case reviews

This information feeds into the PSPs' individual evaluations. In addition, the Chief Quality Officer aggregates and analyzes information across programs and teams to determine if the organization is meeting requirements as a whole and to identify strengths and weaknesses that can then be addressed.

TVC also uses the Caregiver Strain Questionnaire (CGSQ) as a strengths assessment to gain knowledge about the family's needs and track their progress.

Insurance Coverage for FRO Operations

Medicaid contracts generally require providers to have various types of insurance, such as commercial general liability, automobile and professional liability insurance. Medicaid may also stipulate that an organization carry a certain amount of coverage. FIC had to purchase insurance over and above what was in place previously, while TVC had sufficient coverage in place.

Arizona Family Involvement Center

As a Medicaid provider, FIC is required to have the following types of insurance:

- Commercial general liability
- Business automobile liability
- Worker's compensation and employers' liability
- Professional liability

FIC's insurance company reviews its insurance coverage annually to assess whether changes in coverage are indicated based on the size of contracts and services delivered.

Step 7: Develop the Staff

Skilled PSPs are the backbone of parent support services. Step 7 involves hiring, credentialing, training and supervising staff to ensure high-quality and effective services.

Tasks:

1. ***Develop and implement a staffing plan***
    - *Determine the types of staff, staff qualifications and credentialing process that are authorized by Medicaid for parent peer support*
    - *Develop, or modify, a staffing model based on credentialed staff*
    - *Determine if staff will be employees or contractors*
    - *Develop and implement, or modify, a plan for staff recruitment, hiring, and retention*
2. ***Provide staff training, coaching and supervision***
    - *Develop and implement, or modify, a process for assessing staff skills*
    - *Determine the certification and training needed for staff to meet Medicaid requirements*
    - *Design and implement, or modify, competencies and a training program that meets Medicaid requirements for PSPs*
    - *Design and implement, or modify, coaching and supervision processes for staff*

Staffing

The success of parent peer support services hinges on the quality and competence of the PSPs. In most cases, the state Medicaid agency or MCO establishes requirements for staff that are authorized to provide these services, and FROs must hire PSPs who fulfill these requirements. If desired, FROs may layer additional qualifications on the minimum standards specified by Medicaid or MCOs. For example, even if it is not required by the state or MCO, FROs may add a requirement that PSPs have lived experience as a parent or caregiver of a child with behavioral health challenges. Other requirements may be a particular level of education (e.g., a high school diploma) or work experience. FIC lobbied for the flexibility to count lived or volunteer experience rather than only paid work experience; TVC is working with the states toward a similar goal.

"Qualifications should be geared to the role of PSPs. It's ideal if lived and volunteer experience can count rather than just work experience. We have been invited to a Certification Advisory Committee facilitated by the state and, along with other organizations, have the opportunity to provide this input." (TVC)

Increasingly, Medicaid or MCOs are requiring that PSPs be certified when they are hired or that they receive some type of certification within a specified period of time after being hired. TVC only hires certification-eligible PSPs. For both FROs, PSPs must meet general requirements for Medicaid providers, including criminal background checks, child abuse clearances, etc.

With these qualifications established, FROs must then recruit and hire PSPs and determine whether they will be contract staff or employees of the organization. FIC and TVC use employed rather than contracted staff.

The organizations have found a high level of interest in people who want to become PSPs, and have not experienced difficulty finding qualified staff. FIC looks for family members who have been through the child and family team process and are ready to help others. Retention is also reportedly high, with PSPs indicating that they love what they do. The need for flexibility was emphasized by the organizations, since PSPs are likely to experience periodic crises in their own families related to their children with behavioral health challenges.

Arizona Family Involvement Center

The Medicaid program in Arizona specifies three types of behavioral health staff that are qualified to bill for services:

- Behavioral Health Professional (BHP): A licensed professional, e.g., psychiatrist, psychologist, social worker, counselor
- Behavioral Health Technician (BHT): A high school graduate who may have four years of college and no work experience or two years of college with two years of work experience
- Behavioral Health Paraprofessional (BHPP): An individual with six weeks of work experience in a behavioral health setting

Initially, the agency strictly adhered to these qualifications, but currently there is more flexibility, which helps in hiring PSPs. For example, the requirement for experience can now be achieved by lived or volunteer experience rather than just paid work experience.

For parent peer support services, FIC bills under several codes — peer support, family support, case management and behavioral health promotion. In each case, these services can be provided by any of the staff members, but are billed at different rates depending on whether the service was provided by a BHP, BHT or BHPP.

FIC uses employees rather than contract staff. The organization seeks to hire parents who have lived experience and have experienced a child and family team process. FIC looks for candidates who want to give back to other parents/primary caregivers either because they have had a successful experience or because they do not want others to experience what they went through.

Potential PSPs are often identified and referred by staff at the various child-serving agencies who think they would make good candidates. Job fairs, ads and notices on FIC's website are also used for recruitment. Some candidates have difficulty meeting some of the requirements for the job, particularly with respect to previous work experience; the ability to count lived and volunteer experience is helpful in this regard. During interviews, FIC explores each candidate's their passions, personal goals, and what brought them to this work.

Staff turnover is small; some PSPs remain in the role for five to seven years. FIC makes a concerted effort to keep PSPs inspired through a number of mechanisms, such as gratitude moments at staff meetings, leadership training, and opportunities to develop new skills in areas including training, coaching, or supervision. Flexibility is also important to be responsive to the needs of PSPs' own families, given that many have children or youth with challenges and must respond to crises or pressing needs.

Tennessee Voices for Children

TVC's contracts with MCOs specify that PSPs must be certified family support specialists, and TVC only hires PSPs who are "certification eligible." They follow these eligibility criteria:

- High school diploma
- Family member or caregiver of a child with a mental health diagnosis
- Personal experience with children's mental health issues in navigating the service system
- Working experience in a non-profit organization
- Experience working in a child service system

When TVC became a Medicaid provider, there was no need to hire new PSPs. Existing PSPs who were funded under federal system of care grants were transitioned to Medicaid-financed services.

However, when there is a need to recruit and hire new staff, the work history criteria requirements are sometimes problematic. TVC serves on the TDMHSAS Family Support Specialist Advisory Committee, which is currently discussing the benefits of changing the certification requirements so a history of advocacy may substitute for some of the required work experience. TDMHSAS is receptive to feedback on these criteria and making them more appropriate for the PSP role.

Staff Training and Certification

Many state Medicaid programs require PSPs to be certified by a designated certifying authority. Certification is a process used to verify that personnel have adequate training to practice certain disciplines. In 2011, NFFCMH established a national certification process and a set of core competencies for PSPs, and many states are developing their own processes for certification. Certification may involve several components, such as:

- Requirements for a minimum number of training hours in specific areas, e.g., communication skills and family engagement
- A documented number of hours of supervision
- A minimum number of hours of practice as a PSP
- A test with a minimum score to pass before certification

The national certification developed by the Federation is designed to ensure adherence to standards of practice in 11 domains of core competencies, including:

1. Ethics
2. Confidentiality
3. Effecting Change
4. Behavioral Health
5. Education
6. Communication
7. Parenting for Resiliency
8. Advocacy
9. Empowerment
10. Wellness and Natural Supports
11. Knowledge of Local Resources

The certification process may take up to a year or more to complete, and if it is a state requirement that Medicaid providers use staff that are certified, it is important to begin the certification process well in advance.

Whether or not certification is mandatory, most Medicaid agencies and MCOs specify some training and supervision requirements in contracts, typically including initial training and annual continuing education. In addition, FROs may provide training and supervision that go beyond these requirements. Some training modules may be available online so PSPs can complete them at their own pace. Face-to-face training is a central component of training, and some training and/or certification processes add observation and coaching to the protocols.

FIC provides PSPs with foundation skills training, which is specific to the parent support role when they are hired. Intensive follow-up training based on 40 skill sets is provided at six months and one year, including both core and advanced training components. This is supplemented by booster training and monthly training activities. TVC is one of the organizations in Tennessee that conducts training for certification for PSPs statewide through a three-day course focusing on specific competencies.

Resource 6: Staff Training and Certification (See Appendix A) includes national PSP certification information and Tennessee Family Support Specialist Certification Guidelines, Standards, and Procedures. Training descriptions from FIC are also included.

Arizona Family Involvement Center

The state Medicaid agency has some training requirements, but most do not apply to PSPs. The staff training and supervision requirements that do apply come from ADHS/DBHS, which is the agency that manages the Medicaid behavioral health carve-out. Some training is required within 90 days of starting work, and some is required annually. Most training is available online, and the topics include the child and family team process, documentation, ethics, service planning, fraud and abuse, cultural and linguistic competence and others.

When PSPs are hired, FIC provides initial training in skills specifically for PSPs, with follow-up training at six months and one year. Recently, FIC has worked in collaboration with a national consultant, family leaders and provider agencies to identify the core competencies that are important in the PSP's role. This resulted in the development of a training program with 40 skill sets, including core training and advanced training. The training on core competencies is provided through face-to-face training, online courses, observation and coaching.

Training content is organized around the four stages of Wraparound — engagement, planning, implementation, and transition. Rather than being held on four concurrent days, the training is organized as a two-day session followed by sessions three and four in subsequent weeks. This allows PSPs to promptly put into practice what they have learned, and then in the following training sessions, they have the opportunity to share how they were able to utilize those skills. Booster training and additional modules supplement the original training, typically provided in monthly training sessions. A challenge is that, even though the training is required, staff is still responsible for keeping up their productivity targets.

FIC invites other agencies that are also providing parent peer support to participate, as well as parents and primary caregivers who are interested in leadership roles. FIC also attempts to provide professional development opportunities for PSPs. For example, some PSPs have expressed interest in becoming training facilitators, and FIC has provided coaching by experienced trainers to help them become effective in this capacity. Supervision is provided by a staff member who has been a PSP and has worked in the field. Medicaid requires supervision once every two weeks, and all staff must be supervised by a licensed behavioral health professional.

FIC is currently working with the state and other family/peer organizations to develop core competencies for a state certification program. Individuals who are certified will be able to bill using the family support code, with a modifier indicating that trained and certified peer parents are billing this code.

Tennessee Voices for Children

TDMHSAS developed guidelines, standards, and procedures for family support specialist certification. Certification Requirements include:

1. 18 years of age or older
2. High school diploma or GED
3. Self-identify as being or having been the caregiver/family member of a child or youth with a mental, emotional, behavioral, or co-occurring disorder
4. During the last 5 years, actively participated for at least 12 consecutive months in service planning, system navigation and building resilience for a child or youth
5. Successfully complete the evidence-based and/or best practice training recognized by TDMHSAS (NAMI-TN Family Education Program or TVC Parent2Parent Training followed by Family Support Specialist Training OR Certification through the National Certification Commission for Family Support in lieu of state training)

TVC conducts certification training for any PSPs in the state. The training is a three-day course with a manual and competency tests. Individuals or their employers pay a fee of $500 for the course; the state has recently set aside funds for training scholarships.

For its staff, TVC has an orientation package that includes basic training about confidentiality, boundaries and other important topics. Online, self-paced training modules are used for standard workplace training topics such as harassment, universal disease control precautions, confidentiality, etc. Face-to-face training is also provided regularly in-house. One particularly important area for training is how to manage being in a role where it is OK to share your own experiences, but still be professional and create appropriate boundaries. Leadership training has also been provided to program managers over a six-month period through a training curriculum developed by TVC.

Step 8: Initiate Medicaid Services

Most FROs begin providing parent peer support services through grant funding and have established procedures. As a Medicaid provider, the process for service delivery may require changes in procedures, including the referral process, meeting "medical necessity" criteria, and obtaining prior authorization for services. Step 8 involves preparing for and implementing these processes.

Tasks:

1. ***Implement a referral process***
    - *Determine what provider agencies, MCOs or BHOs will refer families to the organization for services and the process for referrals, including any forms that may be required to make a referral*
    - *Develop mechanisms to educate referral sources about parent peer support and appropriate referrals*
    - *Determine the process for self-referrals*
2. ***Implement a process for meeting medical necessity criteria***
    - *Determine if parent peer support services must be deemed medically necessary for Medicaid reimbursement and how the state defines medical necessity*
    - *Develop a process for documenting medical necessity to meet requirements*
3. ***Implement a process for obtaining needed prior authorization for peer support services***
    - *Determine whether prior authorization is required and what is required for ongoing authorizations*
    - *Develop a process for requesting authorization*

Referrals

When parent peer support services are implemented, provider agencies and clinicians may not be familiar with the role and value of these services. As a result, it may be challenging to generate sufficient referrals. Not only is this a loss to families that might benefit, but may also impact the organization's ability to bill Medicaid at levels sufficient for covering its costs. The difficulty in generating referrals is attributed primarily to lack of knowledge about parent peer support services and how partnerships between PSPs and providers can benefit families. FROs have found that intentional outreach to providers about peer support is an effective strategy for educating colleagues and creating family-professional partnerships. The organizations also emphasized the importance of appreciating and respecting the value that both PSPs and providers bring to service delivery, as well as the importance of avoiding adversarial relationships.

"If we don't work for it, referrals will not come as often as we would like. We are always calling providers and MCOs and reaching out to let them know what the service is and how to access it." (TVC)

*"As in all parent-professional relationships, to **have** a partner, you have to **be** a partner." (Jane Walker, FREDLA)*

FIC reaches out to providers to promote the importance of parent peer support and to encourage referrals, particularly during the early phases of services when engagement is important and peer parent support can have an especially positive impact. A recommended strategy is to attempt to negotiate agreements with providers to routinely include parent peer support in the individualized service plans required by Medicaid for service authorization, so parents can easily access these services if they choose to do so. TVC routinely meets with MCOs, providers, and care coordinators to educate them about parent peer support services and how to access them.

Arizona Family Involvement Center

During the early phases of implementation, provider agencies and clinicians were not familiar with the approach, did not recognize the value of PSPs in the service delivery process, and were not making many referrals. One of their concerns was that at child and family team meetings and other venues, PSPs would "tell providers how to do their jobs" or make requests that were unreasonable. It took time for both providers and PSPs to appreciate the value that each brings to the table and to recognize each other's expertise. The RBHA helped with this process by modeling family-professional partnerships and highlighting the role of PSPs and the work of FIC in their newsletter and other communications with their provider network. This helped to establish the credibility of parent peer support services. Education throughout the system is needed on the benefits of peer-delivered services and family-professional partnerships. Both the current RBHA and FIC are working to educate providers, parents and agencies about the role of PSPs, and the power of parent-to-parent support and to promote the importance of these services in collaboration with clinical staff. This enhances the service delivery process and generates more referrals.

FIC emphasized the importance of establishing partnerships with clinicians that allow each to recognize the contribution of the other in serving parents/primary caregivers; and that opens the door for collaboration and referrals. The term "non-adversarial advocacy" is used to describe a role for PSPs that allows them to advocate for the parent/primary caregiver, while at the same time, respecting the work of clinicians. According to FIC, partnership is foundational, and families cannot get what they need without collaboration between PSPs and professionals.

Education about parent peer support is also needed to encourage referrals for parent peer support earlier in the service delivery process. FIC noted that, too often, parent peer support is not incorporated from the outset when it can be the most effective. FIC found it helpful when a packet was given to every family at intake offering parent peer support from FIC if they needed it. However, this practice was discontinued. Although some providers are not familiar with parent peer support and its value, one provider in particular is writing parent peer support from FIC into every initial service plan so families are made aware of the option and can self-select or self-refer to FIC for these services. Without a policy about including parent peer support routinely from the RBHA, FIC must reach out to individual providers to offer information and establish relationships. This is sometimes challenging given that the organization receives referrals from over 30 provider agencies, and there is often staff turnover within agencies requiring that relationships be built all over again.

A challenge for FROs occurs when other provider agencies can also provide parent peer support by hiring their own PSPs. This may create a competitive environment with provider agencies that are less apt to refer families to FIC when they provide their own Medicaid-billable parent peer support.

FIC is training parent partners to go out into the community as ambassadors to share the power of parent-to-parent support and to show how effective this can be when used together with clinical services. The key is 'non-adversarial advocacy', which allows PSPs to advocate for the family's needs, while respecting the role and work of clinicians and creating effective family-professional partnerships." (Arizona FIC)

Tennessee Voices for Children

TVC receives referrals from the MCOs and provider agencies. The organization regularly reaches out to the MCOs, providers and care coordinators to educate them about parent peer support services and how they can help families. Families can also self-refer, and TVC can then contact the MCO to determine if the family has Medicaid coverage and to ask the MCO to review the case and approve the peer support. This referral process is facilitated by good relationships with the behavioral health and medical directors of the MCOs. For the Medicaid system of care pilot project, weekly meetings with partners provide a vehicle for connecting, identifying and referring families who will benefit from parent peer support.

Medical Necessity Criteria

"If a family organization goes into it with the right expectations, it's far less frustrating. It helps to put things in context — Medicaid is a big system with bureaucratic requirements and you're not." (TVC)

In most Medicaid systems, services are not billable if they are not deemed to be "medically necessary". Medical necessity criteria are typically used to authorize services for an initial period of time and for determining whether re-authorization for additional periods of time is needed. It is important for FROs to understand that definitions of medical necessity are highly variable from state to state and potentially among MCOs within a state. Technically, the providers of care determine medical necessity, and MCO reviews are used to ensure that the provider's decision meets the required standards. In some cases, such as in Arizona, medical necessity is determined by a child and family team, and if the service is included in the individualized service plan, then it is considered to be authorized.

Some medical necessity criteria may not fit parent peer support. For example, if only the child is considered to be the "client," then parent peer support may not be deemed medically necessary for the child, although it may be an essential service for the parents. This underscores the importance of working closely with providers to include parent peer support in plans with specific goals for both the parents or primary caregivers and the child.

Prior Authorization

Most Medicaid programs require prior authorization (PA) for services before they can begin. The state Medicaid program, MCO or BHO usually has an online form that must be completed and submitted prior to initiating service delivery.

"Problems with prior authorization may arise if peer support is not considered medically necessary for the child, but is a critical service for the parents." (FIC)

At times, the requested information may not be readily available to obtain a PA. For example, diagnostic codes or treatment plans identifying parent peer support as a needed service may be required for authorization and must be obtained from other service providers. It can take time to gather all of the information, which can delay the start of services to the family. This can pose a dilemma for an FRO that wants to help a family in crisis but has not yet been authorized to provide services, since any services provided before authorization will not be covered. Working with providers to include parent peer support in individualized service plans is critical for obtaining prior authorization so parent peer support services can be initiated and billed on a timely basis. If continued services are needed after the initial period of authorization, the FRO must submit the required document for re-authorization for additional period of time.

Arizona Family Involvement Center

In Arizona, if services are included in the individualized service plan created by the child and family team, they are considered medically necessary and are authorized. However, if parent peer support is overlooked and not included in the plan, it may take months to rectify and involves both time and effort. Other support services also cannot be provided unless they are medically necessary and included in the plan. For example, if transportation is not included in the plan and there is a time lag to correct this, the family may not be able to get to their appointments. A complication may be that parent peer support may not be considered medically necessary for the child who is the identified client, but may be critical for the parents or may be deemed medically necessary for the child and parents, but not for siblings. If a family is involved with the child welfare system, approval must be obtained from child welfare prior to providing any peer support services.

Tennessee Voices for Children

Prior authorization is within the MCO's purview. The MCOs are receptive to TVC's requests and typically approve parent peer support, although the time needed to obtain approval may be longer than ideal. When families are ready to get started, it is difficult to wait for MCO approval. If a family is in crisis, TVC enlists other providers for crisis response services. In most cases, approval is obtained, generally for a period of two to four months. If necessary, TVC resubmits to the MCO for authorization to continue services for an additional period of time. The average time for working with a family is about four to six months.

Step 9: Plan for Sustaining Peer Support and the Family-Run Organization

Sustaining peer support services is a perennial challenge for all FROs. Local, state or federal funding comprises the majority of grants or contracts for FROs, but government funding is subject to changes in administrations and policy. Step 9 involves addressing the key elements of sustainability — planning ahead and diversifying funding streams.

Tasks:

1. *Develop a plan for sustaining parent peer support services*
    - *Determine the need for additional, non-Medicaid funding for sustaining parent peer support*
    - *Develop and implement a plan to sustain parent peer support*
2. *Develop and implement diversified funding for sustaining the FRO*
    - *Determine the need for additional, non-Medicaid funding for sustaining the organization's infrastructure and services*
    - *Develop and implement a plan for diversification and sustainability*

Sustaining Parent Peer Support Services

Sustainability is critical for FROs that often struggle to find long-term, stable financing to maintain their infrastructure and services. Medicaid financing is not seen by these organizations as the only path for sustaining the organizations and parent peer support services.

"It is within the non-Medicaid side of the organization that innovations and new approaches incubate and are tested." (FIC)

Even as Medicaid providers, FROs also provide peer support services that are funded through other mechanisms — grants, Mental Health Block Grants, or state general funds from child-serving agencies. The requirements for parent peer support services tend to be more flexible through these funding streams, prompting FIC to note that new approaches can more easily be tested with non-Medicaid services. FROs should determine if those funding sources for parent peer support will still be available after becoming a Medicaid provider, in addition to pursuing new financing for these services beyond Medicaid.

Arizona Family Involvement Center

Medicaid financing is not seen as a source of funds for sustaining FIC, but rather only for financing parent peer support. For sustaining the overall organization, other funding sources are needed. The organization continues to provide parent peer support, family education and leadership development, which are not financed by Medicaid. FIC is interested in exploring potential contracts with additional child-serving agencies to provide parent peer support to their populations, such as child welfare, juvenile justice, or primary care pediatrics. The organization also works to bring in grants that fit with its mission and to offer training, coaching, technical assistance and other services that are revenue producing. These services are often needed by systems of care.

Tennessee Voices for Children

Medicaid funding is not currently the sole source of funding for peer support and is unlikely to be the sole source in the future. Parent peer support is also funded by federal system of care grants, although it is recognized that those funds are time-limited. The state's mental health authority and children's services agency also finance parent peer support.

Sustaining the Family-Run Organization

"The plan for diversification is still a work in progress, even after 13 years." (FIC)

Just as diversified funding is ideal for parent peer support, multiple and diverse funding streams are needed for the long-term sustainability of FROs. Both of the organizations have multiple sources of funding. FIC continually pursues new funding opportunities for both infrastructure and services, including contracts with child-serving agencies such as child welfare and juvenile justice. TVC recommends investing in highly qualified staff for peer support and for other revenue-producing activities. Long-term plans for sustainability are recommended by the three organizations, along with a conscious effort to continuously identify and pursue new financing opportunities (Kim, Perreault, & Foster, 2011; Optum Health, 2012).

"TVC has a rainy day plan, a tomorrow plan, and a long-term strategic plan based on our mission. For TVC, this means speaking out as active advocates for the behavioral and emotional well-being of children and their families no matter what." (TVC)

Arizona Family Involvement Center

FIC has developed a long-term plan for sustaining the organization that involves multiple current funding sources and a continuous process to seek new sources of funding for both infrastructure and services. Part of this process involves staying abreast of changes in health and mental health care and determining how those changes can be incorporated in the organization's work. FIC is currently exploring contracts with child-serving agencies, such as child welfare and juvenile justice, as new sources of funds for the future.

Tennessee Voices for Children

TVC has emphasized diversified funding sources including grants, fundraising, and training or consultation that generates revenue. A recommended sustainability strategy is to invest in good staff that will be assets to the organization for the long-term — pay them well, train and cross-train them, and provide support and flexibility. Additionally, TVC advises FROs to not neglect marketing their services, including taking advantage of free marketing opportunities such as social media and other communications vehicles. Participation in groups outside of the mental health community can be productive (e.g., civic associations, chamber of commerce, networking groups, etc.), as well as applying for awards that get recognition for the organization in the broader community. Investments or endowments can also be included in sustainability plans and should be considered by FRO boards.

According to TVC, it is critical to have short- and long-term strategic plans that are both conservative and innovative, and reflect a balance in risk-taking. Leaders stressed that the best way to sustain FROs is to have strong relationships with key players in systems and in the community by being bipartisan and positive, and by engaging diverse groups that are aligned with the organization's mission. TVC has made a concerted effort to build productive, positive, non-adversarial working relationships between families and systems.

Conclusion: A Balanced Approach

"Becoming a Medicaid provider has changed what we do and how we do it, but it is worth it. It is important for FROs to stay true to their own model and mission while still becoming a Medicaid provider." (FIC)

As reflected in this toolkit, there are many tasks to be accomplished by FROs in order to become and function successfully as Medicaid providers. Arguably one of the most critical is maintaining a balance between the organization's larger advocacy mission and its new role as an agency that provides Medicaid-billable services. FIC suggested that becoming a Medicaid provider should be seen as a transformation of the organization and that, within that framework, such a balance can be achieved. Although FROs must be prepared to address changes in role and perception resulting from becoming Medicaid providers, there are positive implications of adding this to their portfolios. The FROs noted that the stature of groups is raised and that the importance and legitimacy of peer support services are increased both inside and outside of the organizations. TVC feels that the role of peer support has been professionalized and credibility has been enhanced. Both FIC and TVC have been successful in balancing their service delivery role with their system-level policy and advocacy role.

"In the eyes of external providers and even among the FRO's own staff, peer support can go from being viewed as 'Isn't that nice' to being seen as a viable service that has its own distinct role and value. Becoming a Medicaid provider can validate what FROs do." (Jane Walker, FREDLA)

Finally, the organizations emphasized the critical role of states in recognizing the value of parent peer support and structuring services and financing in a way that makes it a viable service for FROs.

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Arizona Family Involvement Center

FIC recommends that FROs take a "system transformation" perspective and recognize that becoming a Medicaid provider is part of a larger transformation of the organization. It is important for FROs to maintain a balance of the new role as a Medicaid provider and its mission and values as a presence within the community that empowers parents, strengthens youth, builds collaborative partnerships, educates communities, and connects families.

Tennessee Voices for Children

TVC developed a communication plan for the board, staff, and supporters before initiating the process of becoming a Medicaid provider to help them understand that the organization could provide Medicaid-financed services while maintaining its advocacy role. The full support of the all of these groups — both internal and external — is needed to obtain buy-in to the dual role of providing services and advocating. Although parent peer support has been professionalized, the organization continues to have a strong impact through system-level advocacy.

TVC noted that when becoming Medicaid providers, FROs must be honest and careful about potential "mission creep" and reconciling competing goals. For example, there is a dynamic tension between being protective of your expertise and competitive in the marketplace for peer support services, with an advocacy stance of collaborating with potential competitors to provide the best services for families. TVC noted that if an FRO is remaining true to its advocacy mission, it must be OK with sharing expertise, toolkits, training, etc. with other organizations that want to get their finger in the pot. "Our first job is to be advocates."

"It was a very exciting time in the life of TVC to learn that [Medicaid] recognized the value of PSP services by including it in the service array. This allows us to diversify funding, strengthen our efforts and impact more families. TVC is fortunate to have the legacy and reputation for being experts in parent peer support and to work in a state that values these services and looks to us for guidance." (TVC)

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APPENDIX A: RESOURCES

RESOURCE 1:

Considerations for Becoming a Medicaid Provider

- Agency Readiness Tool for Family Run Organizations: Key Questions for Exploring Whether to Become a Medicaid Provider of Family and Youth Peer Support
- At-a-Glance: Pros and Cons of Becoming a Medicaid Provider

Becoming a Medicaid Provider of Family and Youth Peer Support

Considerations for Family Run Organizations

FEBRUARY 2014

CHCS Center for Health Care Strategies, Inc.

Made possible through support from the Centers for Medicare & Medicaid Services

AGENCY READINESS TOOL FOR FAMILY RUN ORGANIZATIONS
Key Questions for Exploring Whether to Become a Medicaid Provider of Family and Youth Peer Support Services

Family run organizations and their boards can use the questions below as a guide for making an informed decision about becoming a Medicaid provider.

Mission

1. In what ways does becoming a Medicaid provider fit or not fit with our mission?
2. In what ways would becoming a Medicaid provider change how families view our organization and staff?
3. How would it change our role in system of care development, as policy advisors, etc.?
4. Will our primary identity shift from that of a family run organization with multiple functions to a provider organization?
5. In what ways will becoming a Medicaid provider impact our ability to advocate for programs and policies in our state on behalf of families?

Practice

1. Will becoming a Medicaid provider detract from the organization's ability to serve a range of families?
2. Is our state's definition of family and youth peer support consistent with our vision and understanding?
3. Under our state's Medicaid regulations, who is authorized to provide family and youth peer support services (e.g., caregivers only, member of broader community with lived experience)?
4. How will becoming a Medicaid provider change or limit the services we provide?
5. What skills do staff have for providing family and youth peer supports as a Medicaid-funded service?
6. What additional training will our staff require in order to meet Medicaid requirements, such as certification and documentation?
7. Do we have a family and youth peer support program foundation in place that gives us the experience to consider offering this program with Medicaid funding?

Administration

1. From an operations perspective, how will becoming a Medicaid provider change the way the organization manages and delivers family and youth peer support services?
2. Does our organization have the administrative staff with the time and skills to do billing or will additional staff be needed?
3. If additional staff are required, what are the positions needed and is the funding we will receive from Medicaid sufficient to cover the additional positions?
4. What technology (hardware and software) will be required for Medicaid billing?
5. Does our organization have the necessary professional insurances in place (e.g. liability)?

Financing Structure and Rates

1. How is our state currently funding family and youth peer support (e.g., waiver, state plan amendment, or other type of state appropriation)?
2. If our organization begins providing family and youth peer support with Medicaid funding, will other state funding continue, in order to serve families not eligible for services under Medicaid?

3. Will our organization bill Medicaid directly, through a subcontract with a traditional provider, or through a firm that provides Medicaid billing services? What is the availability of external agencies and competencies?
4. Does our organization have sufficient funds in reserve to sustain it during the start-up phase of billing, and over the course of a year when billing may fluctuate?
5. What do we have to learn about contracting methods, start-up costs, etc.?
6. How will family and youth peer support staff be paid (e.g., as contractors, employees)? If we choose to pay our staff as employees, are we complying with all federal and state labor laws relating to hiring, benefits, etc.?
7. What rate is Medicaid paying for family and youth peer support in our county or state? How was it determined and does it vary by region within the state? If so, why?
8. Does the Medicaid rate for peer support cover the cost of providing this service and result in a small profit that can go back into building our organization?
9. What services are included and can be billed for (e.g., phone calls with families, care coordinators, others on the child and family team; attendance at school meetings, court hearings, support groups; or training)?
10. What is not included and cannot be billed for (e.g., travel time, documentation, administrative costs, supervision time, training) and will the rates we receive cover these expenses?
11. What other expenses can we anticipate (e.g., mileage costs, non-billable staff hours - holidays, training, vacation, sick leave)?
12. Do we have other funding sources that will cover expenses not covered by Medicaid?
13. What are the billing increments (e.g., 15 minutes, 30 minutes, one hour)? Are there limits to the number of hours we can bill in one day/week per family?

Fund Diversification and Sustainability

1. Will Medicaid funding increase the organization's capacity to serve multi-system involved children and youth by allowing peer support staff to participate on child and family teams and in wraparound care planning – in a manner that is not feasible cost-wise to cover with non-Medicaid funding?
2. Can the organization provide peer support services with different funding sources and eligibility criteria?
3. How will the two types of parent and youth peer support services be handled in our agency (i.e., Medicaid-funded vs. funded by other means)?
4. Do state leaders understand the differences in parent peer support and youth support delivered by a family run organization compared with a traditional clinical services provider or a non-family run organization?

At-a-Glance: Pros and Cons of Becoming a Medicaid Provider

PROS
Medicaid fee-for-service billing is not capped in ways that grant funding may be.
It may be easier to manage service delivery under a contract, as there is consistency, unlike with grant funding, which has start and end dates.
Organizations that become Medicaid providers may be able to assist a greater number of families—both those who are eligible for Medicaid-funded services and those who are not.
Family run organizations can develop a unique understanding of the complexities of delivering a needed service while effectively advocating for improvements from a solution driven perspective.
Family run organizations bring advocacy to service planning for children and families through their peer support role.[x]
Family and youth peer support workers bring firsthand knowledge and insight as to how the system works that helps families identify and ask for the services and supports they need.
Family run organizations that become Medicaid providers have a unique perspective and understanding that adds value in designing the service delivery system.
At the program and policy level, parents and youth who work in peer support roles are able to participate and provide input into agency planning and help to identify service gaps, training needs, and other insights that facilitate continual improvement in services and the practice delivery model.
Becoming a Medicaid provider allows a family run organization to bring its expertise to broader system redesign and quality improvement activities.
Family run organizations are able to get higher rates of involvement with parents/ caregivers and young adults who are willing to complete family satisfaction and other service delivery surveys or focus groups; and have the experience necessary to identify and support family leadership development in the families they work with, expanding workforce capacity and participation on policy and quality assurance boards.
Becoming a Medicaid provider can lift the organization and individuals delivering peer support to a new level of professionalism, as the work becomes more organized and purposeful with an emphasis on accountability and outcomes.
The practice of peer support becomes more focused and outcomes driven.
Organizations that provide family and youth peer support facilitate a focus on the importance of formal parent-to-parent support.
Family run organizations that are part of the Medicaid service delivery system have greater capacity to gather data and impact the utilization of family and youth peer support services.
Family run organizations increase the knowledge and leadership skills of youth and families to promote system transformation and effective and evidence-based service delivery.
By becoming providers, organizations have the opportunity to raise the understanding and value of the expertise that parents hired for parents support positions provide. The value of a parent's "life experience" as a caregiver should be factored into the education or work experience that determines the rate for Medicaid reimbursable services. While there is still confusion about the role and qualifications of family and youth peer support providers, national certification standards have been developed and several states, working with their own family run organizations, are establishing standards. The more stringent requirements set forth by Medicaid for its providers, including background checks etc., that have not historically been required for organizations doing family support work under grants, have served to raise the bar in family run organizations and many use the same criteria, whether it is for Medicaid funded positions or family support positions funded by other sources.

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CONS
Most family run organizations started out of common experience and a passion to help other families, but becoming a Medicaid provider may shift the organization's focus from service provision to administrative processes. It is important to not allow being a Medicaid provider to "take over" every aspect of the organization, but to find the balance; to continue providing services beyond scope of Medicaid; and to host events that are broader than Medicaid, such as Children's Mental Health Awareness Week events, providing training and family education, and promoting informal family-to-family networking.
Traditional providers may lack understanding of, or respect for family run organizations as professional providers of services. The process of becoming a Medicaid provider is a long-term investment of the organization that will require establishing and fostering ongoing partnerships with county and state agencies and an infrastructure that supports the operations of Medicaid billing.
Family run organizations are frequently viewed differently by payers than traditional providers.
Family run organizations must understand payment methodologies and the parameters for negotiating rates for family and youth peer support services (i.e., billing codes and the array of family support service categories that can be billed varies by state/county and may include only a few or many of the following: peer support, family support, respite, transportation, living skills training, case management, behavioral health promotion and prevention, translation or interpretation, for groups or individual support, in addition, rates may be different based on location of service - in-office, vs. in-home or community, etc.).
Family run organizations must be continuously involved in policymaking discussions, as practice models are always changing. The organization's leadership must become a partner in system design and implementation as a form of advocacy.
As with any new contract, start-up costs and funding must be negotiated in order to make it financially feasible. The organization needs to understand whether it will have to use its own funds for start-up, or if that can be negotiated as part of their response to an RFP and development of a scope of work with a Medicaid funder. Things like professional liability insurance, office space, copy machines, technology including internet access and cell phones need to be factored into potential start-up costs.
Becoming a Medicaid provider may mean operating in a cost reimbursement environment based on documentation of performance and outcomes achieved.

RESOURCE 2:

Practice Model

- Arizona Family Involvement Center Parent Peer Support Logic Model
- Arizona Family Involvement Center Parent Peer Support Flow Chart

Family Involvement Center – Parent Support Logic Model /Approach

UNIVERSAL INTERVENTIONS

Parent Partners connect with parents to provide individual support and universal interventions and track participation in interventions. Average case load 40-50

- Telephone Support-Line
- Intake/Assessment
- Parent Education Trainings
- Family Social Events
- Public Awareness Events
- Parent Support Groups
- Youth Support Groups
- Community Time Exchange
- Parent Leadership Development

Types of universal trainings and activities based on requests and trends of parents and youth- monthly calendar of events posted

MODERATE INTERVENTIONS

Parent Partner is assigned to implement parent support plan inclusive all universal and additional interventions. Average case load 20-25

- Evidence based Parent Education Training Services
- Brief individual stabilization and capacity building support (applications, referrals and securing community based services and supports)
- Attendance with parents to care planning and treatment meetings (medical, education, children's behavioral health, juvenile justice, and child welfare)

INTENSIVE INTERVENTIONS

Parent Partner is assigned to implement parent support plan inclusive of universal and individualized intensive interventions. Average case load 12-15

- Individualized parent support, attendance to child family team meetings and implementation of all direct services in parent support plan.

FAMILY INVOLVEMENT CENTER

FAMILY INVOLVEMENT CENTER
FRONT DOOR SERVICES FOR PARENT SUPPORT SERVICES
AN INNOVATIVE SYSTEMS APPROACH (Parent Initiated)

Family attends Intake at **QSP**

FIC services introduced to family at Intake

Family agrees to be contacted by FIC

NO **YES**

PAC Brochure Given to Family For Future Resource

Intake Staff faxes Referral to FIC medical records at

medrecs@familyinvolvementcenter.org

A Complete Referral consists of:

1. Parent Contact Authorization Form
2. Agency Assessment
3. Interim Service Plan indicating:

Referral to FIC for Consult and/or Parent Support & Education

** Must be written clearly in this manner

FIC contacts Parent/Caregiver to set up 1st Face to Face Mtg. within **7 days of Initial Contact**

Family is contacted and a home visit is offered within 7 days.

After 3 telephone attempts **OR** 2 no shows or cancellations by family, FIC will email Intake Agency and archive /close file

Parent Support Tool (PST) is completed by FIC with the Parent/Caregiver during 1st visit. Parent may agree with recommended services OR choose a level of support best for them.

Written recommendation for services based on PST score is sent to Intake Agency by FIC

(13-15) High score **UNIVERSAL SUPPORT**

(8-12) Moderate score **MODERATE SUPPORT**

(5 – 7) Low score **INTENSIVE SUPPORT**

Referral for Formal Parent Partner Services Not Required/ Referral is **DECLINED.**

Intake Agency notified. Family is offered **UNIVERSAL SUPPORT** through FIC

- Parent Assistance Center (PAC) Warm Line or Walk In
- Education and Support Groups

Referral for Formal Parent Partner Services is **ACCEPTED and services begin.** Intake Agency is notified **AND** invites FIC to CFT where **FIC Parent Support Services are added to the CFT plan.**

MODERATE SUPPORT

- Moderate frequency of Parent Partner services
- PAC, Education and Support Groups

INTENSIVE SUPPORT

- High frequency of Parent Partner services
- PAC, Education and Support Groups

Parent has met FIC service plan goals.
2nd administration of the PST is completed with Parent

Discharge Summary sent to Intake Agency.
This will include both pre and post PST scores

RESOURCE 3:

Family-Run Organization Credentials

- Tennessee Requirements for Outpatient Mental Health Facilities
- Tennessee Facilities Requirements

RULES
OF
TENNESSEE DEPARTMENT OF MENTAL HEALTH
AND MENTAL RETARDATION

CHAPTER 0940-5-14
MINIMUM PROGRAM REQUIREMENTS FOR MENTAL HEALTH OUTPATIENT FACILITIES

TABLE OF CONTENTS

0940-5-14-.01 POLICIES AND PROCEDURES FOR OUTPATIENT FACILITIES.

(1) The facility must have a written policy and procedures manual which includes the following elements:

(a) A quality assurance procedure which assesses the quality of care at the facility. This procedure must ensure appropriate treatment has been delivered according to acceptable clinical practice;

(b) A written program description which must be available to staff, clients and members of the public. The description must include, but need not to be limited to, the following:

1. Services offered by the facility, availability of staff (including medical) to provide services and hours of operation,

2. Characteristics of the person(s) to be served,

3. Referral process,

4. Admission criteria,

5. Re-admission criteria,

6. Facility rules for client,

7. Referral mechanisms for services outside the agency (both medical and non-medical),

8. Emergency and non-emergency transportation of clients, and

9. Discharge criteria;

(c) Policies and procedures which address the methods for managing disruptive behavior;

(d) If restrictive procedures are used to manage disruptive behaviors, written policies and procedures must govern their use and must minimally ensure the following:

(Rule 0940-5-.14-.01,continued)

1. Restrictive procedures will be used by the facility only after all less-restrictive alternatives for dealing with the problem behavior have been systematically tried or considered and have been determined to be inappropriate or ineffective,

2. The client must have given written consent to any restrictive measures taken with him/her by the clinical staff,

3. The restrictive procedure(s) must be documented in the Individual Program Plan, be justifiable as part of the plan and meet all requirements that govern the development and review for the plan,

4. Only mental health professionals or mental health personnel may use restrictive procedures and must be adequately trained in their use, and

5. The adaptive or desirable behavior should be taught to the client in conjunction with the implementation of the restrictive procedures; and

(e) A policy which states Physical Holding must be implemented in such a way as to minimize any physical harm to the client and may only be used when the client poses an immediate threat under the following conditions:

1. The client poses an immediate danger to self or others, and/or

2. To prevent the client from causing substantial property damage.

Authority: *T.C.A. § 33-2-504.* ***Administrative History:*** *Original rule filed May 26, 1988; effective July 11, 1988.*

0940-5-14-.02 PERSONNEL REQUIREMENTS FOR OUTPATIENT FACILITIES.

(1) Provide direct-treatment and/or rehabilitation services by mental health professionals or by mental health personnel who are under the direct clinical supervision of a mental health professional.

(2) Maintain a written agreement with or employ a physician to serve as medical consultant to the facility.

(3) If the physician is not a psychiatrist, the facility must also arrange for the regular, consultative and emergency services of a psychiatrist.

(4) In case of a medical or other type of emergency, the facility staff must have immediate access to relevant information in the client's record.

Authority*: T.C.A. § 33-2-504.* ***Administrative History****: Original rule filed May 26, 1988; effective July 11, 1988.*

0940-5-14-.03 CLIENT ASSESSMENT REQUIREMENTS FOR OUTPATIENT FACILITIES.

(1) The facility must ensure that the following assessments are completed prior to the development of the Individual Program Plan:

(a) Assessment of current functioning according to presenting problem including a history of the presenting problem:

(b) Basic medical history and information:

(c) A six-month history of prescribed medications, frequently used over-the-counter medications and alcohol and other drugs; and

(Rule 0940-5-.14-.03,continued)

(d) A history of prior mental health and alcohol and drug treatment episodes.

Authority: *T.C.A. § 33-2-504.* ***Administrative History:*** *Original rule filed May 26, 1988; effective July 11, 1988.*

0940-5-14-.04 INDIVIDUAL PROGRAM PLAN REQUIREMENTS FOR OUTPATIENT FACILITIES.

(1) An Individual Program Plan must be developed for each client which is based on an initial history and ongoing assessment and which is completed within thirty (30) days of admission. Documentation of the Individual Program Plan (IPP) must include the following:

(a) The client's name;

(b) The date of development of the IPP;

(c) Specified client problems in the IPP which are to be addressed within the particular service/program component;

(d) Client goals which are related to specified problems identified in the IPP and which are to be addressed by the particular service/program component;

(e) Interventions addressing goals in the IPP;

(f) The signatures of the appropriate staff;

(g) Documentation of client participation in the treatment planning process;

(h) Standardized diagnostic formulation(s), (e.g., DSM-III, ICD-9); and

(i) Planned frequency of contacts.

Authority: *T.C.A. § 33-2-504.* ***Administrative History:*** *Original rule filed May 26, 1988; effective July 11, 1988.*

0940-5-14-.05 INDIVIDUAL PROGRAM PLAN REVIEW IN OUTPATIENT FACILITIES. The facility must review and, if indicated, revise the IPP every six (6) months.

Authority: *T.C.A. § 33-2-504.* ***Administrative History:*** *Original rule filed May 26, 1988; effective July 11, 1988.*

0940-5-14-.06 CLIENT RECORD REQUIREMENTS FOR OUTPATIENT FACILITIES.

(1) An individual client record must be maintained which includes the following:

(a) Progress notes which must include written documentation of progress or changes which have occurred within the IPP and which must be developed after each service contact;

(b) Documentation of all drugs prescribed or administered by the facility which indicates date prescribed, type, dosage, frequency, amount and reason;

(c) Narrative summary review of all medications prescribed at least every six (6) months which includes specific reasons for continuation of each medication; and

(d) A discharge summary which states, if appropriate, the client's condition at the time of discharge and signature of person preparing the summary.

Authority: *T.C.A. § 33-2-504.* ***Administrative History:*** *Original rule filed May 26, 1988; effective July 11, 1988.*

RULES
OF
TENNESSEE DEPARTMENT OF HEALTH
AND MENTAL RETARDATION

CHAPTER 0940-05-06
MINIMUM PROGRAM REQUIREMENTS
FOR ALL FACILITIES

TABLE OF CONTENTS

0940-05-06-.01 GOVERNANCE REQUIREMENTS FOR ALL FACILITIES.

(1) The governing body must ensure that the facility complies with all applicable federal, state, and local laws, ordinances, rules, and regulations.

(2) The governing body must ensure that the facility is administered and operated in accordance with written policies and procedures.

(3) The governing body must exercise general direction over the facility and establish policies governing the operation of the facility and the welfare of the individuals served.

(4) The governing body must designate an individual responsible for the operation of the facility.

(5) The governing body must ensure that the licensed facility serves only persons whose placement will not cause the facility to violate its licensed status and capacity based on the facility's distinct licensure category, the facility's life safety occupancy classification, and the required staffing ratios, if any.

Authority: *T.C.A. § 33-2-504.* ***Administrative History:*** *Original rules filed May 26, 1988; effective July 11, 1988. Amendment filed May 28, 2010; to have been effective August 26, 2010. Stay of amendment filed by the Tennessee Department of Mental Health and Developmental Disabilities on July 21, 2010; new effective date November 9, 2010. Withdrawal of amendment filed August 2, 2010. Amendment filed August 30, 2010; to have been effective January 29, 2011. Stay of amendment filed by the Tennessee Department of Mental Health and Developmental Disabilities on January 29, 2011; new effective date March 7, 2011. Withdrawal of amendment filed by the Department of Mental Health and Developmental Disabilities on February 25, 2011.*

0940-05-06-.02 POLICIES AND PROCEDURES FOR ALL FACILITIES.

(1) The governing body must ensure that a written policies and procedures manual is maintained. The manual must include the following elements:

(a) A description of each facility service provided by the licensee. The description must include the hours of operation and admission and discharge criteria;

(Rule 0940-05-06-.02, continued)

(b) An organizational chart of a statement which clearly shows or describes the lines of authority between the governing body, the chief executive officer, and the staff;

(c) A policy and procedures which ensure that someone is delegated the authority to act in the absence of the individual responsible for the operation of the facility;

(d) A schedule of fees, if any, currently charged to the client for all services provided by the licensee;

(e) A statement of client rights and the grievance procedures to be followed when a suspected violation of client rights has been reported;

(f) A policy and procedures which ensure the confidentiality of client information and which include the following provisions:

1. The facility staff must comply with applicable confidentiality laws and regulations. (e.g., T.C.A. § 33-3-104(10); federal alcohol and drug regulations found at 42 CFR, Part 2);

2. The client must not be required to make public statements which acknowledge gratitude to the licensee or for the licensee's facility services;

3. The client must not be required to perform in public gatherings; and,

4. Identifiable photographs of the client must not be used without the written and signed consent of the client or the client's guardian;

(g) A medication administration policy and control procedures for facilities involved in the administration of medication to clients;

(h) The plans and procedures to be followed in the event of fire evacuation and natural disaster emergencies;

(i) The plans and procedures to be followed in the event of an emergency involving client care which will provide for emergency transportation of clients, emergency medical care, and staff coverage in such events;

(j) A policy which prohibits clients from having any of the following responsibilities;

1. Responsibility for the care of other clients;

2. Responsibility for the supervision of other clients unless on-duty/on-site staff are present; and,

3. Responsibilities requiring access to confidential information;

(k) A policy and procedures to be followed in the reporting and investigation of suspected or alleged abuse, or neglect of clients, or other critical incidents. The procedures must include provisions for corrective action, if any, to be taken as a result of such reporting and investigation;

(l) A policy and procedures which ensure that volunteers, if used by the facility, are in a supportive capacity and are under the supervision of appropriate designated staff members;

(Rule 0940-05-06-.02, continued)

(m) A policy and procedures which govern the use of client behavior-management techniques, if used by the facility;

(n) A policy regarding the use of human subjects in research, if the facility is involved or planning to be involved in such research, which includes procedures for the following:

1. Identification of subjects, projects, and staff;

2. Provisions to protect the personal and civil rights of the subjects;

3. Obtaining the consent of the subjects involved;

4. Assurance that all research projects are conducted under the direction and supervision of professional staff qualified by education and experience to conduct research;

5. Emergency guidelines for problems that may develop during research activities; and,

6. Appointment of a facility representative to act as coordinator of the research activities.

Authority: *T.C.A. § 33-2-504.* ***Administrative History:*** *Original rules filed May 26, 1988; effective July 11, 1988. Amendment filed May 28, 2010; to have been effective August 26, 2010. Stay of amendment filed by the Tennessee Department of Mental Health and Developmental Disabilities on July 21, 2010; new effective date November 9, 2010. Withdrawal of amendment filed August 2, 2010. Amendment filed August 30, 2010; to have been effective January 29, 2011. Stay of amendment filed by the Tennessee Department of Mental Health and Developmental Disabilities on January 29, 2011; new effective date March 7, 2011. Withdrawal of amendment filed by the Department of Mental Health and Developmental Disabilities on February 25, 2011.*

0940-05-06-.03 FINANCIAL MANAGEMENT OF ALL FACILITIES.

(1) The licensee holding or receiving funds or property for the client as trustee or representative payee will adhere to all laws, state and federal, that govern his position and relation to the client.

(2) The license must prohibit staff and proprietors from borrowing money from clients.

(3) The licensee must ensure that all money held and disbursed in the client's behalf if for the strict, personal benefit of the client.

(4) The licensee must not mix its fund with those of the client.

(5) The licensee must not take funds or property of the client for the facility's own use or gain.

(6) The licensee must provide an annual reporting to the client or the client's parent or guardian of the client's funds being held and disbursed by the facility.

Authority: *T.C.A. § 33-2-504.* ***Administrative History:*** *Original rule filed May 26, 1988; effective July 11, 1988. Amendment filed May 28, 2010; to have been effective August 26, 2010. Stay of amendment filed by the Tennessee Department of Mental Health and Developmental Disabilities on July 21, 2010; new effective date November 9, 2010. Withdrawal of amendment filed August 2, 2010. Amendment filed August 30, 2010; to have been effective January 29, 2011. Stay of amendment filed by the Tennessee Department of Mental Health and Developmental Disabilities on January 29, 2011; new effective date March 7, 2011. Withdrawal of amendment filed by the Department of Mental Health and Developmental Disabilities on February 25, 2011.*

0940-05-06-.04 PERSONNEL REQUIREMENTS FOR ALL FACILITIES.

(1) A job description must be maintained which includes the employment requirements and the job responsibilities for each facility staff position.

(2) A personnel record must be maintained which verifies that each employee meets the respective employment requirements for the staff position held.

(3) Training and development activities which are appropriate in assisting the staff in meeting the needs of the clients being served must be provided for each staff member. The provision of such activities must be evidenced by documentation in the facility records.

(4) Training and development activities which are appropriate in assisting volunteers (if used by the facility) in implementing their assigned duties must be provided for each volunteer. The provision of such activities must be evidenced by documentation in the facility's records.

(5) Direct-services staff members must be competent persons aged eighteen (18) years of age or older.

Authority: *T.C.A. § 33-2-504.* ***Administrative History:*** *Original rule filed May 26, 1988; effective July 11, 1988. Amendment filed May 28, 2010; to have been effective August 26, 2010. Stay of amendment filed by the Tennessee Department of Mental Health and Developmental Disabilities on July 21, 2010; new effective date November 9, 2010. Withdrawal of amendment filed August 2, 2010. Amendment filed August 30, 2010; to have been effective January 29, 2011. Stay of amendment filed by the Tennessee Department of Mental Health and Developmental Disabilities on January 29, 2011; new effective date March 7, 2011. Withdrawal of amendment filed by the Department of Mental Health and Developmental Disabilities on February 25, 2011.*

0940-05-06-.05 INDIVIDUAL CLIENT RECORD REQUIREMENTS FOR ALL FACILITIES. The governing body must ensure that an individual client record is maintained for each client being served which minimally include the following information:

(a) The name of the client;

(b) The address of the client;

(c) The telephone number of the client;

(d) The sex of the client;

(e) The date of the client's birth;

(f) The date of the client's admission to the facility;

(g) The source of the client's referral to the facility;

(h) The name, address, and telephone number of an emergency contact person;

(i) If the facility charges fees for its services, a written fee agreement dated and signed by the client (or the client's legal representative) prior to provision of any services other than emergency services. This agreement must include at least the following information;

1. The fee or fees to be paid by the client;

2. The services covered by such fees, and

(Rule 0940-05-06-.05, continued)

3. Any additional charges for services not covered by the basic service fee;

(j) Appropriate informed, signed, and dated consent and authorization forms for the release or obtainment of information about the client; and

(k) Documentation that the client or someone acting on behalf of the client has been informed of the client's rights and responsibilities and of the facility's general rules affecting client.

Authority: *T.C.A. § 33-2-504.* ***Administrative History:*** *Original rule filed May 26, 1988; effective July 11, 1988. Amendment filed May 28, 2010; to have been effective August 26, 2010. Stay of amendment filed by the Tennessee Department of Mental Health and Developmental Disabilities on July 21, 2010; new effective date November 9, 2010. Withdrawal of amendment filed August 2, 2010 Amendment filed August 30, 2010; to have been effective January 29, 2011. Stay of amendment filed by the Tennessee Department of Mental Health and Developmental Disabilities on January 29, 2011; new effective date March 7, 2011. Withdrawal of amendment filed by the Department of Mental Health and Developmental Disabilities on February 25, 2011.*

0940-05-06-.06 CLIENT RIGHTS IN ALL FACILITIES.

(1) The following rights must be afforded to all clients by all licensees and are not subject to modification.

(a) Clients have the right to be fully informed before or upon admission about their rights and responsibilities and about any limitation on these rights imposed by the rules of the facility. The facility must ensure that the client is given oral and/or written rights information that includes at least the following:

1. A statement of the specific rights guaranteed the client by these rukes and applicable state laws;

2. A description of the facility's grievance procedure;

3. A listing of available advocacy services; and

4. A copy of all general facility rules and regulations for clients.

The information must be presented in a manner that promotes understanding by clients of their rights, and an opportunity must be given to clients to ask questions about the information. If a client who is unable to understand this information at the time of admission later becomes able to do so, the information must be presented to the client at that time. If a client is likely to continue indefinitely to be unable to understand this information, the facility must promptly attempt to provide the required information to a parent, guardian, or other appropriate person or agency responsible for protecting the rights of the client;

(b) Clients have the right to voice grievances to staff of the facility, to the licensee, and to outside representatives of their choice with freedom from restraint, interference, coercion, discrimination, or reprisal;

(c) Clients have the right to be treated with consideration, respect, and full recognition of their dignity and individuality;

(d) Clients have the right to be protected by the licensee from neglect; from physical, verbal, and emotional abuse (including corporal punishment); and from all forms of exploitation;

(Rule 0940-05-06-.06, continued)

(e) Clients have the right to be assisted by the facility in the exercise of their civil rights;

(f) Clients have the right to be free of any requirement by the facility that they perform services which are ordinarily performed by facility staff; and

(g) If residential services are provided, clients must be allowed to send personal mail unopened and to receive mail and packages which may be opened in the presence of staff when there is reason to believe that the contents thereof may be harmful to the client or others.

(2) The following rights must be afforded to all clients by all licensed facilities unless modified in accordance with rules 0940-05-06-.07 or 0940-05-06-.08:

(a) Clients have the right to participate in the development of their individual program plans and to receive sufficient information about proposed and alternative interventions and program goals to enable them to participate effectively;

(b) Clients have the right to participate fully, or to refuse to participate, in community activities including cultural, educational, religious, community services, vocational, and recreational activities;

(c) If residential services are provided, clients must be allowed to have free use of common areas in the facility with due regard for privacy, personal possessions, and the right of others;

(d) If residential services are provided, clients have the right to be accorded privacy and freedom for the use of bathrooms at all hours;

(e) If residential services are provided, clients have the right to be accorded privacy and freedom for the use or bathrooms at all hours;

(f) If residential services are provided and if married clients reside in the facility, privacy for visits by spouses must be ensured, and if both spouses are clients residing in the facility, they must be permitted to share a room; and

(g) If residential services are provided, clients have the right to associate and communicate privately with persons of their choice including receiving visitors at reasonable hours.

Authority: *T.C.A. § 33-2-504.* ***Administrative History:*** *Original rule filed May 26, 1988; effective July 11, 1988. Amendment filed May 28, 2010; to have been effective August 26, 2010. Stay of amendment filed by the Tennessee Department of Mental Health and Developmental Disabilities on July 21, 2010; new effective date November 9, 2010. Withdrawal of amendment filed August 2, 2010. Amendment filed August 30, 2010; to have been effective January 29, 2011. Stay of amendment filed by the Tennessee Department of Mental Health and Developmental Disabilities on January 29, 2011; new effective date March 7, 2011. Withdrawal of amendment filed by the Department of Mental Health and Developmental Disabilities on February 25, 2011.*

0940-05-06-.07 MODIFICATION OR LIMITATION OF RIGHTS OF ALL CLIENTS BY FACILITY RULES, POLICIES, OR PROCEDURES.

(1) The rights of all clients of a facility may only be modified or limited under the following conditions:

(a) It is demonstrated and documented that a legitimate program purpose cannot reasonably by achieved without such modification or limitation;

(Rule 0940-05-06-.07, continued)

(b) No modification or limitation may be made solely for the convenience of facility staff or be more stringent than is necessary to achieve the demonstrated purpose;

(c) Clients or representatives of clients, as appropriate, must be fully informed of proposed facility rules, policies or procedures modifying or limiting client rights, and of the reasons therefore and must be given an opportunity to object; to propose alternatives; and to consult with family, friends, and/or advocacy agencies prior to their implementation; and

(d) Facility rules, policies, or procedures which modify or limit client rights must be in writing and posted in a conspicuous place.

Authority: *T.C.A. § 33-2-504.* ***Administrative History:*** *Original rule filed May 26, 1988; effective July 11, 1988. Amendment filed May 28, 2010; to have been effective August 26, 2010. Stay of amendment filed by the Tennessee Department of Mental Health and Developmental Disabilities on July 21, 2010; new effective date November 9, 2010. Withdrawal of amendment filed August 2, 2010. Amendment filed August 30, 2010; to have been effective January 29, 2011. Stay of amendment filed by the Tennessee Department of Mental Health and Developmental Disabilities on January 29, 2011; new effective date March 7, 2011. Withdrawal of amendment filed by the Department of Mental Health and Developmental Disabilities on February 25, 2011.*

0940-05-06-.08 MODIFICATION OR LIMITATION OF AN INDIVIDUAL CLIENT'S RIGHTS.

(1) The rights of an individual client in a facility may only be modified or limited under the following conditions:

(a) It is demonstrated and documented that such modification or limitation is necessary because of the individual client's physical or mental condition;

(b) To achieve a legitimate goal in the client's individual program plan;

(c) No modification or limitation may be made solely for the convenience of staff or be more stringent than is necessary;

(d) The client or a representative of the client, as appropriate, must be fully informed of the proposed limitation or modification and must be given an opportunity to object, to propose alternatives, and to consult with family, friends, and/or advocacy agencies prior to implementation of the modifications or limitations; and

(e) Any modifications or limitations and the reasons therefore must be documented in the client's Individual Program Plan.

Authority: *T.C.A. § 33-2-504.* ***Administrative History:*** *Original rule filed May 26, 1988; effective July 11, 1988. Amendment filed May 28, 2010; to have been effective August 26, 2010. Stay of amendment filed by the Tennessee Department of Mental Health and Developmental Disabilities on July 21, 2010; new effective date November 9, 2010. Withdrawal of amendment filed August 2, 2010. Amendment filed August 30, 2010; to have been effective January 29, 2011. Stay of amendment filed by the Tennessee Department of Mental Health and Developmental Disabilities on January 29, 2011; new effective date March 7, 2011. Withdrawal of amendment filed by the Department of Mental Health and Developmental Disabilities on February 25, 2011.*

0940-05-06-.09 RESERVED.

Authority: *T.C.A. § 4-4-103, 33-1-302, 33-1-305, 33-1-309, 33-2-301, 33-2-302, 33-2-404, 33-2-405 and 33-2-407.* ***Administrative History:*** *Original rule filed May 28, 2010; to have been effective August 26, 2010. Stay of amendment filed by the Tennessee Department of Mental Health and Developmental Disabilities on July 21, 2010; new effective date November 9, 2010. Withdrawal of amendment filed August 2, 2010. Amendment*

(Rule 0940-05-06-.09, continued)
filed August 30, 2010; to have been effective January 29, 2011. Stay of amendment filed by the Tennessee Department of Mental Health and Developmental Disabilities on January 29, 2011; new effective date March 7, 2011. Withdrawal of amendment filed by the Department of Mental Health and Developmental Disabilities on February 25, 2011.

0940-05-06-.10 RESERVED.

Authority: *T.C.A. § 4-4-103, 33-1-302, 33-1-305, 33-1-309, 33-2-301, 33-2-302, 33-2-404, 33-2-405 and 33-2-407.* ***Administrative History:*** *Original rule filed May 28, 2010; to have been effective August 26, 2010. Stay of amendment filed by the Tennessee Department of Mental Health and Developmental Disabilities on July 21, 2010; new effective date November 9, 2010. Withdrawal of amendment filed August 2, 2010. Amendment filed August 30, 2010; to have been effective January 29, 2011. Stay of amendment filed by the Tennessee Department of Mental Health and Developmental Disabilities on January 29, 2011; new effective date March 7, 2011. Withdrawal of amendment filed by the Department of Mental Health and Developmental Disabilities on February 25, 2011.*

RULES
OF
TENNESSEE DEPARTMENT OF MENTAL HEALTH
AND MENTAL RETARDATION

CHAPTER 0940-5-5
ADEQUACY OF FACILITY ENVIRONMENT
AND ANCILLARY SERVICES

TABLE OF CONTENTS

0940-5-5-.01 STANDARD FOR NEW CONSTRUCTION. The licensee or licensee applicant must ensure that new construction for facilities subject to the licensure jurisdiction of the Department meets the appropriate standards of the edition of the Standard Building Code currently in effect as adopted by the Office of the State Fire Marshall in rule 0780-2-2-.01 of the promulgated rules of the Department of Commerce and Insurance.

Authority: *T.C.A. 33-2-504.* ***Administrative History:*** *Original rule filed November 25, 1981; effective January 20, 1982. Repeal and new rule filed October 27, 1986; effective December 11, 1986. Amendment filed February 5, 1987; effective May 27, 1987. Repeal and new rule filed May 26, 1988; effective July 11, 1988.*

0940-5-5-.02 GENERAL ENVIRONMENTAL REQUIREMENTS FOR ALL FACILITIES.

(1) The facility must be maintained in a safe manner and a continuing effort made to eliminate potential hazards.

(2) The facility must be maintained in a sanitary and clean condition, free from all accumulation of dirt and rubbish, well-ventilated, and free from foul, stale or musty odors.

(3) The facility must be kept free of mice, rats and other rodents.

(4) Housekeeping practices and standards must be maintained which will ensure the eradication of files, roaches, and other vermin.

(5) All interior and exterior stairs and steps must be equipped with securely and safely installed handrails.

(6) All interior and exterior stairways, halls, porches, walkways and all other means of egress and areas of exit discharge must be maintained free of any obstacles, including furniture or other stored items

(7) A heating system must be provided which is capable of maintaining a minimum temperature of sixty-five (65) degrees Fahrenheit and a comfortable humidity level at all times within the facility.

(8) A cooling, natural ventilation or air conditioning system must be provided which is capable of maintaining a maximum temperature of eighty-five (85) degrees Fahrenheit and a comfortable humidity level at all times within the facility.

(Rule 0940-5-5-.02, continued)

(9) Operable windows for ventilation must be provided unless the requirement for operable windows is otherwise exempted by the facility's licensure life safety occupancy classification and the facility is equipped with an air conditioning system.

(10) All operable windows used for ventilation must be equipped with screens which do not render the window unusable if the windows also is required for escape or emergency rescue purposes.

(11) A telephone system must be provided with is capable of ensuring prompt notification in cases of emergencies and which is capable of meeting the needs of the clients served by the facility.

(12) Emergency telephone numbers must be posted for the most local available agencies for fire protection, police or sheriff, ambulance, or medical intervention, and poison control.

(13) An adequate first aid kit must be provided as recommended by the local chapter of the American Red Cross or the facility's medical staff, as applicable.

(14) Drinking water must be provided from a source approved by the Tennessee Department of Health.

(15) A system for the disposal of sewage must be provided which is connected to a public sewage system or which is connected to a private sewage system (septic tank and field system) which has the approval of the local public health agency having jurisdiction.

(16) Natural or artificial lighting must be provided which is adequate for the needs of the clients using the facility.

Authority: *T.C.A. § 33-2-504.* ***Administrative History:*** *Original rule filed November 25, 1981; effective January 20, 1982. Amendment filed November 30, 1983; effective December 30, 1983. Repeal and new rule filed June 30, 1986; effective July 30, 1986. Repeal and new rule filed October 14, 1986; effective November 28, 1986. Amendment filed October 27, 1986; effective December 11, 1986. Repeal and new rule filed May 26, 1988; effective July 11, 1988.*

0940-5-5-.03 ENVIRONMENTAL REQUIREMENTS FOR RESIDENTIAL FACILITIES.

(1) The governing body must ensure that each client is provided with the following:

(a) A separate bed of proper size and height for the client's convenience and comfort;

(b) A mattress and springs, or a mattress foundation, both of which are clean, comfortable, and in good repair;

(c) Clean linens consisting of both a top and bottom sheet, which are clean, in good repair, and are changed as often as needed, but at least weekly;

(d) Bedding, such as blankets, which are clean, in good repair, and appropriate to the weather;

(e) A clean and comfortable pillow unless contra-indicated by the client's choice or for health reasons;

(f) Space in a dresser or chest of drawers which is adequate for the storage of the client's clothing;

(g) Closet or wardrobe space which is adequate for the hanging storage of the client's clothing; and

(h) Access to a mirror at an appropriate height.

(Rule 0940-5-5-.03, continued)

(2) Unless the facility is required to meet Health Care Occupancy standards, or unless the room has a door which leads directly to the outside, then each client bedroom must be provided with a window which meets the following:

(a) Is operable from the inside without the use of special keys, tools, or knowledge;

(b) Provides a clear opening of not less than twenty (20) inches in width, twenty-four (24) inches in height, and five and seven-tenths (5.7) square feet in area; and

(c) The bottom of the opening is not more than forty-four (44) inches from the floor.

(3) Each bedroom must be decorated in an appropriate manner including bedspreads, window coverings, and wall hangings.

(4) Bathrooms must be provided within the facility which are equipped as follows:

(a) One (1) private toilet for each six (6) persons, including staff, who reside in the facility;

(b) One (1) lavatory with hot water for each six (6) persons, including staff, who reside in the facility;

(c) One (1) private tub or shower with hot water for each eight (8) persons, including staff, who reside in the facility;

(d) Tub and shower floor surfaces equipped to be slip-resistant;

(e) Adequate and sanitary soap and towels provided at each lavatory; and

(f) Adequate and sanitary toilet paper provided at each toilet.

(5) A dining area and dining furniture must be provided which are sufficient, appropriate, and in good repair for meeting the needs of the clients.

(6) A combined living and activity area and furnishings must be provided which are sufficient in size, in good repair, and appropriate for meeting the needs of the clients residing in the facility. The area must contain one (1) seating area such as chairs or sofas for each client and other residential furniture such as tables, lamps, wall hangings, a television, and a clock.

(7) An outdoor area must be provided which is neat, free of potential hazards, and is appropriate to meeting the needs of the clients.

Authority: *T.C.A. § 33-2-504.* ***Administrative History:*** *Original rule filed November 25, 1981; effective January 20, 1982. Repeal and new rule filed October 27, 1986; effective December 11, 1986. Repeal and new rule filed May 26, 1988; effective July 11, 1988.*

0940-5-5-.04 ENVIRONMENTAL REQUIREMENTS FOR NON-RESIDENTIAL FACILITIES.

(1) If clients are regularly scheduled to be in the facility for extended periods of time which encompass recognized mealtimes, then the facility must provide a dining area with tables and chairs sufficient to take their meals whether meals are provided by the facility, the client, or other source.

(2) Provide one (1) lavatory and one (1) private toilet for each fifteen (15) persons served in the facility.

(3) Equip each lavatory with adequate and sanitary hand soap and hand towels.

(Rule 0940-5-5-.04, continued)

(4) Equip each toilet with adequate toilet paper.

Authority: *T.C.A. § 33-2-504.* ***Administrative History:*** *Original rule filed November 25, 1981; effective January 20, 1982. Repeal and new rule filed October 27, 1986; effective December 11, 1986. Repeal and new rule filed May 26, 1988; effective July 11, 1988.*

0940-5-5-.05 REQUIREMENTS FOR FACILITIES PROVIDING FOOD SERVICES AND NUTRITION. (All residential facilities required to meet this chapter of rules must comply with the requirements of this rule. Any non-residential facility required to meet this chapter of rules which provides food and nutrition on a regular basis to its clients must comply with the requirements of this rule.)

(1) Food and nutrition must be provided in as normal a fashion as possible.

(2) Records must be maintained which document the content of all meals served for at least the previous thirty (30) days.

(3) Food must be served in appropriate quantity, at appropriate temperatures, and in a form consistent with normal situations.

(4) Clients, including those individuals with physical handicaps, must be allowed to eat meals at a table in a dining area unless temporarily contra-indicated for medical reasons.

(5) Provisions must be made for following special diets for clients when such diets are prescribed for medical or health reasons, and encouragement given the client to follow such special diets.

(6) In residential facilities, provisions must be made for three (3) well-balanced meals at recognized mealtimes with no more than fourteen (14) hours elapsing between the evening supper meal and the following morning breakfast meal.

(7) In residential facilities, a forty-eight (48) hour supply of food must be maintained within the facility which is sufficient for meeting the needs of the clients served in the facility.

(8) Appropriate equipment and utensils for cooking food and serving meals must be provided in sufficient quantity to serve all clients and such equipment and utensils must be in good repair, washed and sanitized after each use.

(9) Kitchens must be equipped with appliances and fixtures which are sufficient and appropriate for cooking meals, refrigerating food, washing utensils and dishes, and the sanitary disposal of waste.

(10) Foods requiring cold storage must be maintained at a temperature of forty-five (45) degrees Fahrenheit or below.

(11) Foods requiring frozen storage must be maintained at a temperature of ten (10) degrees Fahrenheit or below.

(12) All dry foods and goods must be stored in a manner to prevent possible contamination and must be stored a minimum of six (6) inches above the floor.

(13) Garbage (food waste) must be stored in secure containers with tight-fitting lids and liners or discharged from the facility through a properly installed food waste disposal system.

(14) Garbage (food waste) containers must be emptied daily from the facility into secure containers located outside of the facility.

(Rule 0940-5-5-.05, continued)

(15) Provisions must be made for the regular removal or disposal of garbage (food waste) from the facility premises.

Authority: *T.C.A. § 33-2-504.* ***Administrative History:*** *Original rule filed March 16, 1983; effective April 18, 1983. Repeal and new rule filed October 27, 1986; effective December 11, 1986. Repeal and new rule filed May 26, 1988; effective July 11, 1988.*

0940-5-5-.06 REQUIREMENTS FOR FACILITIES PROVIDING CLIENT TRANSPORTATION SERVICES. If the facility or employees of the facility provide transportation to clients in vehicles owned either by the facility or by the employee, then the governing body must ensure that the following requirements are met:

(a) All vehicles must be maintained and operated in a safe manner;

(b) All staff providing transportation must possess an appropriate driver's license from the Tennessee Department of Safety, and documentation of such license must be maintained in the facility's records;

(c) All facility-owned and staff-owned vehicles for client transportation must be adequately covered by vehicular liability insurance for personal injury to occupants of the vehicle, and documentation of such insurance must be maintained in the facility's records; and

(d) Appropriate safety restraints must be used as required by state and federal law.

Authority: *T.C.A. § 33-2-504.* ***Administrative History:*** *Original rule filed October 27, 1986; effective December 11, 1986. Amendment filed February 5, 1987; effective May 27, 1987. Repeal and new rule filed May 26, 1988; effective July 11, 1988.*

0940-5-5-.07 SPECIAL REQUIREMENTS FOR FACILITIES SERVING CHILDREN. (Any facility required to meet this chapter of rules which provides services to children six (6) years of age or younger must comply with these requirements.)

(1) Non-toxic, lead-free paint must be used on all painted surfaces.

(2) Electrical wall outlets which are accessible to children must be protected with covers.

(3) Poisonous and toxic materials must be identified, stored, and used only in such manner and under such conditions as not to pose any threat of poisoning to the clients or contamination of food.

(4) All sources of heat must be protected by screens or other protective barriers to prevent burns or injury to children.

(5) Furnishings and other equipment used in the facility must be free of sharp or projecting objects or surfaces and not pose any potential harm or injury to children.

(6) Steps or stairs which pose a fall hazard to children must be protected by barriers.

(7) Outside play areas must be fenced or otherwise situated to protect children from hazards such as open drainage ditches, adjacent streets, and traffic.

(8) Outside play areas must provide fifty (50) square feet of play area for each child present.

(9) Grass, bark, sand, rubber mats, or other resilient surfaces must be used under play equipment used for climbing or swinging.

(Rule 0940-5-5-.07, continued)

(10) Furniture, equipment, and bathroom fixtures must be sized or adapted for meeting the needs of the children served by the facility.

(11) Equipment must be provided that is sufficient and appropriate for active and quiet play needs and for implementing program activities for each child.

(12) Non-residential facilities must provide nap facilities if the children are scheduled to remain in the facility for as long as six (6) hours.

Authority: *T.C.A. § 33-2-504.* ***Administrative History:*** *Original rule filed May 26, 1988; effective July 11, 1988.*

0940-5-5-.08 SPECIAL REQUIREMENTS FOR FACILITIES PROVIDING VOCATIONAL SERVICES.

(1) Activities of an industrial or productive vocational nature such as assembling, packaging, painting, stripping, wood or metal working, or manufacturing must be conducted in a designated area or room which is separated by fire-rated construction, as required by the applicable life safety rules under Chapter 0940-5-4 of these rules, from any other part of the facility not used for vocational purposes such as classrooms, residential areas, offices, or storage rooms.

(2) Permanent aisles and passageways which provide the most direct route of egress to exits must be clearly identified within open work areas, and such aisles and passageways must be maintained free of obstacles and in good repair.

(3) All floor surfaces, platforms, and other walking surfaces must be maintained in a clean manner and free of holes or projections which constitute hazards.

(4) All materials must be stored in tiers which are stacked, racked, blocked, interblocked, or otherwise secured to prevent sliding, collapsing, or falling.

(5) All powered equipment, machinery, and powered hand tools must be equipped and maintained with the safety guards, shields, and other devices necessary to protect health and safety of the operators and others in the work area.

(6) All exposed rotating parts, motor shafts, drive belts, chains, cables, gears, cutting blades, wheels, and other moving parts of machinery must be adequately guarded.

(7) Personal protective equipment and clothing must be provided to clients and employees, when appropriate, when handling dangerous materials or working at hazardous operations.

(8) All interior floor and wall openings, open-sized mezzanine areas or platforms, which are six (6) feet or more above the adjacent ground level, must be guarded by standard railing.

(9) Natural or adequately-powered ventilation which conforms to ventilation rates of the state-adopted building codes must be provided for all working areas.

(10) Equipment, conductors, controls, and signaling devices which are necessary to provide a complete electrical system must be provided. All specifications and materials must meet state-adopted standards of the building codes, and of the Underwriters' Laboratories, Inc. (or similarly established standards).

Authority: *T.C.A. § 33-2-504.* ***Amendment History:*** *Original rule filed May 26, 1988; effective July 11, 1988.*

0940-5-5-.09 SPECIAL REQUIREMENTS FOR FACILITIES SERVING PERSONS WITH VISION LOSS. The governing body of any residential or non-residential facility, which is required to admit only persons who are capable of self-preservation and which also provides services to one or more persons who have a vision loss, must ensure compliance with the following requirements:

(a) The client must be able to demonstrate independent familiarity with the physical design and layout of the facility and be able to initiate and complete evacuation of the facility without physical assistance;
(b) The facility design and placement of furnishings are consistent, free of special hazards, and made known to the client especially when changes occur in the facility design or placement of furnishings; and

(c) Prior notice of the admission of such persons must be given to the Department's Office of Licensure.

Authority: *T.C.A. § 33-2-504.* ***Administrative History:*** *Original rule filed May 26, 1988; effective July 11, 1988.*

0940-5-5-.10 SPECIAL REQUIREMENTS FOR RESIDENTIAL FACILITIES SERVING PERSONS WITH HEARING LOSS. The governing body of any residential facility, which is required to admit only persons who are capable of self-preservation and which also admits one or more clients who have a loss of hearing, must ensure than when the sounding of the standard fire alarm is not sufficient in notifying a sleeping client who has a hearing loss of the need to evacuate, must then provide a means of such notification which:

(a) Is independent of personal, physical contact or notification by staff or other persons during sleep;

(b) Provides some mechanical means of sensory notification during sleep;

(c) Is consistent in notifying the resident of the need to evacuate; and

(d) Has the prior approval of the Department's Office of Licensure.

Authority: *T.C.A. § 33-2-504.* ***Administrative History:*** *Original rule filed May 26, 1988; effective July 11, 1988.*

0940-5-5-.11 SPECIAL REQUIREMENTS FOR NON-RESIDENTIAL FACILITIES SERVING PERSONS WITH HEARING LOSS. Non-residential facilities which serve a client with a hearing loss must ensure that the means of notifying the client, which may include personal contact by staff, is consistent, is always available, and has the approval of the Department's Office of Licensure.

Authority: *T.C.A. § 33-2-504.* ***Administrative History:*** *Original rule filed May 26, 1988; effective July 11, 1988.*

RESOURCE 4:

Contracts and Rate Setting

- Basics of Rate-Setting for Parent Peer Support (Power Point)
- Arizona Family Involvement Center Sample Scope of Work
- Arizona Family Involvement Center Encounter Rates

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Basics of Rate-Setting for Parent Peer Support Services by Family-Run Organizations

Presented by
Family Run Executive Director Leadership Association

fredla
family-run executive director leadership association

- May 29, 2014

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Sheila A. Pires
Senior Partner, Human Service Collaborative
Core Partner, Technical Assistance Network for Children's Behavioral Health

BASICS OF RATE-SETTING: OVERARCHING CONSIDERATIONS

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Activities = Costs

All of the activities that go into providing a given service translate to costs for the provider of the service ….but

the Medicaid rate may not encompass all of the activities.

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Relationship between Medicaid Service Definition (Allowable Activities) and Rate

Example: Peer Support

Does the service definition allow for ---
- Telephone time?
- Transportation? Meals? Lodging?
- Documentation time?
- Supervision/coaching?
- Training?

How many hours of service (per day, per week, per month, per year) are allowed?

What are the requirements for who can provide the service? Is training required? Certification?

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Steps to Take

- Understand all of the activities involved in providing a given service
- Cost out the activities (for example, estimate how many hours per week a peer support provider will spend filling out required documentation of the activities performed, multiplied by the rate per hour)
- Know what activities Medicaid will allow/cover
- Know what Medicaid is proposing to pay (or is paying)
- Compare your full costs to what Medicaid is paying (or proposing)

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Implications of How Medicaid Pays

- How payment is structured --
  - 15-minute billing increments
  - Monthly or daily case rate
  - "Per session" rate (with minimum time established per session)
- Is there a yearly cap on what can be billed?
- Is payment through a managed care organization (MCO) or behavioral health managed care organization (BHO)? If so, how much will the MCO/BHO pay and how?

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CREATING A RATE FOR PEER SUPPORT

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How do I design a rate for peer support?

- Revisit the steps outlined previously:
  - Identify all of the activities and which are billable
  - Determine your peer support to supervisor ratio
  - Figure out your personnel structure, not including executive management, who are typically included in indirect costs (except in very small organizations)
  - Document your overhead, administrative, and fixed costs
  - Consider the billing structure and whether there is any flexibility (15 minute versus monthly, ability for telephonic consultation, etc)
- Get out the Excel spreadsheet and start playing with numbers!

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Keep in Mind…

- The rate structure that we are going to walk through is for an *organizational rate*. If you are looking to build a rate for a peer support partner only, without organizational costs, supervision, etc, the construct is going to be simpler and the costs will be lower. This rate structure assumes that the peer support partner is within a family support organization or other agency structure.
- As you have more peer support providers or other individuals providing billable services, you will achieve a certain economy of scale and can spread the infrastructure and overhead costs across more direct staff.
- Be practical and realistic—strive for the best possible, appropriate, and reasonable rate but be mindful of what other providers with similar qualifications are paid within your state.

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Build your rate upon the costs of employing 1 Full-Time Equivalent (FTE) peer support partner.

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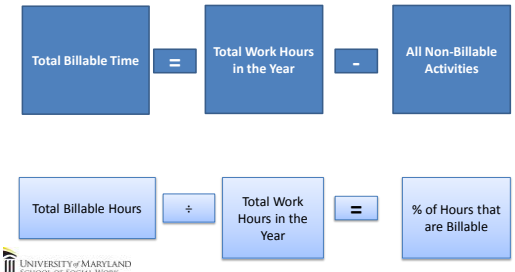
Total Billable Time



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Basic Assumptions
(will vary based on your particular organizational and state requirements)

- 20 days of sick, holiday, and vacation leave per year
- 16 days of training per year
- 44.8 work weeks (after subtracting off sick, holiday, vacation, and training days)
- 8 hour days x 5 days per week x 44.8 weeks = 1792 work hours

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Example of Billable Time Calculation

2080		**Total work hours per year (8 hour day * 260 days)**
-	160	Vacation, sick & holiday leave: 20 days@8 hours per day
-	128	Training: 16 days @8hours per day
1792		**Total Work Hours after Leave & Training**
-		Travel (not with client)
-		Documentation (not with client)
		Total Non-Billable Time
		Total Projected Billable Time
		% Non-Billable

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How much to budget for travel depends on:

- The geographic size of your service area
- Whether you can bill for telephonic peer-to-peer support

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How much to budget for documentation time will depend on:

- Whether you can bill for documentation that is not done in the presence of a client
- The amount of administrative support available to the peer support partners
- The amount of documentation required and the usability of the management information system

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Example of Billable Time Calculation

2080		**Total work hours per year (8 hour day * 260 days)**
-	160	Vacation, sick & holiday leave: 20 days@8 hours per day
-	128	Training: 16 days @8hours per day
1792		**Total Work Hours after Leave & Training**
-	440	Travel (not with client): 10 hours per week *44 weeks
-	260	Documentation (not with client): 1 hour per day * 260 days
988		Total Non-Billable Time
1092		**Total Projected Billable Time**
52.5%		**% Billable**

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Calculating Personnel Costs

- The focus of your rate composition is the peer support partner.
- Assume 1 FTE peer support partner, unless you know otherwise.
- Ideally, use actual costs from your organization or other similar organizations.
- In the absence of actual costs, utilize living or housing wages and profiles of average costs in your geographic area.

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Calculating the Annual Salary Cost for Positions *Other Than* the Peer Support Partner

Annual Salary Cost per 1 FTE Peer Support Partner = **Annual Salary** X **% FTE Per 1 FTE Peer Support Partner**

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Sample Personnel Costs

Personnel	Annual Amount or Rate	%FTE	Salary Cost	Fringe Benefits	Salary + Fringe Cost
Family Support Partner	$39,354	1	$ 39,354		
Family Support Partner Supervisor	$ 50,000	0.10	$ 5,000		
Administrative Assistant	$ 39,354	0.15	$ 5,903		
Billing Support Specialist	$39,354	0.05	$ 1,968		
Administrator	$ 55,000	0.05	$ 2,750		
Total		1.35	$ 54,975		

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Fringe Benefits

- Fringe Benefits can include:
  - FICA/Medicare
  - Retirement
  - Disability insurance
  - Life insurance
  - Unemployment insurance
  - Dental, prescription and health insurance
  - Worker's compensation
- Other costs that may be part of your costs, depending on the size of your organization, are separation leave payments, tuition remission, employee assistance, wellness programs, and other employee benefits.
- Again, use actual costs if you have them. If not, you can use a number like 25% as a proxy cost. If you offer many benefits, you may want to use a higher figure like 30-40%.
- Fringe benefits are calculated as a percent of salary costs
- Most organizations use standardized benefit rates for all employees, regardless of which benefits they take

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Sample Personnel Costs

Personnel	Annual Amount or Rate	%FTE	Salary Cost	**Fringe Benefits @ 25%**	**Salary + Fringe Cost**
Family Support Partner	$39,354	1	$ 39,354	**$ 9,839**	**$49,192.50**
Family Support Partner Supervisor	$50,000	0.10	$ 5,000	**$ 1,250**	**$ 6,250.00**
Administrative Assistant	$ 39,354	0.15	$ 5,903	**$ 1,476**	**$ 7,378.88**
Billing Support Specialist	$ 39,354	0.05	$ 1,968	**$ 492**	**$ 2,459.63**
Administrator	$ 55,000	0.05	$ 2,750	**$ 688**	**$ 3,437.50**
Total		1.35	$ 54,975	**$ 13,744**	**$68,718.50**

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"Other" Costs (aka, everything else!)

- Rent/Office Space Costs (per FTE per year)
- Cellular Phone, Internet & Communications (per FTE per year)
- Mileage
  - Total estimated miles x Privately Owned Vehicle Rate
  - Unless otherwise prescribed, use the U.S. General Services Administration (GSA) rate for operation of a privately owned vehicle (http://www.gsa.gov/portal/content/100715?utm_source=OGP&utm_medium=print-radio&utm_term=mileage&utm_campaign=shortcuts)
  - If you have agency cars available, factor in the cost of maintaining those cars and the cost of gasoline and wear & tear on the vehicle instead of using the GSA POV rate
- Office supplies and maintenance (include any costs for printing, photocopying, fax machine, postage, IT software and equipment, and routine office supplies; per FTE/year)
- Management Information System User Fees (per FTE/year)
- Insurance (general liability, professional liability) per FTE/year

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Personnel	Annual Amount or Rate	%FTE	Salary Cost	**Fringe Benefits @ 25%**	**Salary + Fringe Cost**
Family Support Partner	$39,354	1	$ 39,354	**$ 9,839**	**$49,192.50**
Family Support Partner Supervisor	$50,000	0.10	$ 5,000	**$ 1,250**	**$ 6,250.00**
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Total		1.35	$ 54,975	**$ 13,744**	**$68,718.50**

Except for mileage, costs are based on the total number of FTEs per Peer Support Partner

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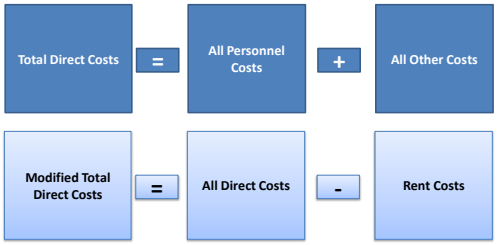
Direct Costs & Modified Total Direct Costs



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Indirect Cost Rate

- Do you have a federally approved indirect cost rate agreement?
- If not, what is the average indirect cost rate that your Medicaid office typically approves?
- If you need to create an indirect cost rate, consider the costs that have not been included in any other line item, including costs for executive administration.
- Often, indirect costs are calculated off of the modified total direct costs. In other situations, it is based on the salary costs or personnel costs only.

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Calculating Indirect Costs

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Total Costs

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Sample Budget for 1 Peer Support Partner

Personnel	Annual Amount or Rate	%FTE	Salary Cost	Fringe Benefits (25%)	Salary + Fringe Cost
Family Support Partner	$ 39,354	1	$ 39,354	$ 9,839	$ 49,192.50
Family Support Partner Supervisor	$ 50,000	0.10	$ 5,000	$ 1,250	$ 6,250.00
Administrative Assistant	$ 39,354	0.15	$ 5,903	$ 1,476	$ 7,378.88
Billing Support Specialist	$ 39,354	0.05	$ 1,968	$ 492	$ 2,459.63
Administrator	$ 55,000	0.05	$ 2,750	$ 688	$ 3,437.50
Total		1.35	$ 54,975	$ 13,744	$ 68,718.50
Other Costs					
Rent ($200/monthper FTEs)					$ 3,240.00
Cellular Phone, Internet & Communications (@$110/month per FTE)					$ 1,782.00
Mileage (10,500 miles per year @ $0.56/mile)					$ 5,880.00
Office supplies and maintenance (incl printing, copier/fax) @ $750 per FTE					$ 1,013
Management Information System User Fees (@$150/FTE)					$ 203
Insurance (general liability, professional liability) @ $1,000 per FTE					$ 1,350
Indirect Cost (7% of modified total direct costs)					$ 5,526
Total Cost FTE					**$ 87,711.69**

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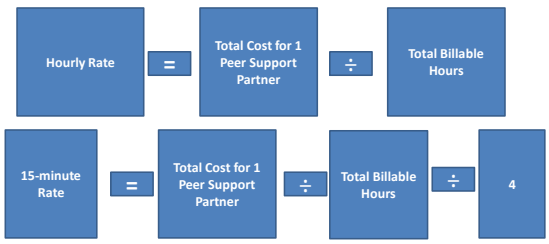
Time to set the rate!



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Sample Rate

Total Projected Billable Time	1092 hours
Total Cost per 1 FTE Peer Support Partner	$ 87,711.69
Hourly Rate	$ 80.32
30-Minute Rate	$ 40.16
15-Minute Rate	$ 20.08

Be ready to negotiate! You may not get the rate you want, but see if you can get a rate that is feasible. (Don't undercut yourself, though!)

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Other Rate-Setting Notes

- Telephonic Rate:
  - If you are able to create a rate for telephonic peer support, consider using a 15-minute rate that is 50% of the standard rate
  - It will be difficult to create a telephonic rate if you have a rate that is in units greater than 1 hour
- If you are creating a daily, weekly, or monthly rate, make sure that you are not just multiplying the hourly rate because that rate factors in non-billable time and it does not consider the number of families on the peer support partner's caseload.

UNIVERSITY of MARYLAND SCHOOL OF SOCIAL WORK

THE TA NETWORK
the technical assistance network for children's behavioral health

Reality Check

State	Medicaid Rate	Medicaid Authorization
Alaska	$17/15 minutes	State Plan Amendment
Arizona	$14.59/15 minutes	State Plan Amendment
Arkansas	$4.25/15 minutes-current $17.23/15 minutes-newly proposed $8.62/15 min-newly proposed telephonic rate	State Plan Amendment
Georgia	$20.78/15-minutes (paid to Organization)	1915(c) PRTF Demonstration Waiver
Indiana	$15/15 minutes	1915(c) PRTF Demonstration Waiver
Kansas	$10/15 minutes (individual) $3/15 minutes (group)	1915(c) HCBS SED Waiver
Massachusetts	$15.42/15 minutes	State Plan Amendment
Michigan	$80/day	1915(c) HCBS SED Waiver & 1915(b) State Plan Amendment
Oklahoma	$9.43/15 minutes	State Plan Amendment

SOURCE: Center for Health Care Strategies. (2012). *Medicaid Financing for Family and Youth Peer Support: A Scan of State Programs.* Technical Assistance Tool. Available from www.chcs.org.

THE TA NETWORK
the technical assistance network for children's behavioral health

Maryland's Reality Check

Medicaid Authorization	Rate	Rate converted into hourly equivalent
1915(c) PRTF Demonstration Waiver Rate	$50/day, for up to 3 hours	$16.60
1915(i) State Plan Amendment (as submitted to CMS 3/14)	**$15.97/15 minutes** **$7.98/15 minutes telephonic rate**	**$63.88** **$31.92**
Individual Therapy provided by an Outpatient Mental Health Clinic	$59.19/30 minutes	$118.38
Individual Therapy provided by other mental health professional	$34.98/30 minutes	$69.96

THE TA NETWORK
the technical assistance network for children's behavioral health

What if you need to make your organization's budget fit an existing rate?

- If you already have a rate and need to figure out the budget for your organization, apply this method backwards.
- Start with the rate and calculate your total anticipated revenue based on billable hours.
- The revenue can then be broken down into personnel and other costs.
- You need to worry more about the caseload and anticipated number of families served if you are working off of a daily, weekly, or monthly rate. If you are working with a 15-minute, 30-minute, or hourly rate, you can use billable hours as the foundation.

UNIVERSITY of MARYLAND SCHOOL OF SOCIAL WORK

1.0 Provider Name:

1.01 Children's Direct Support Provider "DSP"

2.0 Covered Services

2.01 The Provider will provide Support and Rehabilitation Services to children and families, as determined on an individualized basis. In an effort to help them live successfully in the community or return to the community from a higher level of care.

a. Rehabilitation services will include the provision of education, coaching, training, demonstration and other services including securing and maintaining employment. Except for cognitive rehabilitation, which is billed using a CPT code? Rehabilitation services are billed using HCPCS codes. Rehabilitation services include:
   - Skills Training and Development and Psychosocial Rehabilitation Living Skills Training
   - Cognitive Rehabilitation
   - Behavioral Health Prevention/Promotion Education and Medication Training and Support (Health Promotion)
   - Psychoeducational Service (Pre-job Training and job Development) and Ongoing Support to Maintain Employment (Job Coaching and Employment Support)

b. Support services are provided to facilitate the delivery of or enhance the benefit received from other behavioral health services. These services include the following categories:
   - Case Management
   - Personal Care Services
   - Home Care Training Family Services (Family Support)
   - Self-Help/Peer Services (Peer Support)
   - Home Care Training to Home Care Client (HCTC)
   - Unskilled Respite Care

2.1 Professional Standards

2.1.1 The Provider and its subcontractors shall provide services in accordance with the Arizona Vision for Children and the 12 Practice Principles, Nine Guiding Principles for Recovery-Oriented Adult Behavioral Health Services and Systems, Mercy Maricopa Integrated Care (Mercy Maricopa) Provider Manual, the Arizona Department of Health Services/Division of Health Services (ADHS/DBHS) Covered Services Guide, ADHS/DBHS Clinical Guidance Documents, ADHS/DBHS Policy and Procedures Manual, Arizona Healthcare Cost Containment System Medical Policy Manual (AMPM), Arizona Healthcare Cost Containment System Contractor Operational Manual (ACOM), ADHS/DBHS Bureau of Quality & Integration Specifications Manual, Mercy Maricopa Policies and Procedures, and the Mercy Maricopa Collaborative Protocols with System Stakeholders.

2.1.2 The Provider shall meet all ADHS/DBHS requirements for provider eligibility including: licensed by the Division of Licensing Services, registered with the Arizona Health Care Cost Containment System (AHCCCS), and credentialed with Mercy Maricopa. The Provider shall ensure that independent practitioners meet these same requirements.

2.1.3 The Provider shall adhere to all timeliness standards as outlined in the Mercy Maricopa Provider Manual.

2.1.4 The Provider must deliver services when and where the individual needs them within the context of safety for the individual and staff providing the service.

2.1.5 The Provider must maintain complete, accurate, and timely documentation of all delivered **services.**

2.1.6 The Provider must consider the member's language and cultural considerations when providing services.

2.1.7 The Provider will adhere to all cultural competency requirements as outlined in the Mercy Maricopa Provider Manual and Cultural Competency Plan.

2.1.8 The Provider shall encourage family member participation throughout the service planning and treatment processes.

2.1.9 The Provider shall partner with the member to develop an individualized service plan that reflects the member's current strengths, needs and preferences, in accordance with the Mercy Maricopa Provider Manual.

2.1.11 The Provider will train all staff in accordance with the Mercy Maricopa Provider Manual.

2.1.12 Recommended and/or proposed changes to the previously agreed upon scopes of work must be submitted in writing to the PNO for approval. PNOs will submit proposed changes in writing to Mercy Maricopa for final approval.

2.1.13 The Provider shall ensure any reports, community protocols, and advertising materials that contain Mercy Maricopa information are submitted to Mercy Maricopa for approval prior to distribution.

2.1.14 The Provider, in collaboration with Mercy Maricopa, shall develop and maintain relationships with key community constituents, providers, hospitals, stakeholder agencies and community stakeholders to coordinate services and inform them of how to access services and to assess and continuously improve the service delivery system.

2.1.15 The Provider, as requested, shall participate in Mercy Maricopa activities, including, but not limited to network development and quality management initiatives.

2.1.16 The Provider must coordinate benefits with Third Party Liability companies and bill these insurances, as appropriate prior to submitting claims and encounters to Mercy Maricopa.

2.1.17 The Provider shall *have* a sufficient number of qualified staff to deliver, manage and coordinate *service* delivery.

2.1.18 All referrals will be from the referring PNO and/or PNO contracted outpatient provider agency. The provider is responsible to obtain a copy of the referral, the assessment, the Individual Service Plan and additional records that will assist in the coordination of care and *service* delivery.

2.2 **Integrated Health Program Service Requirements**

2.2.1 Mercy Maricopa is dedicated to developing a system that considers the whole person when it comes to accessing healthcare. This includes a focus on a member's behavioral health and physical healthcare needs. With a focus on prevention and wellness, individuals will be screened for Issues that could lead to illness so they can seek treatment early, and services shall be coordinated to promote health and wellbeing.

2.2.2 In collaboration with the CFT, the Provider will coordinate care with AHCCC5 Health Plans, --- -Primary Care Providers and Medicare Providers in- accordance with ADHS/DBH5/ Mercy Maricopa Provider Manual.

2.3 **Program Specific Requirements**

2.3.1 The Provider will utilize a range of services within the following Support and Rehabilitation service codes, and will not limit service provision to one or a few codes when other codes are more appropriate to describe the services requested and provided: H2014, H2014-HQ. H2017, H2025 H0034, H2026, H2027, T1016, T1019, T1020, S5110, H0025, H0038, H0038· HQ. H2016, 55150, 55151, H0043 and CPT Code 97532.

2.3.2 Support and Rehabilitation Services should comprise at least 85% of services provided and case management should be under 15%.

2.3.3 The Provider will have capacity to respond to urgent situations based on individualized family need, not to exceed 24 hours. This includes, but is not limited to, existing children/families and accommodations for immediate needs of new referrals.

2.3.5 The Provider will include, to the extent possible, the participation of at least one **(1)** peer or family member during the interview process when hiring for all direct service staff positions.

2.3.6 The Provider's supervisors and direct support staff will participate in training and meetings as requested by Mercy Maricopa, including at minimum, training in each of the following: overview of support and rehabilitation services; Positive Behavior Support approach; connecting support and rehabilitation services to CFT practice; individualizing support and rehabilitation services; support service provision for specialty populations: and measuring outcomes and transition out of direct support services.

2.3.7 The Provider will provide support and rehabilitation services to children and families in the home and/or community settings and adhere to the following principles:

1) Support services are individualized to each child/youth and family's unique needs and interests
2) Serves all ages of youth, ages 0·17; does not restrict referrals based on age
3) Serves both boys and girls; does not restrict referrals based on gender
4) Serves youth/families in all parts of Maricopa County. Does not reject referrals due to location
5) Provide Services in location of services as identified by the Child and Family Team
6) Provides transportation to and from activities as part of service
7) Willing to transport other family members for activities, when appropriate
8) Have all staff trained on positive behavior support approach
9) Supervises to positive behavior support
10) Individualizes support services for each youth/family; does not use a pre-set program or curriculum for referred individuals (example: living skills curricula, groups, etc.)
11) Training curriculum free from negatives about families
12) Partners with families and provide services based on the individual needs of the child and youth and their family
13) Partners with informal supports and integrates into work; provides them with support and training as needed
14) Connects and collaborates effectively with the CFT
15) Provides purposeful interactions that are tied to a service plan goal that is medically necessary
16) Support Services will focus on children/youth living in the community rather than in institutions or congregate care settings
17) Participates actively in transition planning beginning at intake

3.0 Performance Improvement

3.0.1 The Provider will collaborate with Mercy Maricopa and PNOs in identifying opportunities for improvement and evidence of activities to improve outcomes.

3.0.2 The Provider will participate in the ADHS/DBHS System of Care Practice Review process and implement strategies for improvement as appropriate.

3.0.3 The Provider will support and actively participate in any process improvement initiatives and quality management activities In conjunction with PNOs, ADHS/DBHS, and/or Mercy Maricopa.

3.0.4 The Provider shall comply with audits, inspections and reviews including any reviews conducted by Mercy Maricopa.

3.1 **Performance Measures**

3.1.1 The Provider shall adhere to performance outcome measures developed in collaboration with Mercy Maricopa, PNOs and the Provider.

3.2 **Provider Data and Reporting Requirements**

3.2.1 The Provider will provide written updates on the interventions used and progress toward the ISP objectives to the referring CFT for each CFT or on a minimum of a monthly basis.

3.2.2 The Provider will submit reports as required by Provider Network Organization (PNO), Mercy Maricopa and/or Arizona Department of Health Services.

3.2.3 The Provider will routinely update the PNO on available capacity for accepting new referrals into the program.

3.2.4 The Provider is responsible for updates to Mercy Maricopa's System of Care and Network Development Plan for ADHS/DBHS as requested.

MERCY MARICOPA COMPENSATION EXHIBIT- Contract Year 2014

PROVIDER NAME FAMILY INVOLVEMENT CENTER
TIN 71-0890534

PAYMENT METHODOLOGY:	STANDARD BLOCI<
PROGRAM TYPE:	OUTPATIENT
ENCOUNTER VALUE REQUIREMENT:	100%

Payment For Medically Necessary Covered Services-

Provider must adhere to and perform all services in accordance with Provider's Agreement and Company's Policies and manuals, incorporated here by reference. Mercy Maricopa is purchasing Medically Necessary Covered Services for Eligible and Covered persons as follows:

FUND TYPE	FUNDING PERIOD	AMOUNT
T19- CA/CMDP	4/1/2014 - 9/30/2014	285,504
T19- CA/NONCMDP	4/1/2014- 9/30/2014	554,214
T19- GMH/SA	4/1/2014 - 9/30/2014	-
T19- SMI	4/1/2014 - 9/30/2014	-
T19/T21 DD Adult	4/1/2014 - 9/30/2014	-
T19/T21 DD Child	4/1/2014 - 9/30/2014	-
CMHS-ADULT	4/1/2014 - 6/30/2014	-
CMHS-CHILD	4/1/2014 - 6/30/2014	-
NT-COUNTY	4/1/2014 - 6/30/2014	-
NT-CRISIS	4/1/2014 - 6/30/2014	-
NT-OTHER	4/1/2014 - 6/30/2014	-
NT-SMI	4/1/2014 - 6/30/2014	-
SAPT	4/1/2014 - 6/30/2014	-
GRAND TOTAL		$ **839,718**

SPECIAL NOTES & EXCEPTIONS

Block funding payments will be processed the second full week of the month. All checks will be mailed via standard U.S. mail. Mercy Maricopa reserves the right to charge a special handling fee of $45.00 per check for checks mailed or delivered other than via standard U.S. mail.

Note *- Compensation Exhibits are considered all-inclusive, and therefore replace* ***all prior*** *Compensation Exhibits issued for the same contract year.*

Fee Schedule (2014)

The following items will be required:

Rates Approved by Maricopa County Managed Care Organization 4-1-14

Service Type	Service Code	POS	Units	Rate	Billing Increments
Transportation (per trip)	A0120	99	965	$ 7.55	
Transportation (per mile)	S0215	99	7883		
Counseling: Individual	H0004	53	4		
Counseling: Individual	H0004	12	4		
Counseling: Family (Client prese	H0004	12	69		
Counseling: Family (Client not pr	H0004	53	8		
Counseling: Family (Client not pr	H0004	12	253		
Bx Health Prevention and Promo	H0025	53	6255	$ 31.53	30 min.
Bx Health Prevention and Promo	H0025	12	2	$ 31.53	30 min.
Bx Health Prevention and Promo	H0025	99	15	$ 31.53	30 min.
Peer support (individual)	H0038	53	69	$ 13.39	15 min.
Peer support (individual)	H0038	12	47	$ 22.13	15 min.
Peer support (individual)	H0038	99	43	$ 22.13	15 min.
Peer support (group)	H0038	53	7511	$ 6.76	15 min.
Peer support (group)	H0038	12	321	$ 11.26	15 min.
Peer support (group)	H0038	99	152	$ 11.26	15 min.
Living skills (Individual)	H2014	53	135	$ 15.19	15 min.
Living skills (Individual)	H2014	12	2028	$ 25.17	15 min.
Living skills (Individual)	H2014	99	1155	$ 25.17	15 min.
Living skills (group)	H2014	53	3617	$ 7.59	15 min.
Living skills (group)	H2014	12	263	$ 12.59	15 min.
Living skills (group)	H2014	99	109	$ 12.59	15 min.
Family Support	S5110	53	1012		
Family Support	S5110	12	6789	$ 25.67	15. min.
Family Support	S5110	99	1929	$ 25.67	15 min.
Interpretive Services	T1013	99	5377		
Case Management (BHT)	T1016	53	13442	$ 14.00	15 min.
Case Management (BHT)	T1016	12	6987	$ 24.08	15 min.
Case Management (BHT)	T1016	99	3392	$ 24.08	15 min.
Case Management (BHP)	T1016	53	5	$ 18.50	15 min.

Service Type - general category (e.g. Crisis, Outpatient, Residential, Transportation, etc.)
Service Code - Valid CPT, HCPCS, Rev Code
Modifier - Valid Modifer
POS - Place of Service code
Units - Units billed for a specificied time period (e.g. most recent 6 months)
BHT = Behavioral Health Technician
BP = Behavioral Health Professional (Licensed)

RESOURCE 5:

Documentation

- Arizona Family Involvement Center Record Audit
- Arizona Family Involvement Center Support Plan, Monthly Summary, References for Progress Notes, and Sentence Starters

FAMILY INVOLVEMENT CENTER
INTERNAL EMR AUDIT

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Reviewer Name: _____
Assigned Staff: _____
Client Name: _____
CIS #: _____

Performance Measures	Yes	No	N/A	Comments
Section I: Chart Elements				
Is there a request for Direct Support Provider?	☒	☐	☐	
AHCCCS Eligibility (with TPL Letter when applicable) when accepted?	☒	☐	☐	
Is there documentation that coverage with Medicaid has been verified yearly?	☒	☐	☐	
Is there consent to Treatment (including all signatures)?	☒	☐	☐	Date of meeting is incomplete on page 1
There is documentation of permission to leave detailed VM?	☒	☐	☐	
Is there a current Referring Provider CFT Service Plan(with signatures)?	☒	☐	☐	2 months old
Does the CFT Service Plan include appropriate FIC Services?	☒	☐	☐	
Is there a current Referring Provider Assessment?	☒	☐	☐	
Is the assessment date is defined as the month, day, and year that the assessment was initially signed by a staff member?	☒	☐	☐	
Is the assessment is signed by a BHP within 30 days of the encounter?	☒	☐	☐	
Does the billing diagnosis match the current Assessment?	☒	☐	☐	
Is there a current FIC Support Plan?	☐	☒	☐	
Are the signatures on the Support Plan dated to the plan date?	☐	☒	☐	
Is the Support Plan signed and dated by the recipient/guardian and at least one staff member?	☐	☐	☒	no support plan to sign
Is the Support Plan date defined as the month, day, and year that the recipient/guardian agreed to and signed the service plan?	☐	☐	☒	no support plan to sign
Section II: Documentation Elements				
Is the referral Acceptance notice faxed & uploaded?	☒	☐	☐	
Are all Monthly Summaries faxed & uploaded?	☒	☐	☐	
Is the closure Summary faxed & uploaded?	☒	☐	☐	

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Performance Measures	Yes	No	N/A	Comments
Have requests for missing referring provider documents have been made?	☐	☒	☐	no requests for ISP's documented
Section III: Culturally Competent Services				
Have we identified and provided for the special needs of children and families needing culturally and linguistically appropriate services and support at intake and during all stages of care? (documentation in Spanish and English)	☒	☐	☐	
Is the Support Plan present in English & Spanish?	☐	☐	☒	
Are oral interpretation services documented in client record?	☐	☐	☒	
Section IV: Support Plan Elements				
Is the Support Plan was written under a current assessment?	☐	☐	☒	
Is there documented evidence that services are provided in alignment with the most recent CFT plan?	☐	☐	☒	
Does the record reflect interventions being utilized with youth and family?	☐	☐	☒	
Is there consistent documented evidence that the child is progressing towards achieving their treatment goals?	☐	☐	☒	
If the youth is not progressing, is there evidence that alternative treatment approaches are being considered?	☒	☐	☐	
• Is this being reported to the CFT team?	☒	☐	☐	evidenced by CFT notes of kinship care
Section V: Communication Elements				
Does the provider actively attend and participate in all CFT's either by phone or in person?	☒	☐	☐	
Does the record reflect communication with parents or guardian on a consistent basis? (phone calls, emails, etc.)	☒	☐	☐	
Is there evidence of communication with the Case Manager between CFT meetings? (phone calls, emails, etc.)	☒	☐	☐	
Is there documented (emails, fax coversheets, etc.) evidence that monthly summaries are sent to the referring agency?	☒	☐	☐	
Does the monthly summary reflect progress reported in clinical documentation? (progress notes in alignment with monthly summary documentation)	☒	☐	☐	

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Performance Measures	Yes	No	N/A	Comments
Section VI: Transition Planning Elements				
Does record reflect discussion of transition at the beginning of services?	☐	☒	☐	
Is the length of stay and rationale for services being clearly communicated to the CFT team?	☒	☐	☐	
• Has the team identified when services will end?	☒	☐	☐	baseed on youth movement out of state
Has the provider connected the youth and family to Natural and Informal Supports in his/her community that could eventually replace the need for professional services?	☒	☐	☐	PP made support suggestions in CFT's and visits, services were ended before exploration of all suggestions.
Section VII: PBIS Elements				
Does the provider use a Positive Behavior Support Approach with youth and families?	☒	☐	☐	
• Activities and decisions center around increasing choices for the youth and family and documentation focuses on strengths and positive factors	☒	☐	☐	
• There is a focus on enjoyable activities and involvement rather than simply verbal teaching and verbal interventions.	☐	☐	☒	
• Activities and interactions focus on helping youth and family develop a life full of purpose and meaning	☒	☐	☐	
• Challenging behavior is demystified and broken into small, understandable parts	☒	☐	☐	as well as CFT team memebers to assist with separate parts.
• There is a focus on positive integration with the community	☒	☐	☐	
• The focus is not centered on simply “stopping bad behavior”	☒	☐	☐	
• There is a focus on building a positive reputation for the youth/family and on developing respected roles	☒	☐	☐	
Section VIII: Progress Note Elements				
Does the place of service identified matched the note content?	☒	☐	☐	
Are progress notes are written from the family perspective?	☐	☒	☐	most notes are written from PP perspective of family
Totals	**19**	**3**	**7**	

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Support Service Plan

Child/Youth Name: _____ CIS Number: _____

Parent/Caregiver: _____ Support Worker: _____

Plan Date: _____ Review Date: _____

Individuals at Planning Meeting(s):
Referring Provider Goal:
Plan for discharge:

Need Statement:	
Objective:	
Progress Rating: (Circle one in each column)	**Strengths to achieve this goal:**
Progress Key: / **Desired Measure:** 1- We're trying / 1- We're trying 2- We're getting better / 2- We're getting better 3- We're getting close / 3- We're getting close 4- We've got it / 4- We've got it	

Method & Frequency

Case Management	____ to ____ times a week/month	Individual Counseling	____ to ____ times a week/month
Family Support	____ to ____ times a week/month	Family Counseling, Child Present	____ to ____ times a week/month
Peer Support	____ to ____ times a week/month	Family Counseling, w/out Child Present	____ to ____ times a week/month
BH Promotion	____ to ____ times a week/month	Group Counseling	____ to ____ times a week/month
Group Living Skills	____ to ____ times a week/month	Transportation	____ to ____ times a week/month
Group Peer Support	____ to ____ times a week/month		

Support Service Plan

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Objective:	
Progress Rating: (Circle one in each column)	**Strengths to achieve this goal:**
Progress Key: / **Desired Measure:** 1- We're trying / 1- We're trying 2- We're getting better / 2- We're getting better 3- We're getting close / 3- We're getting close 4- We've got it / 4- We've got it	

Method & Frequency

Case Management	____ to ____ times a week/month	Individual Counseling	____ to ____ times a week/month
Family Support	____ to ____ times a week/month	Family Counseling, Child Present	____ to ____ times a week/month
Peer Support	____ to ____ times a week/month	Family Counseling, w/out Child Present	____ to ____ times a week/month
BH Promotion	____ to ____ times a week/month	Group Counseling	____ to ____ times a week/month
Group Living Skills	____ to ____ times a week/month	Transportation	____ to ____ times a week/month
Group Peer Support	____ to ____ times a week/month		

☐ Yes, I am in agreement with the types and levels of services included in my service plan.

☐ No, I disagree with the types and/or levels of some or all of the services included in my service plan. By checking this box, I will receive the services that I have agreed to receive and may appeal the treatment team's decision to not include all the types and/or levels of services that I have requested.

Signatures (with credentials as applicable)

Parent/Legal Guardian Name (if applicable): _____

Signature: _____ Date: _____

Parent/Legal Guardian Name (if applicable): _____

Signature: _____ Date: _____

Child/Youth Name: _____

Signature: _____ Date: _____

Support Worker: _____

Signature: _____ Date: _____

Job Title/Credentials: _____

Supervisor: _____

Signature: _____ Date: _____

Job Title/Credentials: _____

Behavioral Health Professional Name: _____

Signature: _____ Date: _____

Job Title/Credentials: _____

MONTHLY TREATMENT SUMMARY

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medrecsna@familyinvolvementcenter.org

To: _____

Agency: _____

Fax Number: _____

Re: _____

(Behavioral Health Recipient Name)

CIS Number: _____

Month Ending (month/year): Select Month Select Year

Services provided by the Family Involvement Center: *(Check all that apply)*

☐ Family Support	☐ Group Peer Support	☐ Individual Counseling
☐ Peer Support	☐ Group Living Skills	☐ Group Counseling
☐ Living Skills	☐ Behavioral Health Promotion	☐ Family Counseling with Client
☐ Case Management	☐ Transportation	☐ Family Counseling without Client
☐ Translation	☐ Group Translation	

Brief description of progress towards treatment objective(s)

Objective(s):

Progress towards meeting objectives:

Projected transition/closure date: Select Month Select Year

Progress towards transitioning out of FIC services:

	(Signature on file)	
Staff Print Name	**Signature and Title**	**Date**
Staff Phone Number	**Fax Number**	

QUICK REFERENCES FOR PROGRESS NOTE SERVICES

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medrecs@familyinvolvementcenter.org

PRESCOTT-
8766 E State Route 69, Suite G
Prescott Valley, AZ 86314
(P) 928-379-5077 (F) 928-458-5915
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Service	Description	Examples of Relevant Activities	Key Questions	Who can bill	Important Notes
Treatment Services: Treatment services are provided by or under the supervision of a BHP to reduce symptoms and improve or maintain functioning.					
Counseling **H0004, H0004 HR, H0004 HS, H0004 HQ**	An interactive therapy designed to elicit or clarify presenting and historical information, identify behavioral problems or conflicts, and provide support, education or understanding for the person, group or family to resolve or manage the current problem or conflict and prevent, resolve or manage similar future problems or conflicts.	See Description	1. How did you engage in an interactive therapy to reduce symptoms and improve or maintain functioning? 2. Who was present and where did the session take place?	BHPs or BHTs (**who are approved by the Clinical Director and who receive additional supervision)	- Code varies by where the counseling takes place and who was present -Level 1: no -Level 2&3: yes -HCTC: yes -**Individual** or **Group** -Member Present: not required
Rehabilitation Services: Rehabilitation services include the provision of education, coaching, training, demonstration and other services including securing and maintaining employment to remediate residual or prevent anticipated functional deficits.					
Skills Training **H2014, H2014 HQ; H2017**	Teaching independent living, social, and communication skills to persons and/or their families in order to maximize the person's ability to live and participate in the community and to function independently.	Examples of areas that may be addressed include self-care, household management, social decorum, same- and opposite-sex friendships, avoidance of exploitation, budgeting, recreation, development of social support networks and use of community resources.	1. What living skill related to the objective did you personally teach? 2. How did you personally teach the living skill related to the objective?	BHPs, BHTs, or Para-professionals	- Progress notes should reflect the teaching/learning of a living skill related to the consumer's plan -Level 1: no -Level 2&3: no -HCTC: yes, with override -**Individual** or **Group** -Member Present: required
Behavioral Health Prevention/ Promotion Education **H0025**	Services to a target population to affect knowledge, attitude and/or behavior. Education and training are single or multiple sessions provided to an individual or a group of persons and/or their families related to the enrolled person's treatment plan.	Education and training sessions are usually presented using a standardized curriculum with the purpose of increasing an individual's behavioral knowledge of a health-related topic such as the nature of an illness, relapse and symptom management, medication management, stress management, safe sex practices, HIV education, parenting skills education and healthy lifestyles (e.g., diet, exercise).	1. What Behavioral Health Prevention or Promotion Topic did you teach? 2. How did this help increase the person's knowledge of a health-related topic related to their treatment plan?	BHPs or BHTs, or people who are educators or subject matter experts. This may also include other medical personnel, such as LPNs or RNs who are not allowed to bill independently using CPT codes.	- 30-minute increments -Level 1: no -Level 2&3: no -HCTC: yes -**Group** only -Member Present: not required

QUICK REFERENCES FOR PROGRESS NOTE SERVICES

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Service	Description	Examples of Relevant Activities	Key Questions	Who can bill	Important Notes
Support Services: Support services are provided to facilitate the delivery of or enhance the benefit received from other behavioral health services.					
Case Management **T1016 HO or HN**	A supportive service provided to enhance treatment goals and effectiveness. Notes: -CM does not include administrative functions such as authorization of services and utilization review, time driving, or writing notes and reports. -Multiple provider agencies may bill for this service during the same time period when more than one provider is simultaneously providing a case management service (e.g., a staffing). In addition, more than one individual within the same agency may bill for this service	Assistance in maintaining, monitoring and modifying covered services; Brief telephone or face-to-face interactions with a person, family or other involved party for the purpose of maintaining or enhancing a person's functioning; Assistance in finding necessary resources other than covered services to meet basic needs; Communication and coordination of care; Coordination of care activities related to continuity of care between levels of care (e.g., inpatient to outpatient care) and across multiple services; Outreach and follow-up of crisis contacts and missed appointments; Participation in staffings, case conferences or other meetings with or without the person or his/her family participating	1. How did you coordinate the person's care?	BHPs, BHTs, or paraprofessionals	-Billing is limited to individual providers who are directly involved with service provision to the person -Emails must be about a specific individual, must include a copy of the email, and be billed as POS 11-office -Voice messages must have sufficient documentation justifying a case management service and should be billed as POS 11-office. Leaving a name and number asking for a return call is not sufficient -Level 1: yes -Level 2&3: yes -HCTC: yes -Individual only -Member Present: not required
Family Support **S5110**	A face-to-face interaction with family member(s) directed toward restoration, enhancement, or maintenance of the family functioning to increase the family's ability to effectively interact and care for the person in the home and community.	May involve support activities such as assisting the family to adjust to the person's disability, developing skills to effectively interact and/or manage the person, understanding the causes and treatment of behavioral health issues, understanding and effectively utilizing the system, or planning long term care for the person and the family.	1. How did you interact with a family member to help enhance the family's functioning? 2. How did your interaction with a family member help increase their ability to interact with or care for the person?	BHPs, BHTs, or paraprofessionals	-Work done with the person alone cannot be called family support -Level 1: yes -Level 2&3: yes -HCTC: yes, with override -Individual only -Member Present: not required

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Peer Support **H0038,** **H0038 HQ,** **H2016**	Self-help/peer services are provided by persons who are or have been consumers of the behavioral health system; Self-help/peer services are intended for enrolled persons and/or their families who require greater structure and intensity of services than those available through community-based recovery fellowship groups and who are not yet ready for independent access to community-based recovery groups.	This may involve assistance with more effectively utilizing the service delivery system (e.g., assistance in developing plans of care, identifying needs, accessing supports, partnering with professionals, overcoming service barriers) or understanding and coping with the stressors of the person's disability (e.g., support groups), coaching, role modeling and mentoring.	1. How did you use your knowledge or experiences to help the person (or their family) navigate behavioral health matters?	Must be employed by or contracted with a licensed facility; Self-help/peer services may also be provided by a licensed behavioral health agency using BHPs, BHTs, or Para-professionals	-Level 1: yes -Level 2&3: yes -HCTC: yes -Individual or Group -Member Present: not required
Non-emergency Transportation **S0215,** **S0215 TN,** **A0120,** **A0120 TN**	Transportation services involve the transporting of a person from one place to another to facilitate the receipt of, or benefit from, medically necessary covered behavioral health services, allowing the person to achieve his/her service plan goals. The service may also include the transportation of a person's family/caregiver with or without the presence of the person, if provided for the purposes of carrying out the person's service plan (e.g., counseling, family support, case planning meetings). Urban transports are defined as those originating within the Phoenix or Tucson metropolitan areas. All other transports are defined as rural. Odometer readings (or other RBHA approved documentation methods that clearly and accurately support mileage) are required when billing transportation services.	Transporting persons and/or families who are unable to arrange or pay for their transportation or who do not have access to free transportation in order to access medically necessary covered behavioral health services.	1. Can you identify the pick-up and drop-off locations? 2. What medically necessary covered behavioral health service did you transport to or from?	BHPs, BHTs, or paraprofessionals Must have drivers with valid driver's licenses and any insurance as required by state law.	-Can be done in any vehicle, including personal cars -Report *both* mileage & a base rate -If transporting multiple members, can bill for each enrolled member -Level 1: yes -Level 2&3: yes -HCTC: yes -Individual or Group -Member Present: not required

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Interpretive (Translation) Service Progress Note Reference

Support Code:	Objective:	How support relates to objective / benefits the child:	Client/Family Reaction:	Place:	Start Time:	End Time:
INDIVIDUAL TRANSLATION						
Translation (Provided to an individual or family) **T1013**	Family will receive services in their primary language of Spanish La familia recibira servicios en su idioma natal que es Español.	Translation services were provided to (name of mom /child/ parent /etc) by (name of interpreter) from (name of interpreter's agency,) or (*"Independent Contractor"*, if no agency) to interpret from English to their primary language of Spanish. This service took place on an individual basis. See other progress note for details regarding the service that was provided during this time.	***EXAMPLE:*** *Moderate progress toward objective as evidenced by…being engaged with provider and expressing a desire to meet her goals.*	99- Other	5:00 pm	8:00 pm
Behavioral Health Promotion **H0025**	***EXAMPLE:*** *Parents will gain tools to help them with parenting skills*	***EXAMPLE:*** *Assisted mom in understanding IEP process for her son Timmy. Interpretive services were provided for mom from English to her primary language of Spanish. See other progress note for details regarding the interpretive services.*	***EXAMPLE:*** *Moderate progress toward objective as evidenced by…being engaged with provider and expressing a desire to meet her goals.*	11- Office	5:00 pm	8:00 pm
GROUP TRANSLATION						
Translation (Provided to a Group) **T1013**	Family will receive services in their primary language of Spanish La familia recibira servicios en su idioma natal que es Español.	Translation services were provided to (name of mom /child/ parent /etc) by (name of interpreter) from (name of interpreter's agency,) or (*"Independent Contractor"*, if no agency) to interpret from English to their primary language of Spanish. This service took place in a group setting, for which multiple families received interpreting services. See other progress note for details regarding the service that was provided during this time.	***EXAMPLE:*** *Moderate progress toward objective as evidenced by…being engaged with provider and expressing a desire to meet her goals.*	99- Other	5:00 pm	8:00 pm
Behavioral Health Promotion **H0025**	***EXAMPLE:*** *Parents will gain tools to help them with parenting skills*	***EXAMPLE:*** *The topic taught during this session was _____. This session was designed to help parents learn tools to help them communicate with their children. (Insert details about the group session). Interpretive services were provided for mom from English to her primary language of Spanish. See other progress note for details regarding the interpretive services.*	***EXAMPLE:*** *Moderate progress toward objective as evidenced by…being engaged with provider and expressing a desire to meet her goals.*	11-Office	5:00 pm	8:00 pm

Sentence Starters

Case Management

I coordinated care by assisting ___ in accessing community resources including:
I coordinated care by attending the ____ for the purpose of…
I coordinated care by meeting with ____ to discuss…
I coordinated care by speaking with ____on the phone to discuss…
I coordinated care by connecting the family to natural supports including…

Skills Training

I taught the social skill of making friends by…
I taught the social skill of improving family relationships by…
I taught the social skill of Play and Recreation by…
I taught the social skill of Self-awareness by…
I taught the communication skill of Calm and positive communication by…
I taught the communication skill of Understanding intent by…
I taught the living skill of Household management by…
I taught the living skill of Budgeting by…
I taught the living skill of Self-Care by…
I taught the living skill of Nutrition by…
I taught the living skill of Decision making by…
I taught the living skill of Responsibility by…
I taught the living skill of Planning by…
I taught the living skill of Use of community resources by…

Peer Support

I supported ____ using my experience with…
I helped ____ navigate system issues based on my experience with…

Family Support

I provided family support by assisting ___ to adjust to ___'s challenges by…
I provided family support by assisting ___ to develop skills to effectively interact with ___ by…
I provided family support by assisting ___ to understand the causes and treatment of behavioral health issues by…
I provided family support by assisting ___ to understand and effectively utilize the system by…
I provided family support by assisting ___ in transitional planning for ___ by…

Behavioral Health Promotion

I taught ____ using ____ curriculum for the purpose of…

Personal Care

I provided the personal care service with the support activity of cleaning by…
I provided the personal care service with the support activity of food preparation by…
I provided the personal care service with the support activity of getting ready for ___ (school, bed, work, etc—these activities include bathing, dressing, oral hygiene, etc.) by…

Individual Counseling

I provided individual counseling for ___ by eliciting and/or clarifying presenting and historical information including…
I provided individual counseling for ___ by identifying behavioral challenges and providing support, education, and understanding for ___ regarding…
I provided individual counseling for ___ by identifying conflicts with ___ and providing support, education, and understanding regarding…
I provided individual counseling for ___ by helping resolve ___ (problem/conflict/issue) and offering solutions to prevent this in the future as evidenced by…

Family Counseling

I provided family counseling for ___ by eliciting and/or clarifying presenting and historical information including…
I provided family counseling for ___ by identifying behavioral challenges and providing support, education, and understanding for ___ regarding…
I provided family counseling for ___ by identifying conflicts with ___ and providing support, education, and understanding regarding…
I provided family counseling for ___ by helping resolve ___ (problem/conflict/issue) and offering solutions to prevent this in the future as evidenced by…

Group Counseling

I provided group counseling for ___ by eliciting and/or clarifying presenting and historical information including…
I provided group counseling for ___ by identifying behavioral challenges and providing support, education, and understanding for ___ regarding…
I provided group counseling for ___ by identifying conflicts with ___ and providing support, education, and understanding regarding…
I provided group counseling for ___ by helping resolve ___ (problem/conflict/issue) and offering solutions to prevent this in the future as evidenced by…

RESOURCE 6:

Staff Training and Certification

- Tennessee Voices for Children Job Description, Job Expectation, and Roles
- Organizational Considerations for Training and Certifying Parent Support Providers
- National Certification Commission Parent Support Provider Certification Domains
- Tennessee Family Support Specialist Certification Guidelines, Standards, and Procedures
- Arizona Family Involvement Center Training Descriptions

TENNESSEE VOICES FOR CHILDREN

Tennessee's Federation of Families for Children's Mental Health

JOB DESCRIPTION

Title: Family Support Provider
Immediate Supervisor: Family Connection Supervisor
Program: Family Connection
Salary: $27,500

Qualifications: Minimum of high school diploma – bachelor degree preferred. Family member or caregiver of child with mental health diagnosis. Personal experience with children's mental health issues and in navigating child-serving systems. Non-profit organization experience and work history within child serving systems preferred.

Skills & Knowledge Required:

- Knowledge of the service area and of resources for children with mental health issues.
- Knowledge and personal experience with children who have behavioral disorders.
- Knowledge and experience with the juvenile justice, educational, and other child-serving systems.
- Desire to help and support parents of children with SED, with strong customer service skills.
- Commitment to system of care principles, cultural competency & effective team work.
- Excellent communication, organizational, problem-solving/creative thinking skills.
- Established support system and access to resources.
- Basic computer and writing skills.

Duties & Responsibilities/Principal Activities:

- Assists the family in navigating various child-serving systems and in connecting with resources.
- Assists assigned families in securing both formal & informal supports to meet the family's needs.
- Assists families/caregivers to develop attainable goals that help the child function better in the home, school and community through promoting and modeling system of care.
- Facilitates Child and Family Team (CFT) meetings:
    - Develops agenda with caregiver; lead the meeting if caregiver not willing/ready to do so.
    - Arranges for time and place of meeting.
    - Ensures that CFT and other required paperwork are completed as instructed.
    - Completes and disseminates service plan to team members with their tasks highlighted.
    - Schedules subsequent CFT meetings and provides members with date, time & location.
    - Partners with family/CFT members in identifying and overcoming barriers/service gaps.
- Monitors the progress of the Service Plan as the primary contact person for completion of tasks.
- Assists the family in securing medication management, psychological/psychiatric evals if needed.
- Assists Behavioral Specialist in completing Strengths-Based Assessment and flex fund requests.
- Models and teaches effective advocacy skills, provides caregiver active support and regular visits.
- Other duties and/or tasks as assigned.

Acknowledgement:
I have read and understand this job description, its duties, responsibilities, requirements and principal activities.

Employee Signature Printed Name Date

Care Coordinators

- Responsible for ensuring all phases and activities of the Wraparound Process are done to high quality and fidelity
- Member and family engagement through education
- Completion of Strengths and Culture Discovery in collaboration w/ FSS
- Creation of Child & Family Team (CFT) and scheduling of case conferences/CFT meetings in collaboration with FSS and family members
- Using CFT process, develop and coordinate Individual Service Plan
- Linkage to community resources, clinical services, and natural supports
- Accountable to CFT for communication, quality and fidelity of implementation of Wraparound process
- In consultation with Therapist, ensure Crisis and Safety Plans and Assessment(s) are completed
- Skills building as appropriate
- Team maintenance transition coordination

Clinicians/Therapists

- Complete clinical assessment(s) as needed
- Provide oversight of clinical record
- Therapeutic intervention/ Evidence-based practice
- Participate in and provide consultation to Child & Family team
- Translate clinical jargon for family and CFT
- Active participant on Child & Family Team
- Provide case consultation and/or case supervision to Care Coordinators

Family Support Specialists/Providers

- Provide system navigation and engagement through education and direct support
- Model appropriate collaboration with schools, healthcare providers, and community partners
- Participate in CFTs to assist with the development of individualized, goal-specific service plans
- Help support crisis stabilization
- Assist with monitoring the progress of the individualized service plan
- Model strengths-based approaches and sharing experiences
- In collaboration with Care Coordinator, complete Strengths, Needs and Cultural Discovery and Caregiver Strain Questionnaire
- Assist in identifying informal and formal supports
- Provide direct support to caregivers in carrying out plan strategies
- Link to natural supports and community resources
- Facilitate parent support groups and train family leaders
- Assist with school and court related meetings to support parents in advocacy efforts

Care Coordinator's Activities Leading Up to 1st Child & Family Team Meeting

Referral Received

- Pay attention to the reason for referral.
- Contact FSS and discuss referral.
- Discuss with the FSS potential dates available for first contact.
- Read any documents attached to referral, but remember that the family will tell their own story.

First contact

- The CC and FSS should explain the reason for contact was that a referral was made for Wraparound.
- If the FSS is not assigned or on the initial phone call, the CC should introduce the role of the FSS and inform the family the FSS will also be attending the first meeting.
- This is a good time to begin the 'hard' conversations by stating the reason for referral and putting it on the table right from the beginning.
- Listen to the family's story if they need to talk before the first meeting.
- Provide a brief explanation of Wraparound.
- Set time for first face to face and again remind the family that the CC and FSS will attend.

1st face to face

- This meeting could take a couple hours. Should be broken up into several contacts prior to the first CFT.
- Can take place anywhere the family is comfortable and should be at convenient times for the family.
- Introduce yourself and the FSS.
- Allow the opportunity for the FSS to explain their role and engage the family, if they have not made contact prior to the first meeting.
- The CC and FSS should explain the wraparound process including expectations and committments.
- Gather comprehensive history to create a written family story.
- Discuss reason for referral to continue those 'hard' conversations.
- Develop Family Vision and identify strengths.
- Create an initial crisis/safety plan and address any immediate crisis situations.
- Get any initial paperwork signed.

2nd face to face

- The CC and FSS are doing the following things together with the family:
- Continue to listen to the family's story.
- Get forms or other documents signed.
- Discuss possible team members to include natural suppoprts.
- Set location, time, & day for CFT.
- Talk with the family about the crisis plan & ask is it working?
- Make any changes to crisis plan as necessary.
- Present needs lists.
- Have family prioritize their top 2-3 needs to be presented at the CFT meeting.
- Conduct initial CANS with the family in partnership with the FSS.

Set-up for 1st meeting

- Invite all team members. (Ideal to send Wraparound information with written invitation.)
- Assist the family in setting agenda in partnership with the FSS.
- Prepare family and team members for how the meeting will go -- explain the Wraparound process.
- Write out the initial strengths list, family vision, needs, & crisis plan for discussion at the 1st CFT.
- Prepare to present CANS information for initial meeting.
- The CC and FSS should meet to discuss the 1st CFT to ensure they are both on the same page.

1st Child & Family Team Meeting

- Introductions.
- Provide a brief overview of how the meeting will go and describe Wraparound to team.
- Develop ground rules.
- Share family vision with team and make any changes the family suggests.
- Develop a CFT mission statement.
- Review functional strengths already discovered and add to list -- make sure to include team strengths.
- Identify & prioritize needs -- remember you may not be able to address all needs at the 1st meeting, but need to start with issues related to the referral & crisis plan.
- Brainstorm & choose interventions for the initial needs to be addressed. These interventions should be connected to the strengths.
- Review crisis plan and make any necessary changes.
- Assign tasks.
- Schedule next CFT (once every 30 days).

CC – Care Coordinator
CFT – Child & Family Team
FSS – Family Support Specialist

Family Support Specialist's Activities Leading Up to 1st Child & Family Team Meeting

Referral Received

- Read Referral.
- Discuss referral with the CC.
- Discuss with the CC potential dates available for first contact.
- Read any documents attached to referral, but remember that the family will tell their own story.

First contact

- The FSS, with the CC, should explain the reason for contact was that a referral was made for Wraparound and the FSS should explain Wraparound from a family's perspective.
- Explain the role of the FSS to the family.
- Listen to the family's story and meet all family members.
- Help family to understand Wraparound as a positive opportunity to access what they need.
- Set time for first face to face and again remind the family that the CC and FSS will attend.
- Remember to start a contact sheet for the family and begin documenting all contacts.

1st face to face

- This meeting could take a couple hours. Should be several contacts prior to the first CFT.
- Meet the family in a location and at a time the family feels comfortable.
- Begin to build trust with the family.
- Share personal examples or experiences as appropriate.
- Explore how comfortable the family feels with regard to advocating for themselves and their family to determine how much coaching and support they will need from the FSS.
- Leave written materials for the family including the Wraparound Handbook for Families.
- Answer any questions after going through handbook.
- Participate in discussions around crisis stabilization ensuring the plan is individualized & realistic for the family.
- Invite the family to support groups & other organized activities.

2nd face to face

- Share resources in the community that may be able to provide necessities the family needs (i.e. foodbanks, respite, shelter, clothing).
- Decrease anxieties and worries of the family by sharing how you survived stressful experiences.
- Help the family think through their strengths, needs, and vision so they are prepared to share with team members.
- Help the family talk about sensitive issues and manage thier emotions so the conversation remains respectful and constructive.
- Ask the family if they need support with any school or court issues or mental health appointments.

Set-up for 1st meeting

- FSS works with the CC to summarize needs, strengths, and vision of the family.
- By spending time with the family, the FSS becomes aware of individuals who provide support for the family who could be members of the team.
- The family may ask the FSS to help them invite individuals to the team.
- FSS, using family stories to illustrate, acts as a bridge builder to encourage collaboration between the family and team members.
- Ensure CFTs are scheduled and held at locations and times comfortable for the family.
- FSS, along with the CC, sends out meeting notices and reminders.
- FSS works with family and the CC to set the agenda for the first CFT.
- FSS discusses with the family where they would like the FSS to sit during the 1st CFT (i.e. beside them, across from them, so they can see the FSS, etc.).

1st Child & Family Team Meeting

- Offer support to the family to participate in making ground rules, expressing their strengths, vision, and needs.
- Help the family to say "no" to suggestions they don't feel will work for them.
- Help the family contribute to the development of strategies that are relevant to them.
- Ensure the family's perspective is recognized by asking the family questions during the CFT.
- The FSS helps other team members understand the family's perspective.
- Review the initial plan with the family to ensure the family understands it.
- FSS agrees to complete tasks as appropriate for their role.
- Assists the family in creating tracking sheets to report back to the team the progress made toward achieving their outcomes.

CC – Care Coordinator
CFT – Child & Family Team
FSS – Family Support Specialist

Family Connection

Title: Family Support Provider

Program Requirements:

1. Full-time case Load requirement: 14-16 clients
2. Client visits: 1-2 face-to-face visit per week per client as applicable
3. While we encourage all employees to utilize the resources for concurrent documentation; all client related documentation is required to be entered into Qualifacts within 72 business hours
4. SNCD completed within 60 days of enrollment
5. CFTM Scheduled every 30 to 60 days
6. ISP updated with each CFTM
7. All required documents uploaded into QF document library for each client (as applicable):
    a. Diagnosis
    b. Intake Paperwork/Referral Form
    c. Informed Consent Form
    d. Consumer Rights
    e. Notice of Privacy Practices
    f. Releases of Information
    g. Grievance Statement
    h. Caregiver Strain Questionnaire
    i. Assessments/Psychological
    j. Court Orders
    k. Permanency Plans
    l. Other Agency CFTM's
    m. IEP or School Records

Additional Expectations:

1. Tentative schedules are to be documented in QF no later than Monday at 10am for the current week.
2. Timesheets will be due no later than Mondays at 8am of a pay week (bi-weekly).
3. Mileage and all supporting documentation are due no later than COB on the 5th of each month.
4. Advances and all supporting documentation are due the next business day after a trip return.
5. Employee will contact supervisor via email, text or phone when calling out sick or more than 15min late.
6. Employee will meet twice monthly for supervision (1 individual meeting and 1 team meeting).
7. Employee will meet once monthly for Team meeting.
8. Networking Database entries will be entered within 72 hrs. of the event
9. Employee will update the Relias Training Log and a copy of training certificates will be scanned and uploaded into the Relias system monthly.
10. Employees need to have thorough working knowledge of all agency policies documented in the Policy and Procedure manual and seek guidance from HR when questions arise.
11. When asked for media statements, letters of support, employment references and other TVC agency statements, employees will refer to the media policy as well as the directing requests to the leadership team.

I have read and understood the requirements of my position within Family Connection.

_____ _____ _____

Employee Signature *Supervisor Signature* *Date*

ORGANIZATIONAL CONSIDERATIONS FOR TRAINING AND CERTIFYING PARENT SUPPORT PROVIDERS

National Federation of Families for Children's Mental Health

Sandra Spencer, B.S., Executive Director
Lynda Gargan, Ph.D., Senior Managing Director
Director, National Parent Support Partner Certification Initiative
240-406-1490
www.fcmh.org

POLLING QUESTION

My role can best be described as *(choose one)*

____ National level planner/administrator/policy maker
____ State level planner/administrator/policy maker
____ Community level planner/administrator/policy maker
____ Family/youth organization
____ Advocate
____ Parent/Caregiver
____ Service Provider
____ Researcher/Academician

WHAT IS A PARENT SUPPORT PROVIDER?

PARENT SUPPORT PROVIDERS (PSPs) ARE PRIMARY CAREGIVERS WHO HAVE THE "LIVED EXPERIENCE" OF BEING ACTIVELY INVOLVED IN RAISING A CHILD WHO EXPERIENCES EMOTIONAL, DEVELOPMENTAL, BEHAVIORAL, SUBSTANCE USE, OR MENTAL HEALTH CHALLENGES. PSPs HAVE EXPERIENCE NAVIGATING CHILD-SERVING SYSTEMS TO ACCESS SERVICES AND SUPPORTS. PSPs HAVE RECEIVED SPECIALIZED TRAINING TO ASSIST AND EMPOWER OTHER FAMILIES WHO ARE RAISING CHILDREN WITH SIMILAR EXPERIENCES.

A QUICK HISTORY OF THE PSP INITIATIVE

2007 Collection and Analyses of Job Descriptions from Across the Field
2010 Competencies Established via a Consensus Process
2010 DACUM Job Task Analysis Completed
2012 Pilot Certification Exam Launched

CURRENT STATUS OF PARENT SUPPORT PROVIDER NATIONAL CERTIFICATION

- **189 Individuals Currently Hold National PSP Certification**
- **35 States and the District of Columbia are Utilizing Nationally Certified Parent Support Providers**

ELIGIBILITY CRITERIA

Parent Support Providers must have the *Lived Experience* of parenting a child who has experienced social, emotional and/or behavioral challenges

ADDITIONAL ELIGIBILITY CRITERIA

- ✓ 8 Contact Hours of Training in Each of the 11 Competency Domains or Equivalent On-the-Job Training (total 88 hour minimum)
- ✓ 1000 Hours of Experience Performing Parent Support Tasks (paid or unpaid)
- ✓ Agreement to Abide by the Code of Ethics
- ✓ A Passing Score on the National Examination

FAMILY-DRIVEN

Family-driven means families have a primary decision making role in the care of their own children as well as the policies and procedures governing care for all children in their community, state, tribe, territory and nation. This includes:

- ✓ Choosing supports, services, and providers;
- ✓ Setting goals;
- ✓ Designing and implementing programs;
- ✓ Monitoring outcomes;
- ✓ Partnering in funding decisions; and
- ✓ Determining the effectiveness of all efforts to promote the mental health and well being of children and youth

YOUTH GUIDED

Youth guided means that young people have the right to be empowered, educated, and given a decision making role in the care of their own lives as well as the policies and procedures governing care for all youth in the community, state and nation. This includes giving young people a sustainable voice and then listening to that voice.

PERSON CENTERED

Person-centered planning is a process, directed by the family or the individual with long term care needs, intended to identify the strengths, capacities, preferences, needs and desired outcomes of the individual. The family or individual directs the family or person-centered planning process. The process includes participants freely chosen by the family or individual who are able to serve as important contributors. The family or participants in the person-centered planning process enables and assists the individual to identify and access a personalized mix of paid and non-paid services and supports that will assist him/her to achieve personally-defined outcomes in the most inclusive community setting. The individual identifies planning goals to achieve these personal outcomes in collaboration with those that the individual has identified, including medical and professional staff. The identified personally-defined outcomes and the training supports, therapies, treatments, and or other services the individual is to receive to achieve those outcomes becomes part of the plan of care.

SELF-DETERMINATION

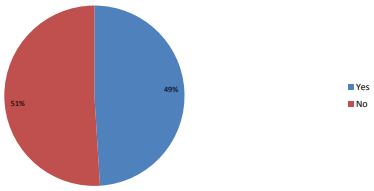
Self-determination and self-direction are the foundations for recovery as individuals define their on goals and design their unique path(s) towards these goals. Individuals optimize their autonomy and independence to the greatest extent possible by leading, controlling and exercising choice over the services and supports that assist their recovery and resilience. In doing so, they are empowered and provided the resources to make informed decisions, initiate recovery, build on their strengths and gain or regain control over their lives.

MEDICAID AND PEER SUPPORT

- ➢ Peer Support Services are now included in the Medicaid State Plans of 32 States, many as part of the Rehab Option. These services for many states cover adults only. In May, 2013, a joint CMS/SAMHSA Bulletin was released that confirmed the inclusion of families and youth in the definition of "Peer".

http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Downloads/Clarifying-Guidance-Support-Policy.pdf

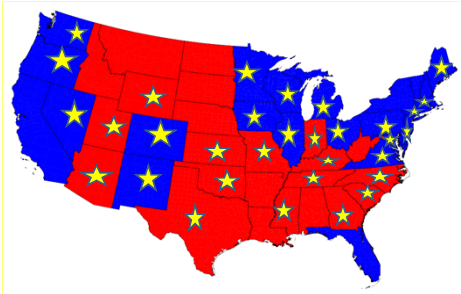
IS YOUR STATE UTILIZING MEDICAID FUNDS FOR PARENT SUPPORT PROVIDER SERVICES?



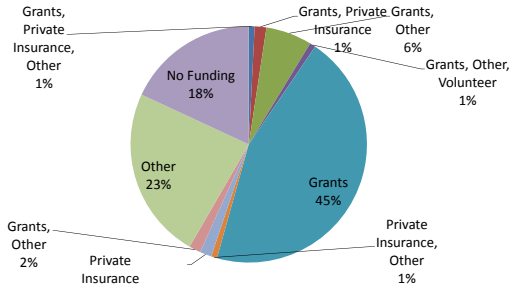
CURRENT STATES WITH PEER SUPPORT INCLUDED IN THEIR MEDICAID STATE PLAN

- Alaska
- Arizona
- Colorado
- Connecticut
- District of Columbia
- Georgia
- Illinois
- Indiana
- Iowa
- Kansas
- Kentucky
- Maine
- Massachusetts
- Michigan
- Minnesota
- Mississippi
- Missouri
- Nevada
- New Jersey
- New Mexico
- North Carolina
- Ohio
- Oklahoma
- Oregon
- Pennsylvania
- South Carolina
- Tennessee
- Texas
- Utah
- Virginia
- Washington
- Wisconsin
- Wyoming

PEER SUPPORT IS BIPARTISAN



CURRENT FUNDING SOURCES



POLLING QUESTION

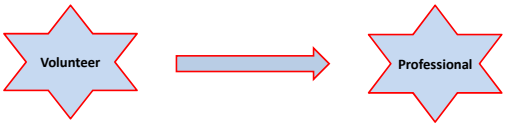
Are Parent Support Provider services funded in your state *(choose all that apply)*

___ Yes, Medicaid funding only
___ Yes, Medicaid, and grant funding
___ Yes, grant funding only
___ No
____ Other *(please specify)*

WORKFORCE OPPORTUNITIES

In a June, 2012 joint SAMHSA/HSRA Working Session, Administrators Hyde and Wakefield placed a strong emphasis on the need to develop and sustain a nontraditional workforce.

EVOLVING ROLE OF PARENT SUPPORT PROVIDERS



Informal Supports

Formal Supports

HOW ARE PSPs EMBEDDED IN THE MENTAL HEALTH SYSTEM?

- Parent Support Providers are Utilized Within:
  - ❖ Schools
  - ❖ Clinics
  - ❖ Mobile Crisis Teams
  - ❖ Intensive In-Home Teams
  - ❖ Courts

ORGANIZATIONAL STRATEGIES

- ✓ Create a Vision
- ✓ Conduct an Environmental Scan
- ✓ Conduct an organizational self-assessment
- ✓ Create a Plan
- ✓ Implement the Plan

TO BE RESOLVED……

Creating vs. Adapting a Model: While many models for adult Peer Supports are available, the models for family support are emerging. "Family" support differs from "Adult" support and states/organizations will need to address these differences as they begin to develop their model.

CREATING THE VISION

Identify key stakeholders to participate in a consensus building process to develop a vision of the Parent Support services that your organization wants to provide

CONDUCTING AN ENVIRONMENTAL SCAN

- Learn what others are doing in your community, your state, and across the nation
- Learn how other organizations have implemented PSP services. Is your community saturated with PSP services or are there none in existence?

ORGANIZATIONAL SELF-ASSESSMENT

- Do the organization's vision, mission and philosophy statements reflect the principles of family-driven, youth-guided, person-centered and self-determined supports?
- Does the organization promote professional-family partnerships with the parents of the children it serves?
- Does the organization staff's language and actions communicate the acknowledgement that parents want what is best for their children and that their experience should be highly valued?
- Do the organization's leaders model collaboration with children and youth and their families?

ORGANIZATIONAL SELF-ASSESSMENT CONTINUED

- Are the organization's policies, programs and staff practices consistent with a family-driven, youth-guided, and person-centered approach?
- Are family members encouraged to review their children's records and work with staff to correct inaccuracies?
- Are professionals committed to providing practical information to parents and youth in order for them to give informed consent regarding services and supports?
- Would it be evident to visitors that the organization places a high value on balanced, respectful relationships with children, youth, and their families?

IMPORTANT CAVEAT FOR ADVOCACY ORGANIZATIONS

If the organization is contemplating expanding from advocacy to becoming a provider of reimbursed services, it is extremely important to take a cultural pulse and ensure that your organization is fully prepared for this evolution.

TEAM SELF-ASSESSMENT

As an organization plans to provide PSP services, these questions are extremely important to discuss with all team members to ensure that healthy relationships will evolve.

- Do I believe that children, youth and their families bring unique perspectives and expertise to the clinical relationship?
- Do I encourage children, youth and their families to speak freely?
- Do I listen respectfully to the opinions of children, youth and their families?
- Do I encourage children, youth and their families to participate in decision-making about the planning and evaluation of services and supports?
- Do I encourage children, youth and their families to be active partners in assuring the quality of services and supports?

CREATE A PLAN

Once important information has been analyzed and assimilated, create a plan that will work for your organization and that ensures the organization's best chances for success.

PLAN YOUR WORK AND WORK YOUR PLAN!!!

IMPLEMENTATION OF PLAN

- Establish a training curriculum
- Develop a supervision schedule
- Develop an outcome database
- Ensure appropriate administrative support (liability insurance, equipment, etc)
- Develop an outreach strategy
- Create a CQI process

UNIQUE CONSIDERATIONS WHEN PROVIDING PSP SERVICES

PSPs often utilize the same services and supports for their own children that are used by the parents they are helping. This raises a number of logistical concerns. These concerns are generally procedural and should be discussed and resolved.

- How can the privacy of the children, youth and other family members of the PSP be protected?
- Will the PSP with a behavioral health challenge be treated similarly than a clinician who also has behavioral health challenges?
- Can co-workers socialize with a PSP in the same manner they socialize with other co-workers since they, their child, or their family member might become recipients of services and supports from the agency?

ADDITIONAL UNIQUE CONSIDERATIONS

PSPs come from all types of backgrounds. They have common competencies and experiences as parents and caregivers. Some have very minimal formal education but have extensive experience in coordinating services and supports for their children. Some have advanced degrees. Some have their own emotional, behavioral or mental health challenges.

COMMON QUESTIONS FROM CO-WORKERS

- Will they have a relapse?
- Will they keep information confidential?
- Will they have the same access to information as clinical staff or other team members?
- Will they respect professional and personal boundaries?
- Are they considered colleagues?

ENCOURAGE HONEST, THOUGHTFUL CONVERSATIONS

SUMMARY

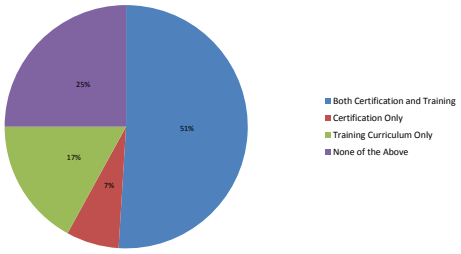
Through careful planning, honest discussion, and meticulous execution, organizations enhance their chances for successful outcomes as Parent Support Provider services are implemented.

Anticipate questions, particularly if the organization has not previously provided peer support services. Through meaningful discussions, the organizational culture will strengthen and evolve.

MEDICAID AND CERTIFICATION

Medicaid requires that a certification process must be in place if Peer Support Services are reimbursed. While many states have a certification process for adults, many have not yet created a certification process for families.

Does Your State/Organization have a Certification and/or Training for Parent Peer Support?



HOW DO CERTIFICATE PROGRAMS AND CERTIFICATION DIFFER?

CRITERIA	CERTIFICATE PROGRAM	CERTIFICATION
ELIGIBILITY	Willingness to attend a training program. Typically open to both novice and experienced individuals	Typically includes educational/experiential requirements including work experience
PROGRAM FOCUS	Assessment of skills learned in a specific training venue focused upon a set of learning objectives.	Assessment of skills, knowledge, and/or competencies required for successful performance of a professional role.
PROGRAM CONTENT	Content may include knowledge, skills, or competencies related to an occupational or professional role or general interest or leisure pursuits.	The knowledge, skills, and competencies of a specific occupational or professional role are the focus and are identified through a formal study by a third party of experts.
AWARD	Indicates completion of a course or series of courses with a specific focus	Indicates mastery/competency as measured against a defensible set of standards, usually by application and/or exam
RECERTIFICATION REQUIREMENT	May or may not require recertification. Certificates typically do not include time limits.	Recertification is required on a prescribed timeline and typically includes educational and/or experiential requirements.

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TRAINING PLAN

- **Identify External Requirements (Accreditation, Medicaid, State, etc.)**
- **Identify Organizational Requirements**
- **Invest in Conversations with Key Stakeholders to Build Consensus About Core Competencies**
- **Review Available Training Curriculums… Don't Spend Time Recreating the Wheel!**

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ELIGIBILITY CRITERIA

Parent Support Providers must have the *Lived Experience* of parenting a child who has experienced social, emotional and/or behavioral challenges

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POLLING QUESTION

Is "Lived Experience" a requirement for Peer Support Providers in your state/organization?

____ Yes
____ No
____ I'm not sure

EXPERIENCE IS NOT UNIVERSAL

EFFECTIVE PARENT SUPPORT PROVIDERS UNDERSTAND THAT EVERY FAMILY IS UNIQUE AND THAT THE CULTURE, BELIEFS, AND EXPERIENCES OF EACH FAMILY MUST BE RESPECTED.

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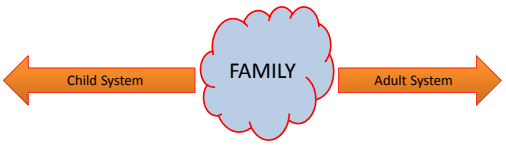
A FAMILY'S ROLE CHANGES AS THEIR CHILDREN TRANSITION INTO ADULTHOOD



PARENT SUPPORT PROVIDERS MUST EVOLVE WITH THE FAMILY

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WHAT ARE THE CHARACTERISTICS OF AN EFFECTIVE PARENT SUPPORT PROVIDER

Great Question!!

- EFFECTIVE LISTENING SKILLS
- COLLABORATIVE
- ADAPTABLE
- NON-JUDGEMENTAL
- RESOURCEFUL, CREATIVE
- RESPECTFUL
- CONFIDENTIAL
- POSITIVE PROBLEM SOLVER

ELEVEN DOMAINS OF COMPETENCE

1. Ethics
2. Confidentiality
3. Effecting Change
4. Behavioral Health
5. Education
6. Communication
7. Parenting for Resiliency
8. Advocacy
9. Empowerment
10. Wellness and Natural Supports
11. Local Resources

SUPERVISION PLAN

Supervision plans should include the following 3 elements:

- Peer to peer
- Clinical
- Team

SUMMARY

Training and supervision are extremely important elements in the support of Parent Support Providers. Through the creation of core competencies, intertwined with unique characteristics, an organization can enhance the likelihood of excellent outcomes for their PSP services.

Lived experience is the benchmark for selecting PSPs however, there are many other characteristics that must be considered to ensure success.

Certification: Readiness for Family-Run Organizations

Presented by: Family-Run Executive Director Leadership Association (FREDLA)

Georgetown Training Institutes 2014

FREDLA…Who We Are

- New National Organization – formed in 2013
- TA Network Partner
- FREDLA seeks to strengthen the leadership and organizational capacity of Family-Run Organizations focused on the wellbeing of children and youth with mental health, emotional, or behavioral challenges and their families

FREDLA…What We Do

- Develop & offer professional development opportunities
- Promote the role of Family-Run Organizations
- Establish an evidence base for the work of Family-Run Organizations
- Create a national voice for Family-Run Organizations on relevant issues

Certification: Key Areas of Consideration

- State vs. National
- Separate vs. Combined
- Role of Family Run Organization
- Continuous Quality Improvement
- Finance Mechanisms
- Lived Experience

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National or State Based

- Will our Certification Model be State Based or will we use the National Certification Initiative?
- If we design a state based model, will it align with the core competencies of the National Certification Initiative?
- If we use the National Certification Initiative, what additional components, if any, will we need to develop?
- Do we have current staff who would be eligible to pursue certification if we chose National Certification?
- If not, would a state based model be an advantage?

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Parent Support Provider Certification Survey

- In May, FREDLA conducted a survey of statewide family-run organizations in preparation for a webinar titled: Parent Support Provider Certification: National & State Opt
- 42 states opened the survey with 39 providing responses

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Survey Results…

- Approximately 25 family-run organizations responded to the full survey
- Of those responding, most indicated they are in the early developmental stages of creating a Parent Support Provider certification model
- The majority of family-run organizations responding indicated they are struggling with numerous issues affecting implementation

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National or State-Based…

- 31 states have a model or are in the process of developing a model
- 25 of those indicate they are utilizing or are developing a state based model

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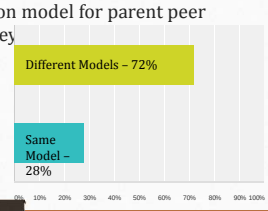
Separate vs. Combined

- Will the certification model we select be the same as that used for adult peer support providers or different?
- If we choose the same model, will there be a need for additional specialized training for parent peer support providers?
- If additional specialized training is needed, would a separate model be an advantage?
- If we choose the same model, will this meet any state requirements for certification?

Separate Certification Models

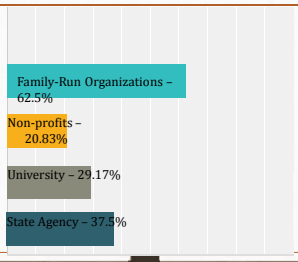
- Over 25% of those states responding indicated they use the same certification model for parent peer support providers as they



Role of Family Run Organizations - Trainers

- Who will be the training body for Certification in your state?
- Does the family run organization want to be the Training Body?
- If the family run organization is the Training Body, can they also be:
  - Certification Body?
  - Providers of Parent Peer Support?

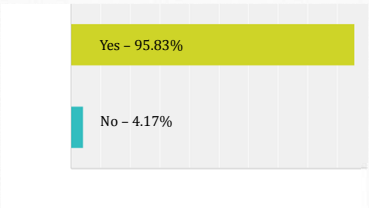
Training of Parent Peer Support Providers…



Lived Experience

- Peer: a person who belongs to the same age group or social group as someone else
- Value
  - Unique Connection
  - Shared language
  - Empathy vs. Sympathy
  - Trust

Lived Experience…



Role of Family Run Organizations – Certification Body

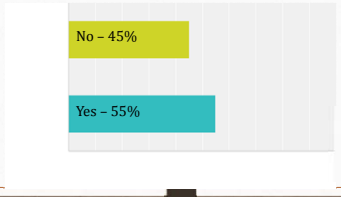
- Who will serve as the Certification Body in your state?
- Does the family run organization want to serve as the Certification Body?
- If the family run organization is the Certification Body, can they be:
  - Trainers?
  - Providers?

Certification Requirements

- 70% of the states responding require m
  40 hours of training to become certified
- 80% have no minimum requirement of
  providing parent peer support services
  seeking certification

Exam to Certify…

- Approximately half of states are requiring a written exam to become certified



Finance Mechanisms

- Will there be a cost for certification?
- If so, who will be responsible for paying the cost?
- Once providers receive certification, how will these positions be funded?
  - Grant dollars
  - State funds
  - Medicaid
  - Private foundations

Certification Cost…

- 65% of states have no cost for certification
- 60% of the states who charge have a fee of more than $200
- The state is the most common source of payment for states who have a charge

Role of Family Run Organization - Provider

- Who will employ the Parent Peer Support Providers in your state?
- Does the family run organization want to be a provider of Parent Peer Support services?
- If the family run organization serves as an employer & provider, can they be:
  - Trainers?
  - Certification Body?

Employment…

- 91% of states have agencies other th
  Family-Run Organization employing
  Parent Support Providers

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Continuous Quality Improvement

- What quality controls will exist in your certification model?
- How will you ensure fidelity to the model?
- How will providers be supervised?
- What will be required to maintain certification?
- Will providers be required to re-certify?
- How will you ensure lived experience?
- How will you evaluate the efficacy of Parent Peer Support services?
- What role will the family run organization play in continuous quality improvement efforts?

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Families Together in New York State

Families Together in NYS

Families Together is a non-profit, family-run organization that strives to establish a unified voice for families of children and youth with social, emotional and behavioral challenges. Our mission is to ensure that every family has access to needed information, support, and services.

New York Family Peer Advocate Credential

Credentialing Agency: Families Together in NYS, Inc.

Endorsed and Supported by: NYS Office of Mental Health

Academic Partners: NYU Child Study Center and the NYU McSilver Institute

Family Peer Support Services: Common definition but no single program or fiscal model. Uneven development.

Advocates: 230 of approximately 400 have the FPA Credential

Requirement: HCBS waiver, state-operated inpatient, residential programs, and proposed for all Medicaid

FPSS Funding: Varies. MMC for children in 2016

New York State FPA Credential Requirements At-A-Glance*	
Lived Experience	Applicants must be the parent (foster, adoptive, or biological) or primary caregiver of a child or adolescent with a serious social, emotional, behavioral, mental health or developmental disability (with onset prior to the age of 18).
Age	Applicants must be at least 18 years of age.
Education	HS diploma or GED (In exceptional cases, documentation of comparable skills may be accepted.)
Training and Continuing Education	Successful completion of Parent Empowerment Program (PEP) training. 40 hour training plus 12 consultation calls. Training delivered by Family Partner and Clinical Partner. Three-year renewal requires 30 hours of continuing education.
Work or Formal Volunteer Experience	1000 hours (six months full-time or one year half-time) documented service providing peer-to-peer family support and advocacy services to other parents/caregivers in either a paid or 'formal' volunteer capacity.
Complete Application	Including: ▪ Supervisor's Letter of Recommendation ▪ Two Additional Letters of Recommendation ▪ Signed Family Peer Advocate Code of Ethics ▪ Statement of Lived Experience ▪ Resume ▪ Completed Professional Development Plan

New York Family Peer Advocate Credential

- Based on emerging consensus about the FPSS model and core competencies
- Family-run organization + state agency + academic partners
- Strike a balance between rigor and feasibility
- Commitment to evolving the profession and FPA Credential based on data, reflection and ongoing feedback from families, advocates, funders and other partners.


Keys to Success
Partner with State Agencies
Build Consensus Early
Provide Ongoing Professional Development Opportunities
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Keys to Success
Role Clarification
Parent Support Provider
Supervisor
Evaluate Outcomes
Provide Ongoing Education Opportunities for Partner Agencies
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Certification of Parent Support Providers

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1

What is Certification?

- Adherence to a set of standards of practice in ten domains of core competencies
- Adherence to a Code of Ethics
- On-going training requirement for re-certification
- Required peer supervision

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Parent Support Providers Core Principle and Definition

This is **not** a clinical service.

It is a peer-to-peer service.

- The Parent Support Provider is a peer of the parent that is being supported. Their relationship is based on the sharing their own parenting or "lived experience".
- For purposes of certification in the field of parent support in children's mental health, "parent" in "parent support" means:

A person who is parenting or has parented a child experiencing emotional, behavioral or mental health disorders and can articulate the understanding of their experience with another parent or family member. This person may be a birth parent, adoptive parent, family member standing in for an absent parent or a person chosen by the family or youth to have the role of parent.

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Parent Support Provider Service Definition

- The focus of the service is on empowering parents and caregivers to parent and advocate for their child/youth with emotional, mental or behavioral health related disorders or challenges
- The scope of the service involves assisting and supporting family members to navigate through multiple agencies and human service systems (e.g. basic needs, health, behavioral health, education, social services, etc).
- It is strength-based and established on mutual learning from common lived experience and coaching that
  - promotes wellness, trust and hope
  - increases communication and informed decision making and self-determination
  - identifies and develops advocacy skills
  - increases access to community resources and the use of formal and natural supports
  - reduces the isolation that family members experience and the stigma of emotional, behavioral and mental health disorders

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Domains of Competency

1. Ethics
2. Confidentiality
3. Effecting Change
4. Behavioral Health
5. Education
1. Communication
2. Parenting for Resiliency
3. Advocacy
4. Empowerment
5. Wellness and Natural Supports

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Ethics

- Cultural and linguistic competency
- Peer to peer principles (family-driven, youth-guided, consumer driven)
- Compliance with laws and regulations
- Duty to do no harm
- Responsibility to remain current in the field
- Responsibility as a certificant
- Principles of non-exploitation

Confidentiality

- HIPAA, IDEA, 42 CFR
- Inter agency protocols (ROI, MOA, MOU)
- Understanding conflict of interest
- Teaching family members about confidentiality
- Child/adult protection, juvenile justice and criminal prosecution related issues
- Duty to warn and domestic violence issues

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IDEA and Other Education Information

- Timelines, procedures and regulations
- Resources for parents
- Communicating written goals and outcomes
- Working with enforceable regulations
- Mediation
- Pre-teaching effective meeting skills to parents and youth

Currency on Children's Behavioral Health Prevention and Treatment

- Diagnoses and assessments
- Medication
- Treatment – EBP, PBE and other practices
- Finding and summarizing research and published literature
- Addressing complex health information

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Effecting Change

- Preparing adults for the decision-making process and behavior change
- Supporting opportunities for self-efficacy
- Using conflict and discrepancy for decision-making
- Finding and using psycho-educational material
- Use of support groups

Communication

- Understanding cultural/linguistic diversity
- Using distance communication technology
- Translating & assisting adults to communicate emotions
- Assisting adults with assertive communication
- Mediation techniques
- Informed and shared decision making

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Parenting for Resiliency

- Identifying culture, family and individual values
- Physical and emotional development of children and youth
- Use of control, choices and consequences
- Shared decision-making
- Crisis planning and intervention
- Transition to adulthood skills

Advocacy in and Across Systems

- People-first, strength-based language and approach
- Understanding the mission and tasks of service systems for children
- Understanding funding streams of services
- Mediation techniques
- Organizational behavior and decision-making

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Empowerment

- Implementation of consumer/family-driven and youth-guided approach
- Promotion of self-determination
- Teaching self-assessment and goal setting
- Understanding stigma
- Bridge building and group leadership
- Leadership development

Wellness and Natural Supports

- Crisis prevention and management for children and adults
- Self care and wellness planning
- Using spirituality and culture strengths
- Identifying family and community strengths
- Community organizing and problem solving

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Certification Opportunities

- Certified Parent Support Provider ™
  - Entry level
  - Professional level
  - Wraparound specialization
  - Cognitive Disability specialization
- Certified Parent Support Provider Supervisor ™
- Certified Youth Support Provider ™
- Certified Youth Support Provider Supervisor ™

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11

Tennessee Department of Mental Health and Substance Abuse Services

STATE OF TENNESSEE
DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

FAMILY SUPPORT SPECIALIST CERTIFICATION PROGRAM GUIDELINES, STANDARDS AND PROCEDURES

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TDMHSAS Family Support Specialist Certification Program

TENNESSEE DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

FAMILY SUPPORT SPECIALIST CERTIFICATION PROGRAM

I. INTRODUCTION

The Family Support Specialist Certification Program (FSSCP) provides State certification for individuals who provide direct *caregiver-to-caregiver* support services to families of children and youth with *mental, emotional, behavioral, or co-occurring disorders.* Because of their life experience in caring for children with these disorders and navigating *child-serving systems*, Certified Family Support Specialists (CFSSs) are able to use their unique experience to inspire hope and provide support to others who are facing similar challenges. This program will allow Certified Family Support Specialists to provide a level of service and support beyond that of clinical staff.

The Certified Family Support Specialist can perform a wide range of tasks to assist *caregivers* in managing their child's illness and fostering *resiliency* and hope in the *recovery* process. These direct *caregiver-to-caregiver* support services include, but are not limited to, developing formal and informal supports, assisting in the development of *strengths-based* family and individual goals, serving as an *advocate*, *mentor*, or *facilitator* for resolution of issues that a *caregiver* is unable to resolve on his or her own, or providing education on system navigation and skills necessary to maintain a child with *emotional, behavioral or co-occurring disorders* in their home environment.

Direct *caregiver-to-caregiver* support services provided by a Certified Family Support Specialist are a vital resource to assist families and others who are caring for children and youth with *emotional, behavioral, or co-occurring disorders.* To achieve the *resiliency* and *recovery* goals of the child and family, the CFSS promotes self-determination, personal responsibility, the skills, knowledge and confidence to be an effective *advocate* for his/her child, and inspires a sense of hope that *resiliency* and *recovery* are achievable goals.

II. CERTIFIED FAMILY SUPPORT SPECIALIST DEFINITION

A Certified Family Support Specialist (CFSS) is a person who has self-identified as the *caregiver* of a child or youth with a *mental, emotional, behavioral or co-occurring disorder* and who has successfully navigated the child-serving systems to access treatment and resources necessary to build *resiliency* and foster success in the home, school, and community. This individual has successfully completed training recognized by TDMHSAS on how to assist other *caregivers* in fostering *resiliency* in their child, based on the principles of *resiliency* and *recovery*.

This certification does not in any way indicate that the Certified Family Support Specialist is qualified to diagnosis an illness, to prescribe or provide medication or clinical treatment, or to provide direct *caregiver-to-caregiver* services independent of a TDMHSAS-licensed or otherwise approved agency.

III. CERTIFICATION ELIGIBILITY

In order for an individual to be eligible for certification, certain qualifications of personal experience, training, employment, and job duties must be met.

- **Personal Experience**
    - Self-identify as being or having been the *caregiver*/family member of a child or youth with a *mental, emotional, behavioral, or co-occurring disorder*.
    - Personal experience regarding navigating the child-serving systems as the *caregiver*/family member of a child or youth with a *mental, emotional, behavioral or co-occurring disorder*.
    - Have actively participated for at least twelve consecutive months at any time during the past five years in service planning, system navigation, and building *resiliency* for a child or youth.
    - Have a minimum of six months work experience (paid and/or volunteer) as a *Family Support Specialist, Support Group Facilitator, Caregiver Educator* and/or *other relevant experience.*
- **Training**
    - Completion of the required *evidence-based* and/or *best practice* Family Support Specialist Training Programs currently recognized by TDMHSAS.
    - Mastery of *competencies* through testing and evaluation as required by the Family Support Specialist Training Programs, including the Professional Competencies Course, recognized by TDMHSAS.
- **Employment / Volunteer Experience**
    - Be under the direct supervision of a *mental health professional* as defined by TDMHSAS.
    - Provide direct *caregiver-to-caregiver support* services.

IV. CFSS EMPLOYMENT GUIDELINES

A CFSS, either employed or volunteer, must be under the direct supervision of a *mental health professional* as defined by TDMHSAS Licensure Rules. A mental health professional as defined by TDMHSAS is a board-eligible or board-certified psychiatrist, or a person with at least a

master's degree and/or clinical training in an accepted mental health field which includes, but is not limited to, counseling, nursing, occupational therapy, psychology, social work, vocational rehabilitation, or activity therapy.

As part of his or her job duties, a CFSS must perform tasks described in the CFSS Scope of Activities. The Scope of Activities shows the wide range of tasks a CFSS can perform to assist the child or youth and the family in regaining control over their own lives based on the principles of *resiliency* and *recovery*. The ability to perform any or all of the tasks in the course of the CFSS's job duties is demonstrated by the mastery of *competencies* through testing and evaluation as required by the Family Support Specialist Training Programs recognized by TDMHSAS (see Section VI.A.6, page 6).

Receipt of Certification does not offer or guarantee employment or job placement. Each Certified Family Support Specialist should apply for positions available in his or her community.

V. Employment Standards for Reimbursable Services

If the delivery of the Certified Family Support Specialist service is to be rendered as a Medicaid (TennCare) covered service, then the following guidelines must be met:

A) Applicants or active CFSS must be employed to work in the role as a paid Certified Family Support Specialist by an agency that is licensed by TDMHSAS and authorized to participate in the Medicaid (TennCare) program.

B) Agencies that are licensed by TDMHSAS and authorized to participate in the Medicaid (TennCare) program shall:

   1) Establish criteria, under which they hire, train and retain Certified Family Support Specialists

   2) Provide supervision for Certified Family Support Specialists in accordance with acceptable guidelines and standards of practice as defined by the State and the Centers for Medicare and Medicaid Services.

C) Each Certified Family Support Specialist providing Medicaid-reimbursable services must be under the supervision of a mental health professional as defined by the State of Tennessee. The mental health professional must work for an agency that is licensed by TDMHSAS and authorized to participate in the Medicaid program. A *mental health professional* means a board eligible or a board certified psychiatrist or a person with at least a Master's degree and/or clinical training in an accepted mental health field which includes, but is not limited to, counseling, nursing, occupational therapy, psychology, social work, vocational rehabilitation, or activity therapy.

VI. CERTIFICATION

To become a CFSS in the State of Tennessee, each applicant must meet all minimum requirements, as outlined in the FSSCP Guidelines, Standards and Procedures.

A. Certification Requirements

To become a CFSS in the State of Tennessee, all applicants must meet the following minimum requirements:

1) Be at least eighteen (18) years of age or older;

2) Hold a high school diploma or a General Educational Development (GED);

3) Self-identify as being or having been the *caregiver*/family member of a child or youth with a *mental, emotional, behavioral, or co-occurring disorder;*

4) Provide a statement of personal experience regarding navigating the child-serving systems as the *caregiver*/family member of a child or youth with a *mental, emotional, behavioral or co-occurring disorder*;

5) During the last five (5) years, have actively participated for at least twelve (12) consecutive months in service planning, system navigation, and building *resiliency* for a child or youth;

6) Successfully complete the *evidence-based* and/or *best practice* training currently recognized by TDMHSAS listed below:

   - ONE of the following trainings:
     (a) National Alliance on Mental Illness of Tennessee's (NAMI-TN) Family Education Program
     (b) Tennessee Voices for Children's (TVC) Parent-2-Parent Training

   FOLLOWED BY

   - Family Support Specialist Professional Competencies Course *(TVC/NAMI-TN)*

OR

   - Effective December 1, 2013, applicants may provide documentation of Certification as a Parent Support Provider through the National Certification Commission for Family Support to serve in lieu of currently required State of Tennessee trainings as noted in Section VI.A.6.

- For information on trainings, contact the Office of Statewide Systems of Care (OSSOC) at-1-615-253-4160 or Melissa McGee at Melissa.McGee@tn.gov.

- Other *evidence-based* and/or *best practice* family support specialist training programs may be considered if appropriate documentation related to the program's curriculum, requirements, and *competencies* are approved by the OSSOC.

7) Successfully demonstrate mastery of the following *competencies* through testing and evaluation as required by one of the *evidence-based* and/or *best practice* Family Support Specialist Training Programs recognized by TDMHSAS:

- An understanding of the basic skills and knowledge needed to provide direct *caregiver-to-caregiver* support services and the ability to apply basic skills to routine tasks.
    - Knowledge of the structure of the *child-serving systems* and how they work
    - Knowledge of the *child-serving systems* and community resources and how to access them
    - An understanding of the Certified Family Support Specialist Scope of Activities
    - An understanding of the Certified Family Support Specialist Code of Ethics
    - Knowledge of the meaning and role of providing direct *caregiver-to-caregiver* support services as a Certified Family Support Specialist
    - Knowledge of how to document activities related to delivery of direct *caregiver-to-caregiver* support services
    - Knowledge of how to help *caregivers* combat negative self-talk, overcome fears, and solve problems
    - Knowledge of how to help *caregivers* articulate, set, and accomplish goals
    - Knowledge of how to teach *caregivers* to create their own family and *individualized plans of care*
    - Knowledge of how to teach *caregivers* to work with mental health or *co-occurring disorder* professionals in order to obtain the services they want
    - Knowledge of how to create and facilitate a variety of family and individual activities that support and strengthen *resiliency*
- An understanding of *resiliency* and the ability to use their personal story to help others. This includes, but is not limited to, the following:
    - How *resiliency* is fostered in children and youth and what is helpful and not helpful
    - The ability to identify the power of a *caregiver's* beliefs and values and how they support or work against success
    - The basic definition and dynamics of the *wraparound* process
    - The ability to articulate what has been helpful and what has not been helpful in their own experience as a *caregiver*

- The ability to discern when and how much of one's personal story to share and with whom

- An understanding of healing and collaborative relationships and the ability to establish such relationships with other *caregivers* and within the workplace.
  - The dynamics of relationships, including power differentials, conflict, and trust
  - The ability to apply this knowledge to deal personally with conflict and difficult *interpersonal relations*
  - The concept of *seeking out common ground* in establishing collaborative relationships
  - The meaning and importance of family and *cultural* differences and beliefs
  - The ability to ask *open-ended questions* that direct a person to his or her strengths
  - The ability to participate in *healing communication*
  - The ability to interact sensitively and effectively with people of other *cultures*
  - The role of direct support to *caregivers* of children or youth with *emotional, behavioral or co-occurring disorders*

- An understanding of the importance of and have the ability to maintain *self-care*.
  - The dynamics of *stress* and burnout
  - The role of one's own *wellness plan*
  - The ability to identify one's own strategies for *self-care*
  - The ability to develop and utilize a personal *support network* for both personal and professional activities

8) Have a minimum of six (6) months paid and/or volunteer work in a support capacity in any or all of the following roles:

- *Family Support Provider*: a person eighteen (18) years of age or older who has been trained to act as an *advocate*, support, and care coordinator for *caregivers* of children and youth with *mental, emotional, behavioral, or co-occurring disorders.*

- *Caregiver Educator:* a person eighteen (18) years of age or older who has lived experience and has been trained to provide information and education to other *caregivers* so they can make sound decisions about the resiliency and *recovery* process and treatment. Examples include, but are not limited to, being a family education course teacher, teaching various educational topics at a psychosocial program, or providing

caregivers with educational activities that promote *resiliency* and *recovery*.

- *Support Group Facilitator*: a person eighteen (18) years of age or older who has been trained to lead self-help activities in a group setting with the goal of providing emotional support to the participants. These groups can be structured around specific support needs which include, but are not limited to, support groups for parents of children with *serious emotional disturbance* (SED) or *co-occurring disorders* (COD), and women's or men's support groups.

- *Other Relevant Experience*: a person eighteen (18) years of age or older who has other employment or volunteer experience that enhances and supports work as a Family Support Specialist. This experience may be considered if appropriate documentation related to the employment or volunteer program, mission and objective is approved by the OSSOC.

9) Either as an employee or a volunteer, be under the direct supervision of a *mental health professional*.

10) Read, understand, and agree to the following:

- Successful completion of the required currently recognized *evidence-based* and/or *best practice* Family Support Specialist Training Programs
- The Family Support Specialist Training Program required *competencies*
- Paid and/or volunteer employment experience
- The Certified Family Support Specialist Scope of Activities
- The Certified Family Support Specialist Code of Ethics

B. Term of Certification

The term of certification shall be one (1) year.

VII. CERTIFICATION PROCEDURE

<u>It is the applicant's responsibility to ensure that all required documents are accurately completed and submitted</u>.

The completed application and other required documents, with the exception of the Employment Summary Form, must be submitted by the applicant via mail directly to:

Office of Statewide Systems of Care
ATTN: FSSCP - Certification
Andrew Jackson Building, 5th Floor
500 Deaderick Street
Nashville, TN 37243

- Required application documents:
    - Application Process Checklist
    - Completed Application
    - Statement of personal experience
    - Copy of high school diploma or General Educational Development (GED) (verification upon request).
    - Completed Employment Summary Form (Applicable only to applicants who are employed). The Employment Summary Form must be completed, signed and submitted by the direct supervisor to the OSSOC if the individual is employed.
    - Copies of the certificates of completion from the required *evidence-based* and/or *best practice* Family Support Specialist Training Programs currently recognized by TDMHSAS.
    - Three (3) Completed Statement of Support Forms (Applicants should make copies of the form and ask each supporter to return the completed form to you in a sealed envelope).
    - Signed Acknowledgement of the Certified Family Support Specialist Scope of Activities
    - Signed Acknowledgement of the Certified Family Support Specialist Code of Ethics
- If the submitted application packet is not complete, a deficiency letter stating what documentation is missing will be mailed to the applicant within ten (10) business days. All documentation requested in the deficiency letter must be received by the OSSOC within thirty (30) calendar days of the date of the deficiency letter.
- An application packet not completed within thirty (30) calendar days will be closed. The applicant must then submit a new application packet with all the required documentation for consideration.
- When the application packet is complete, the file will be promptly reviewed by the OSSOC and a certification determination made. Upon successful review, the applicant will be mailed the certificate within four weeks.

The OSSOC will only discuss the application status with the applicant. Please inform all others that updates must be obtained from the applicant.

To obtain a CFSS Application and related forms, contact the Office of Statewide Systems of Care at 615-253-4160 or visit the OSSOC website at**: http://tn.gov/mental/children/child_tfsscp.shtml .**

VIII. REPORTING CHANGES

A CFSS must notify in writing the OSSOC, within ten (10) business days of any of the following:

- Any change in name, address, or other contact information.
- Any change in employment or employment status.

  - An updated Employment Summary Form must be completed and signed by the immediate supervisor and faxed by the employer to the OSSOC.

- Any change in the agency staff person responsible for providing supervision, even if agency does not change.

  NOTE: A CFSS must at all times be under the direct supervision of a *mental health professional* as defined by TDMHSAS.

- He or she no longer provides direct *caregiver-to-caregiver support* services.
- He or she violates the CFSS Code of Ethics.

NOTE: Failure to provide notification of any of these changes may result in, but is not limited to, termination of certification.

IX. CERTIFICATION RENEWAL

To maintain active certification status, the Certified Family Support Specialist must:

- complete and submit a Certification Renewal application annually within the current term of certification;
- if employed with an agency that is a TDMHSAS-licensed or otherwise approved agency submit employment form signed by the supervisor;
- remain under the direct supervision of a *mental health professional* as defined by TDMHSAS;
- provide documentation of the successful completion of recognized on-going CFSS education;
- have no reports of violation of the CFSS Code of Ethics; and
- submit any other documents requested by the OSSOC.

A. Certification Renewal Procedure

Each Certified Family Support Specialist is responsible for renewing his or her certification, and must submit the Certification Renewal application and all other required documentation, at least forty-five (45) calendar days prior to the end of the current certification period. Unless renewed annually and prior to expiration of certification, the certification shall expire one year from the certification date.

To obtain an application for Certification Renewal, contact the Office of Statewide Systems of Care at 1-615-253-4160 or visit the OSSOC website at: **http://tn.gov/mental/children/child_tfsscp.shtml.**

B. Ongoing Education Guidelines

Fifteen (15) hours of on-going CFSS education are required annually to maintain active certification and must be earned within the annual certification period. On-going

education trainings are not transferable to any other certification period and are intended to enhance the knowledge and skill base of the CFSS.

C. Ongoing Education Standards

Certified Family Support Specialists must complete:

- All in-service trainings required by their employing agency, **and**
- A minimum of two (2) on-going CFSS education trainings, seminars, workshops, or post-secondary courses totaling at least fifteen (15) hours within, but not limited to, the following categories:
    - Family Dynamics
    - Juvenile Justice issues
    - Cultural Competency
    - Special Education Law and Rights
    - Child Welfare issues
    - Substance Abuse in Adolescence
    - Child and Youth Development
    - Social Skills training
    - Basic Wellness
    - Suicide Awareness and Prevention
    - Recovery in the Fields of Mental Health and Co-Occurring Disorders
    - Caregiver Support Services Promoting Resiliency and Recovery

D. Verification Procedure

Each Certified Family Support Specialist must submit an On-Going Education Verification form for each training event. The information below is required to confirm successful completion of the OSSOC recognized on-going CFSS education trainings:

- Certificate of Attendance and/or Completion
    - CFSS Name
    - Certificate must be signed by the trainer
    - Training Date and number of Training hours
    - Title and/or Category of the Training

OR

- For post-secondary courses: official transcripts must be mailed directly from the school to the OSSOC. **Do not** direct the school to send the transcript to your attention.

Documentation of in-service trainings required by the employing agency should be placed in the CFSS's personnel file and copies made available to the OSSOC upon request.

To obtain an On-Going Education Verification form, contact the OSSOC at 1-615-253-4160 or visit the OSSOC website at: **http://tn.gov/mental/children/child_tfsscp.shtml.**

X. TERMINATION OF CERTIFICATION

Termination is the loss of certification.

A. Termination due to deficient documentation

1) Causes
   - Failure to provide required on-going education documentation prior to the annual certification date
   - Failure to complete and submit an application for renewal
   - Failure to submit any other documentation and/or information required by the OSSOC

2) Requirements for Reinstatement of Certification
   - Resubmission of a complete application packet, **and**
   - Submission of an On-going Education Verification form confirming fifteen (15) hours of on-going education earned within one (1) year prior to the resubmission of the application, **and**
   - Submission of any other documentation and/or information required by the OSSOC.

B. Termination due to change in job duties

1) Cause
   - The Certified Family Support Specialist no longer performs any of the duties specified in the Scope of Activities

2) Requirements for Reinstatement of Certification
   - Submission of a complete application packet, including an Employment Summary form verifying that the applicant now performs duties specified in the Scope of Activities, **and**
   - Submission of an On-going Education Verification form confirming fifteen (15) hours of on-going education earned within one (1) year prior to the resubmission of the application, **and**
   - Submission of any other documentation and/or information required by the OSSOC.

C. Termination due to willful misrepresentation or Code of Ethics violation

1) Causes

- Failure to adhere to the Certified Family Support Specialist Code of Ethics
- Knowingly providing false information on any document submitted to the OSSOC

2) Requirements for Reinstatement of Certification

The individual may not apply for reinstatement prior to one (1) year following his or her termination.

- Submission of a complete application packet, including an Employment Summary form verifying that the applicant now performs duties specified in the Scope of Activities, **and**
- Submission of an On-going Education Verification form confirming fifteen (15) hours of on-going education earned within one (1) year prior to the resubmission of the application, **and**
- Submission of a report, including supporting documentation, stating the nature of the violation, an acknowledgment of the violation, and all remedies and/or corrective actions taken to ensure that the violation does not recur, **and**
- Submission of any other documentation and/or information requested by the OSSOC, **and**
- A recommendation to reinstate the individual by the Certified Family Support Specialist Advisory Council, based on review of the following:

  a) The seriousness of the violation
  b) The acknowledgment of the violation by the individual
  c) The corrective action(s) taken

XI. INACTIVE STATUS

A. Deactivation of Certification

A Certified Family Support Specialist whose certification is in good standing and is in good standing with his or her employer may request inactive status for up to one (1) year if unable to meet the requirements of certification due to, but not limited to, the following:

- A decline in physical health and/or mental health
- Extenuating personal circumstances

  Examples:

  - Death of a spouse, child, parent or close relative

  - Prolonged illness of a spouse, child, parent or close relative
  - Divorce or marriage
  - "Loss of" or "Change in" employment
  - Birth of a child
  - Military Deployment
- Other extenuating employment circumstances

Inactive status will not be granted for failure to comply with the On-Going Education Guidelines of certification or reported violations of the CFSS Code of Ethics.

It is the responsibility of the CFSS to ensure that all required documents are completed and submitted. Only completed requests will be processed.

The completed Inactive Status Form and any other required documents must be submitted by the applicant and mailed directly to:

Office of Statewide Systems of Care
ATTN: FSSCP – Inactive Request
Andrew Jackson Building, 5th Floor
500 Deaderick Street
Nashville, TN 37243

Please allow ten (10) business days for documents mailed to the OSSOC to be reviewed.

The OSSOC will only discuss the status with the applicant. Please inform all others that updates must be obtained from the applicant.

To obtain an Inactive Status Form, contact the Office of Statewide Systems of Care at 615-253-4160 or visit the OSSOC website at: **http://tn.gov/mental/children/child_tfsscp.shtml**.

B. Reactivation of Certification

Reactivation of expired certification may be accomplished through submission of all documents required by the OSSOC. For more information, please contact the Office of Statewide Systems of Care at the OSSOC website at: **http://tn.gov/mental/children/child_tfsscp.shtml**, or Melissa McGee at 615-253-4160 or Melissa.McGee@tn.gov.

XII. AGENCY RESPONSIBILITIES

- A CFSS must be under the direct supervision of a *mental health professional* in accordance with acceptable guidelines and standards of practice as defined by TDMHSAS.
- Agencies that are licensed by TDMHSAS shall establish criteria under which they hire, train and retain CFSSs.

- The CFSS's direct supervisor shall immediately contact the OSSOC, and shall complete and submit an amended Employment Summary Form to the OSSOC within ten (10) business days, if any of the following occur:
  - A change in the CFSS's name, address, or other contact information.
  - A change in the CFSS's employment status.
  - A change in the agency staff person responsible for providing direct supervision.
  - The CFSS no longer provides direct *caregiver-to-caregiver support* services.
  - The CFSS violates the CFSS Code of Ethics.
- The agency shall ensure that all services rendered by the CFSS are under a comprehensive, *individualized plan of care,* which is *child-centered* and *family-driven*.
- The agency shall ensure that the CFSS maintains active certification and meets all on-going education requirements.
- The agency shall obtain copies of all documentation related the CFSS's certification, including certifications and recertifications, agency in-service trainings, and on-going CFSS education certificates, and maintain this documentation in the CFSS's personnel file.

NOTE: If the CFSS's services are to be rendered as a Medicaid covered service, these additional guidelines must be met:

- The CFSS must be employed by an agency licensed by TDMHSAS and authorized to participate in the Medicaid program.
- The agency shall provide all required in-service trainings as specified in the TDMHSAS Managed Care Standards for the Delivery of Behavioral Health Services.

XIII. GRIEVANCE PROCEDURE

When an applicant is denied certification, questions the outcome of an application review, or is subjected to an action by the OSSOC that he or she deems unjustified, the applicant may file a grievance when there is a valid, factual reason to dispute a determination made by the OSSOC.

The applicant must submit the grievance within thirty (30) calendar days of receipt of notice of denial or of any other action deemed by the applicant to be unjustified.

It is the applicant's responsibility to submit the grievance and any other documents required by the OSSOC to:

Office of Statewide Systems of Care
ATTN: FSSCP - Grievance
Andrew Jackson Building, 5th Floor
500 Deaderick Street
Nashville, TN 37243

Please allow ten (10) business days for documents mailed to the OSSOC to be received and reviewed.

The OSSOC will only discuss the grievance status with the applicant. Please inform all others that updates must be obtained from the applicant.

The Advisory Council will review the grievance and make recommendations. TDMHSAS, as the authorizing entity for certification, will make the final decision as to what remedy, if any, is required.

XIV. PROGRAM OVERSIGHT

The TDMHSAS Office of Statewide Systems of Care (OSSOC) administers the FSSCP.

- The Advisory Council is comprised of Certified Family Support Specialists appointed by the OSSOC and representatives from TDMHSAS, family and consumer organizations, and other relevant entities in the *child-serving systems*. The Advisory Council shall meet at least quarterly to provide guidance on certification standards, procedures and training. The Advisory Council is responsible for reviewing applications and making recommendations for certification, recertification, and decertification to TDMHSAS based on the requirements as outlined by the FSSCP Guidelines, Standards and Procedures. The Advisory Council is also involved in reviewing grievances, as well as providing input on certification process issues as requested by TDMHSAS.
- TDMHSAS, through the OSSOC, is the authorizing entity for certification. TDMHSAS is responsible for program standards and administration, and the final decision on certification, recertification, and decertification of each applicant is under the authority of TDMHSAS.
- The Division of Mental Health Services (DMHS) provides guidance related to funding and the CFSS's role within the service delivery system.

The OSSOC shall develop and revise as needed the FSSCP Guidelines, Standards and Procedures, so that the appropriate authority to grant certification and set acceptable professional standards is established.

XV. CFSS SCOPE OF ACTIVITIES

In rendering services to children, youth and families, the CFSS follows *system of care* (SOC) values and principles:

- Services should be *child-centered*, community-based and *culturally and linguistically competent.*
- Services should be *family-driven* and *youth-guided*.
- Children with mental, emotional and/or behavioral (MEB) health disturbances should have access to a comprehensive array of services that address the child's physical, emotional, social and educational needs.
- Children with *MEB* should receive individualized services in accordance with the unique needs and potentials of each child and guided by an *individualized service plan.*
- Children with *MEB* should receive services within the least restrictive, most normative environment that is clinically appropriate
- The families and surrogate families of children with *MEB* should be full participants in all aspects of the planning and delivery of services.
- Children with *MEB* should receive services that are integrated, with linkages between child-serving agencies and programs and mechanisms for planning, developing, and coordinating services.
- Children with *MEB* should be provided with *case management* or similar mechanisms to ensure that multiple services are delivered in a coordinated and therapeutic manner and that they can move through the system of services in accordance with their changing needs.
- Early identification and intervention for children with *(MEB)* should be promoted by the SOC in order to enhance the likelihood of positive outcomes.
- Children with *MEB* should be ensured smooth transitions to the adult service system as they reach maturity.
- The rights of children with *MEB* should be protected and effective advocacy efforts for children and youth with *MEB* should be promoted.
- Children with *MEB* should receive services without regard to race, religion, national origin, sex, physical disability, or other characteristics; and services should be sensitive and responsive to *cultural differences* and special needs.

The Scope of Activities shows the wide range of tasks a Certified Family Support Specialist can perform to assist the child or youth, and family in regaining control over their own lives based on the principles of *resiliency*. The Certified Family Support Specialist does not diagnose an illness, prescribe or provide clinical services.

1) Utilizing unique experiences as a *caregiver* of a child or youth with MEB or*, co-occurring disorders,* the Certified Family Support Specialist shall:
    a) Teach and role model the value of every individual's experience caring for a child or youth with an MEB *or co-occurring disorder;*
    b) Model effective coping techniques and advocacy skills;
    c) Encourage *caregivers* to develop informal and formal networks of support that are responsive to the *culture* and unique needs of

their child and family;

d) Foster a full and equal partnership with the child, family, and *caregiver*.

2) Utilizing direct *caregiver-to-caregiver* support and interaction and a goal-setting process, the Certified Family Support Specialist shall:

a) Educate *caregivers* regarding diagnoses, cause of disorders, treatments, and treatment adherence techniques.

b) Understand and utilize specific interventions necessary to assist *caregivers* in developing a *Child and Family Team* and in establishing and meeting their child and family's individualized goals;

c) Lead as well as model how to facilitate collaborative working relationships with providers, school staff, and other professionals to positively transform the treatment experience of the child, youth, and family;

d) Teach relevant skills needed for effective advocacy and navigation of the *child-serving systems*, including child welfare, juvenile justice, education, mental health, and transition services;

e) Assist *caregivers* in meeting their child's or youth's educational needs through support, education, and guidance in school related meetings (504, Individual Education Plans, etc.) and the special education system;

f) Assist *caregivers* in identifying and connecting with services addressing substance abuse and *co-occurring disorders* as well as providing information and other resources;

g) Teach the child, family, and *caregiver* how to identify and utilize their strengths in achieving the family's goals;

h) Assist *caregivers* in articulating their goals and objectives for their family;

i) Assist *caregivers* in creating their *Child and Family Team* and *individualized service plan* (e.g., *wraparound* plan, *crisis plan*, etc.);

j) Assist *caregivers* in establishing and maintaining informal and formal supports;

k) Assist *caregivers* in learning how to access community resources and in making positive treatment choices for their child and family;

l) Appropriately document activities provided to *caregivers* in either their individual records or program records.

m) Assist *caregivers* in identifying resources for specialty services such as DD/MR, adult children with special needs, medically fragile, etc.

3) The Certified Family Support Specialist shall maintain a working knowledge of current trends and developments in the fields of mental health, *co-occurring disorders*, education/special education, child welfare regulations, child/adolescent development and basic wellness, SOC and *peer support* services by:

a) Reading books, current journals, and other relevant material;

b) Developing and sharing *strengths-based* material with other Certified Family Support Specialists;

c) Attending recognized seminars, workshops, and educational trainings.

4) The Certified Family Support Specialist shall serve as a *caregiver* support agent by:

a) Providing and promoting effective family-based services (e.g. *wraparound*, Parents as Teachers, etc.);
b) Assisting *caregivers* in obtaining services that are responsive to each family's individual needs and *culture*;
c) Assisting *caregivers* in becoming *advocates* for their child through knowledge, skills and confidence;
d) Assisting *caregivers* in developing problem-solving skills to respond effectively to child and/or family crises;
e) Fostering a sense of hope and *resiliency* in *caregivers*;
f) Sharing his or her unique perspective on caring for a child or youth with MEB *or co-occurring disorders* with non-*caregiver* staff;
g) Assisting non-*caregiver* staff in identifying programs and environments that foster hope and *resiliency* and are *family-driven* and *youth-guided* in nature.

XVI. CERTIFIED FAMILY SUPPORT SPECIALIST CODE OF ETHICS

These principles will guide Certified Family Support Specialists in their various roles, relationships, and levels of responsibility in which they function professionally.

1) The primary responsibility of a Certified Family Support Specialist is to help *caregivers* achieve their family's needs, wants, and goals.

2) The Certified Family Support Specialist will maintain high standards of personal and professional conduct.

3) The Certified Family Support Specialist will conduct himself or herself in a manner that maintains his or her own wellness.

4) The Certified Family Support Specialist will openly share with *caregivers*, other CFSSs and non-caregivers his or her stories as a *caregiver* of a child or youth with MEB *or co-occurring disorders* as appropriate for the situation in order to promote and support *resiliency.*

5) The Certified Family Support Specialist will respect at all times the rights and dignity of those he or she serves.

6) The Certified Family Support Specialist will never intimidate, threaten, harass, use undue influence, use physical force, use verbal abuse, or make unwarranted promises of benefits to the individuals he or she serves.

7) The Certified Family Support Specialist will not practice, condone, facilitate, or collaborate in any form of discrimination on the basis of ethnicity, race, sex, sexual orientation, age, religion, national origin, marital status, political belief, mental or physical disability, military and/or veteran status, or any other preference or personal characteristic, condition, or state.

8) The Certified Family Support Specialist will promote thoughtful, informed decision making for those he or she serves in all matters.

9) The Certified Family Support Specialist will respect the privacy and confidentiality of those he or she serves.

10) The Certified Family Support Specialist will comply with mandated reporting requirements for abuse and neglect of children and vulnerable adults.

11) The Certified Family Support Specialist will promote and support services that foster hope and *resiliency* and maintenance of a child or youth with mental, emotional or behavioral health issues in the home, school, and community.

12) The Certified Family Support Specialist will be directed by the philosophy that parents and *caregivers* should be equal partners in the treatment of their children.

13) The Certified Family Support Specialist will be directed by the knowledge that all individuals have the right to live and receive services in the least restrictive and least intrusive environment.

14) The Certified Family Support Specialist will not enter into dual relationships or commitments that conflict with the interests of those he or she serves.

15) The Certified Family Support Specialist will never engage in sexual and/or intimate activities with any individual he or she serves.

16) The Certified Family Support Specialist will not abuse prescription medications or alcohol or use illegal substances under any circumstances.

17) The Certified Family Support Specialist will keep current with emerging knowledge relevant to *resiliency*, *family-driven* care, and child/adolescent issues and will share this knowledge with other Certified Family Support Specialists.

18) The Certified Family Support Specialist will not accept gifts of significant value from those he or she serves.

19) The Certified Family Support Specialist will provide direct *caregiver-to-caregiver* support services as defined by the Scope of Activities.

APPENDIX A

STATE OF TENNESSEE
DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

FAMILY SUPPORT SPECIALIST CERTIFICATION PROGRAM FORMS

Certified Family Support Specialist Application Process Checklist

Please complete and submit the checklist below verifying that all required documents are enclosed with the application prior to mailing:

	Yes	No
1) Application Process Checklist	___	___
2) Completed Certified Family Support Specialist Application	___	___
• Do not alter the application from its original format. • Write legibly in only black or blue ink. • Do not use nicknames or abbreviated forms of your legal name.		
3) Statement of personal experience	___	___
4) Copy of high-school diploma or GED	___	___
5) Employment Summary, if employed completed and submitted by employer to the OSSOC	___	___
6) Copies of the certificates of completion from the required evidence-based and/or best practice Family Support Specialist Training Programs recognized by TDMHSAS below:		
NAMI-TN Family Education Program **or**	___	___
Parent-2-Parent Training (TVC)	___	___
and		
Family Support Specialist Professional Competences Course *(TVC/NAMI-TN)*	___	___
or		
National Certification	___	___
7) Three (3) completed Statements of Support	___	___
8) Signed Certified Family Support Specialist Scope of Activities	___	___
9) Signed Certified Family Support Specialist Code of Ethics	___	___

This completed checklist verifies that my application packet has been completed prior to its submission.

_____ _____

Signature of Applicant Date

STATE OF TENNESSEE
DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES
OFFICE OF STATEWIDE SYSTEMS OF CARE
Andrew Jackson Building, 5th Floor
500 Deaderick Street
NASHVILLE, TENNESSEE 37243

CERTIFIED FAMILY SUPPORT SPECIALIST Application

Name *(please print)* _____

Address _____

City_____ **State**_____ **ZIP**_____

Phone (_____) _____-_____ **Work (_____)** _____-_____

Email _____

1) The OSSOC requires a minimum of a high school diploma or GED. Do you have a high school diploma or GED? If yes, please attach a copy.

Yes ☐ **No** ☐

2) Are you employed by an agency that is a TDMHSAS-licensed or otherwise approved agency and under the direct supervision of a mental health professional in accordance with acceptable guidelines and standards of practice as defined by TDMHSAS?

Yes ☐ **No** ☐

If **Yes,** *please have your immediate supervisor complete and submit the attached Employment Summary Form to the OSSOC with attention to Melissa McGee at Melissa.McGee@tn.gov or by fax: 615-253-6822.*

3) Are you/have you been the caregiver of a child or youth diagnosed with a mental, emotional, behavioral or co-occurring disorder by a physician or psychologist?

Yes ☐ **No** ☐

4) Have you self-disclosed that you are or have been a caregiver of a child or youth who is diagnosed with a mental, emotional, behavioral or co-occurring disorder and who is receiving or has received mental health or co-occurring disorder services?

Yes ☐ **No** ☐

5) In the last five (5) years, have you actively participated in a minimum of twelve (12) consecutive months in the service planning , system navigation, and building resiliency for a child or youth with a mental, emotional, behavioral, or mental health disorder? (must show experience in leadership, advocacy, and support)

Yes ☐ **No** ☐

6) Have you demonstrated successful completion of the required evidence-based and/or best practice Family Support Specialist Training Programs recognized by TDMHSAS? If yes, please attach copies of the certificates of completion.

Yes ☐ **No** ☐

7) Have you worked with other caregivers of children or youth diagnosed with emotional, behavioral or co-occurring disorders for at least six (6) months (paid or volunteer) as a family support specialist, support group facilitator, caregiver educator, or other relevant experience?

Yes ☐ **No** ☐

8) Indicate below the paid and/or volunteer experiences you have had in working with other caregivers of children who are recipients of mental health or co-occurring disorder services:

a) Family Support Specialist Years ___ Months ___ **(circle one)** Paid / Volunteer

Current Position? Yes ____ No ___

Agency _____

Phone Number (____) _____ - _____

Position Held _____

Briefly Describe Your Work Responsibilities:_____

_____

Supervisor's Name _____

Phone Number (____) _____ - _____

b) Support Group Facilitator Years ___ Months ___ **(circle one)** Paid / Volunteer

Current Position? Yes ____ No ___

Agency _____

Phone Number (____) _____ - _____

Position Held _____

Briefly Describe Your Work Responsibilities:_____

_____

Supervisor's Name _____

Phone Number (____) _____ - _____

c) Caregiver Educator Years ___ Months ___ Paid / Volunteer **(circle one)**

Current Position? Yes ____ No ___

Agency _____

Phone Number (____) _____ - _____

Position Held _____

Briefly Describe Your Work Responsibilities:_____

_____

Supervisor's Name _____

Phone Number (____) _____ - _____

d) Other Relevant Experience Years ___ Months ___ Paid / Volunteer **(circle one)**

Current Position? Yes ____ No ___

Agency _____

Phone Number (____) _____ - _____

Position Held _____

Briefly Describe Your Work Responsibilities:_____

_____

Supervisor's Name _____

Phone Number (____) _____ - _____

My signature affirms that all of the information contained in this application is true and correct to the best of my knowledge and has been completed by no other person. I understand that knowingly providing false information will be grounds to deny or terminate my certification.

Applicant's Signature _____ Date _____

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DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES
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NASHVILLE, TENNESSEE 37243

Statement of Personal Experience

Because of his or her life experience in caring for a child with a *mental, emotional, behavioral, or co-occurring disorder* and in navigating *child-serving systems* to access resources necessary to build *resiliency*, a Certified Family Support Specialist is uniquely able to provide support to and inspire hope in others who are facing similar challenges

Certified Family Support Specialist Applicant:

_____

(Please Print Name)

Please answer the following questions to the best of your ability. Your responses will help us get to know you and will assist the OSSOC and / or the Advisory Council in identifying qualified applicants.

Write or type your answers on separate paper, and submit them with your application packet.

A. Describe in 5-10 sentences your experience as a *caregiver* of a child or youth with *mental, emotional, behavioral, or co-occurring disorders.*

B. What experiences have you had in assisting or advocating for families of children and youth with *mental, emotional, behavioral (MEB), or co-occurring disorders*? (For example, support group leadership, self-advocacy, public testimony, programs you started)

C. Describe in 5-10 sentences what *resiliency* means to you and how you've strengthened *resiliency* in your child and family.

D. Describe in 5-10 sentences how you practice *self-care*.

E. Describe in 5-10 sentences why you would like to become a Certified Family Support Specialist.

F. Describe in 5-10 sentences why you believe that you would be a good candidate to work with other *caregivers* of children and youth with *MEB, or co-occurring disorders.*

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Employment Summary

The person named below is completing an application to be certified as a Family Support Specialist with the OSSOC. In order to complete the application process, the immediate supervisor must complete the following form regarding the applicant's employment, work responsibilities and supervisory plan. Once the form is completed, submit it to TDMHSAS Family Support Specialist Certification Program at 615.253.6822. If you have questions, please contact the Office of Statewide Systems of Care or Melissa McGee at 615-253-4160 or Melissa.McGee@tn.gov.

1) Prospective Certified Family Support Specialist:

_____

(Please Print Name)

2) Is the applicant named above employed to work in the role as a paid Family Support Specialist?

Yes ☐ **No** ☐

3) **Title of Applicant's paid position within the agency**

_____

Date of employment as a Family Support Specialist _____

4) Number of hours assigned to work in this position per week: _____

5) A Certified Family Support Specialist must be under the supervision of a *mental health professional* in accordance with acceptable guidelines and standards of practice as defined by TDMHSAS. A Mental Health Professional as defined by TDMHSAS is a board eligible or a board certified psychiatrist or a person with at least a Master's degree and/or clinical training in an accepted mental health field which includes, but is not limited to, counseling, nursing, occupational therapy, psychology, social work, vocational rehabilitation, or activity therapy. Please provide the following information regarding the agency staff that provides direct supervision:

6) Name _____ Phone (____) ____ - _____

Job Title _____ Credentials _____

Agency _____ Email _____

Address _____

City _____ State _____ ZIP _____

6) Please describe the nature of the applicant's work responsibilities in the position and role as a paid Family Support Specialist within the agency:

_____

_____

_____

_____

_____

7) Please describe in detail the nature of your direct one-on-one clinical supervision interactions with this applicant:

_____

_____

_____

_____

_____

8) Please describe in detail the professional development plan or goals for this individual within the agency:

_____

_____

_____

_____

_____

My signature below affirms that all of the information contained in this document is true, and that I support this application.

Signature of Direct Supervisor _____ Date _____

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Certified Family Support Specialist Statement of Support

The person named below is completing an application to be certified as a Family Support Specialist. All applicants must submit (3) three statements of support in order to complete the application process. You have been chosen by the applicant to provide a statement for this purpose. Once the statement of support is completed, place the form in an envelope, seal the envelope, sign the seal of the envelope with your signature, and return the envelope to the applicant so it can be submitted with the application. We appreciate your support of this applicant. If you have questions, please contact the Office of Statewide Systems of Care or Melissa McGee at 615-253-4160 or Melissa.McGee@tn.gov.

1) Prospective Certified Family Support Specialist:

_____

(Please Print Name)

2) Please describe your knowledge of the applicant's ability to work in the role of a Family Support Specialist:

_____

_____

_____

_____

_____

_____

_____

_____

3) Please describe the nature of your relationship with the applicant (personal or professional):

4) Please describe the strengths and any potential weaknesses of the applicant in their ability to provide services as a Family Support Specialist :

Supporter Contact Information

(Please Print)

Name _____

Agency _____

Address _____

City, State, ZIP _____

Email _____

Phone (____) ____ - _____

My signature below affirms that all of the information contained in this document is true, and that I support this application.

_____ _____

Signature of Supporter Date

STATE OF TENNESSEE
DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES
OFFICE OF STATEWIDE SYSTEMS OF CARE
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NASHVILLE, TENNESSEE 37243

Acknowledgement of the Certified Family Support Specialist Scope of Activities

By initialing and signing below, you understand that you are required to follow the professional standards detailed in the Certified Family Support Specialist Scope of Activities. Your initials and signature are required in this section.

By affixing my initials and signature below:

I acknowledge that I have received a copy of the most current Certified Family Support Specialist's Scope of Activities and will be responsible for obtaining all future amendments and modifications thereto.

Initials _____

I further acknowledge that I have read and understood all of my obligations, duties and responsibilities under each principle and provision of the Certified Family Support Specialist Scope of Activities and will read and understand all of my obligations, duties and responsibilities under all future amendments and modifications to the Scope of Activities.

Initials _____

_____ _____
Print Full Name Date

_____
Signature

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DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES
OFFICE OF STATEWIDE SYSTEMS OF CARE
Andrew Jackson Building, 5th Floor
500 Deaderick Street
NASHVILLE, TENNESSEE 37243

Acknowledgement of the Certified Family Support Specialist Code of Ethics

By initialing and signing below, you understand that you are required to follow the professional standards of conduct detailed in the Certified Family Support Specialist Code of Ethics. Your initials and signature are required in this section.

By affixing my initials and signature below:

I acknowledge that I have received a copy of the most current Certified Family Support Specialist's Code of Ethics and will be responsible for obtaining all future amendments and modifications thereto.

Initials _____

I further acknowledge that I have read and understood all of my obligations, duties and responsibilities under each principle and provision of the Certified Family Support Specialist Code of Ethics and will read and understand all of my obligations, duties and responsibilities under all future amendments and modifications to the Code of Ethics.

Initials _____

_____ _____
Print Full Name Date

_____
Signature

STATE OF TENNESSEE
DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES
OFFICE OF STATEWIDE SYSTEMS OF CARE
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NASHVILLE, TENNESSEE 37243

CERTIFIED FAMILY SUPPORT SPECIALIST INACTIVE STATUS REQUEST

A Certified Family Support Specialist whose certification is in good standing and is in good standing with his or her employer and is unable to meet the requirements of certification due to an unforeseen circumstance, may request inactive status.

Inactive status will not be granted for failure to comply with the On-Going Education Guidelines of certification or reported violations of the Certified Family Support Specialist Code of Ethics.

- Do not alter the form from its original format.
- Write legibly in only black or blue ink.
- Do not use nicknames or abbreviated forms of your legal name.

1) Name *(please print):* _____

Certification Number: _____ Certification Date: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone: (_____) _____ - _____ Email: _____

3) Are you currently employed by an agency that is a TDMHSAS-licensed or otherwise approved agency, and under the direct supervision of a mental health professional?

Yes ☐ **No** ☐

If yes, please provide the following employment information:

Employer: _____

City: _____ State: _____ ZIP: _____

Supervisor's Name: _____

Telephone Number: (_____) _____ - _____

3) Please briefly describe the extenuating circumstance(s) that renders you unable to meet the required competencies and/or scope of activities requirements of certification:

_____

_____

_____

_____

My signature below affirms that all of the information contained in this verification form is true and correct to the best of my knowledge. I understand while on inactive status, I will not present myself as a Certified Family Support Specialist, and nor will I engage in or perform any activity for which a Family Support Specialist certification is required.

I understand that knowingly providing false information shall be grounds to terminate my certification.

_____ _____

Signature of Applicant Date

Do Not Write Below This Line

Internal TDMHSAS – OCY Use Only

Date received: _____

Date reviewed: _____ Approved _____ Not-approved _____

Date letter of findings mailed to applicant: _____

If approved, date inactive status letter was mailed to agency: _____

Date information was recorded in data-base: _____

Notes: _____

_____

_____

Processed by: _____

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DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES
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CERTIFIED FAMILY SUPPORT SPECIALIST ON-GOING EDUCATION VERIFICATION

An individual, who is certified as a Family Support Specialist, shall satisfactorily complete a minimum of fifteen (15) hours of continuing education trainings in conjunction with the certification renewal process. Only continuing education trainings recognized by the OSSOC shall be used to satisfy the continuing education requirement.

- Do not alter the form from its original format.
- Write legibly in only black or blue ink.
- Do not use nicknames or abbreviated forms of your legal name.
- Attach a copy of the Certificate of Attendance or Completion for each training listed.

Name *(please print):*_____

Certification Number: _____ Certification Date: _____

Address: _____

City_____ State_____ ZIP_____

Phone Number: (_____) _____ - _____ Email: _____

List the title, date, sponsoring organization / association / agency and the number of hours for each on-going training attended.

1) _____ _____
Title of On-Going Education Sponsor

_____ _____
Number of Training Hours Date

2) _____ _____
Title of On-Going Education Sponsor

_____ _____
Number of Training Hours Date

3) _____ _____
Title of On-Going Education Sponsor

_____ _____
Number of Training Hours Date

4) _____ _____
Title of On-Going Education Sponsor

_____ _____
Number of Training Hours Date

My signature below affirms that all of the information attached to and contained in this verification form is true and correct to the best of my knowledge. I understand that knowingly providing false information shall be grounds to terminate my certification.

_____ _____
Signature of Applicant Date

Do Not Write Below This Line

Internal TDMHSAS – OCY Use Only

Date received: _____

Date reviewed: _____ Approved _____ Not-approved _____

Date letter of findings mailed to applicant: _____

Date information was recorded in data-base: _____

Notes: _____

_____

_____

_____

_____

Processed by: _____

APPENDIX B

STATE OF TENNESSEE
DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

FAMILY SUPPORT SPECIALIST CERTIFICATION PROGRAM

FREQUENTLY ASKED QUESTIONS

ACRONYMS

GLOSSARY OF TERMS

STATE OF TENNESSEE
DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES
OFFICE OF STATEWIDE SYSTEMS OF CARE
Andrew Jackson Building, 5th Floor
500 Deaderick Street
NASHVILLE, TENNESSEE 37243

FREQUENTLY ASKED QUESTIONS

1) What is a Certified Family Support Specialist?

A Certified Family Support Specialist (CFSS) is a person who has self-identified as the *caregiver* of a child or youth with *a mental, emotional, behavioral or co-occurring disorder* and who has successfully navigated the child-serving systems to access treatment and resources necessary to build *resiliency* and foster success in the home, school, and community. This individual has successfully completed training recognized by TDMHSAS on how to assist other *caregivers* in fostering *resiliency* in their child based on the principles of *resiliency* and *recovery*.

2) Why are direct "caregiver-to-caregiver" services important?

Caregiver-to-caregiver services are used to assist other *caregivers* of children or youth diagnosed with *mental, emotional, behavioral, or co-occurring disorders* to enhance *resiliency* in youth by providing support, modeling effective advocacy skills, assisting with system navigation, and by offering hope as a *caregiver* who has overcome barriers to parenting a child with an *emotional, behavioral or co-occurring disorder*. By providing positive images of *caregivers* of children or youth diagnosed with such disorders, Family Support Specialists can also have a positive impact on the negative attitudes sometimes found among mental health service providers.

3) What is the purpose of the TDMHSAS Family Support Specialist Certification Program?

The purpose of the Certification Program is to ensure that individuals who provide direct *caregiver-to-caregiver* support services meet acceptable minimum standards.

4) Who oversees the TDMHSAS Family Support Specialist Certification Program?

The OSSOC develops and administers the policies and procedures within TDMHSAS guidelines to grant certification and to ensure that acceptable professional standards are established.

5) Where can a Certified Family Support Specialist work?

Programs in which Certified Family Support Specialist can be utilized include, but are not limited to, community mental health centers, educational settings, family support centers, juvenile justice settings, crisis stabilization units, case management, psychosocial rehabilitation, advocacy organizations and inpatient hospital settings.

6) What types of services can a Certified Family Support Specialist provide?

Certified Family Support Specialists may provide, but are not limited to, assistance in the development of formal and informal supports, of *strengths-based* family and individual goals, services as an *advocate*, *mentor*, or *facilitator* for resolution of issues that a *caregiver* is unable to resolve on his or her own, or education on system navigation and skills necessary to maintain a child with *a mental, emotional, behavioral, or co-occurring disorder* in their home environment.

7) Does TDMHSAS provide employment or job placement?

No. TDMHSAS does not offer or guarantee employment or job placement.

8) Who will supervise the Certified Family Support Specialist and how?

Each Certified Family Support Specialist must be under the supervision of a mental health professional as defined in the CFSS Employment Guidelines.

9) Where are Family Support Specialist trainings offered and is a fee involved?

For information on recognized trainings, please contact the Office of Statewide Systems of Care or Melissa McGee at 615-253-4160 or Melissa.McGee@tn.gov.

10) How can provider agencies ensure that Certified Family Support Specialist employees maintain confidentiality?

Maintaining confidentiality and privacy of all individuals receiving services is a legitimate concern and major issue to emphasize with all employees, not just Certified Family Support Specialist employees.

All employees should receive Title 33 training, Health Insurance Portability and Accountability Act (HIPAA) training and education on their duty to uphold confidentiality. Every employee should be aware that all information regarding a person's *recovery* and treatment status is confidential.

11) What is the salary range for Certified Family Support Specialist?

Many CFSS may work part time, while others work full time. The salary range is determined by the provider agency and program.

12) <u>I have a post-secondary degree. May I submit a copy of that diploma for my application packet?</u>

Yes. While a post-secondary degree is not required for certification, you may submit a copy of a post-secondary diploma (verification upon request) in place of a high-school diploma or GED.

ACRONYMS

BRIDGES	**B**uilding **R**ecovery of **I**ndividual **D**reams and **G**oals through **E**ducation and **S**upport (a Tennessee Mental Health Consumers' Association (TMHCA) psycho-education course)
COD	Co-Occurring Disorder
CFSS	Certified Family Support Specialist
DMHS	TDMHSAS's Division of Mental Health Services
FSSCP	Family Support Specialist Certification Program
GED	General Educational Development (a high school equivalency diploma)
HIPAA	Health Insurance Portability and Accountability Act
MEB	Mental, Emotional and/or Behavioral Disorders
NAMI-TN	National Alliance on Mental Illness of Tennessee
OSSOC	TDMHSAS's Office of Statewide Systems of Care
PSSCP	Peer Support Specialist Certification Program
SED	Serious emotional disturbance
SOC	System of Care
TDMHSAS	Tennessee Department of Mental Health and Substance Abuse Services
TJC	The Joint Commission
TMHCA	Tennessee Mental Health Consumers' Association
TVC	Tennessee Voices for Children

GLOSSARY OF TERMS

Advocate
An advocate speaks on the behalf of another person, an advocate values independence and self-determination. An advocate helps another in navigating the service array and being aware of rights.

Behavioral disorder
A behavioral disorder is one of the most common forms of SED among children and youth and is the most frequently cited reason for referral to mental health services. Behavioral disorders become apparent when the individual displays a repetitive and impact-persistent pattern of behavior that substantially interferes with or limits a child's role or functioning in family, school, or community activities.

Best practice
Best practice is the best clinical or administrative practice or approach at the moment, given the situation, the consumer's or family's needs and desires, the evidence about what works for this situation/need/desire, and the resources available. Sometimes, the term "best practice" is used synonymously with the term "evidence-based practice." Sometimes, "best practice" is used to describe guidelines or practices driven more by clinical wisdom, guild organizations, or other consensus approaches that do not include systematic use of available research evidence.

Caregiver
A person who provides support to the disabled, ill, or dependent individual, and has principal responsibility for taking care of his needs. This person may or may not be a direct family member.

Caregiver (to-Caregiver) Support
Caregiver-to-caregiver services are used to assist other *caregivers* of children or youth diagnosed with *mental, emotional, behavioral, or co-occurring disorders* to enhance *resiliency* in youth by providing support, modeling effective advocacy skills, assisting with system navigation, and by offering hope as a *caregiver* who has overcome barriers to parenting a child with an *emotional, behavioral or co-occurring disorder*.

Case management
The provision of, and the assurance that an individual receives, comprehensive, intensive and individualized treatment for SED that conforms to and addresses an individualized plan of care, and entails monitoring to ensure progress or completion of tasks.

Certified Family Support Specialist
A Certified Family Support Specialist (CFSS) is a person who has self-identified as the *caregiver* of a child or youth with an *emotional, behavioral or co-occurring disorder* and who has successfully navigated the child serving system to access treatment and resources necessary to build *resiliency* and foster success in the home, school and community. A CFSS has undergone training recognized by TDMHSAS on how to assist other *caregivers* in fostering *resiliency*. Direct *peer-to-peer support* services provided by the CFSS are a vital resource to assist families and others who are caring for children and youth with *emotional, behavioral or co-occurring disorders*.

Child and family team
The child family team consists of the child/youth (when appropriate), family or other *caregivers*, formal (mental health professionals, school staff, etc.) and informal supports. The team assists the family in developing and implementing a plan of care based on the family's unique strengths and needs.

Child-centered
Services are planned and provided with the unique strengths and needs of the child in mind rather than fitting the child into an existing service.

Child-serving systems
Child-serving systems are those systems that provide services to children with *serious emotional distur*bance and their families according to their legal mandates and best practices in each specific field.

Competencies
Competencies are elements of a knowledge base and a set of skills that include technical/subject matter, know-how, experience, and training. They are particular strengths and abilities relative to the practice of a profession measured against a standard.

Co-occurring disorder
The term *co-occurring disorders* (COD) refers to co-occurring substance-related and mental health disorders. Clients with CODs have at least one substance-related disorder as well as at least one mental health disorder.

Crisis plan
The crisis plan is developed by the child family team and focuses on a concrete plan of action for use in the event of a mental health crisis.

Cultural competency
A set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. Competency implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and need presented by families and their communities.

Cultural differences
Differences among individuals based on a number of factors including but not limited to race, ethnicity, religious orientation, political affiliation, sex, education level, individual family values and beliefs**.**

Culture(s)
Culture refers to an integrated pattern of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups.

Emotional disorder
An emotional impairment exhibited by a child or youth that disrupts his academic and/or developmental progress, and family and interpersonal relationships.

Evidence-based
Evidence-based practice is the integration of best research evidence with clinical expertise and patient values, or clinical or administrative interventions or practices for which there is consistent scientific evidence showing that they improve client outcomes. The term evidence-based practices sometimes encompasses the terms, best, promising, and emerging practices.

Facilitator
An individual who helps in a group discussion with understanding common objectives and assists in planning without taking a position in the discussion. A facilitator will assist a group in achieving a consensus on disagreements.

Family-Driven
Family-driven means families have a primary decision-making role in the care of their own children. This includes:

- Choosing culturally and linguistically competent supports, services, and providers;
- Setting goals; and
- Monitoring outcomes.

Family Support Provider
An advocate, support, and care coordinator for *caregivers* of a child or youth with SED.

Healing communication
Communication that is *nonjudgmental*, demonstrates respect and dignity, and promotes unconditional positive regard in an effort to assist another person healing their emotional pain and *stress*.

Individualized service plan
Individualized plan of care
A plan that is comprehensive, coordinated, age-appropriate, provides smooth transition through life stages, involves families as appropriate, and is developed by qualified professionals in consultation with service recipients and family members as appropriate.

Interpersonal relations
Therapeutic processes that are used to facilitate interaction between individuals as contrasted with a medical or professional/client relationship model.

Mental Health Professional
A board eligible or a board certified psychiatrist or a person with at least a Master's degree and/or clinical training in an accepted mental health field which includes, but is not limited to, counseling, nursing, occupational therapy, psychology, social work, vocational rehabilitation, or activity therapy.

Mental illness
A psychiatric disorder, alcohol dependence, or drug dependence; does not include mental retardation or other developmental disabilities.

Mentor
A caring individual who, along with parents or guardians, provides youth with support, advice, friendship, reinforcement and examples that can help youth from all circumstances succeed.

Nondirective
An unobtrusive approach in counseling which encourages free expression and problem resolution by the individual.

Nonjudgmental
An attitude that avoids or suspends judgmental criticism of what a person in expressing.

Open-ended questions
Questions which do not require a specific answer. Most therapists are trained to ask open-ended questions as a way of allowing clients to talk about whatever is important to them, which encourages them to share important material.

Peer
A consumer of mental health services who works with other mental health consumers.

Peer counseling
Peer counselor
Peer counseling is the process by which a trained peer gives *nonjudgmental*, *nondirective* support to a peer who is experiencing a personal crisis. It is short-term and provided by a peer instead of a mental health professional.

Peer educator
A consumer of mental health services who works with other consumers on educational issues.

Peer (-to-peer) support
Mutual support – including the sharing of experiential knowledge and skills and social learning – plays an invaluable role in *recovery*. Consumers encourage and engage other consumers in *recovery* and provide each other with a sense of belonging, supportive relationships, valued roles, and community.

Resiliency
Resiliency is an inner capacity that when nurtured, facilitated, and supported by others, empowers children, youth, and families to successfully meet life's challenges with a sense of self-determination, mastery, hope, and well-being.

Self-Care
A *caregiver's* intentional self-regard, attitudes, and behaviors that prioritizes one's own needs for support, information, and resources to reduce stress and prevent burnout. A plan to sustain one's own wellness.

Seeking out common ground
Finding common interest and or experiences to foster trust and open dialog with another.

Serious emotional disturbance (SED)
Children with SED are defined as persons from birth to age 18, who currently or at any time during the past year, have had a diagnosable *mental*, *behavioral*, or *emotional disorder* that is of sufficient duration to meet diagnostic criteria for the disorder specified by the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV-TR) and has resulted in a functional impairment that substantially interferes with or limits a child's role or functioning in family, school, or community activities. Serious (MEB) do not include developmental disorders, substance-related disorders, or conditions or problems classified in the DSM-IV-TR as "other

conditions that may be a focus of clinical attention unless they co-occur with another diagnosable serious emotional disturbance."

Strengths-based
A strengths-based approach assumes people are, or have the capacity to become competent. The approach focuses on personal development of the family's strengths rather than treatment of deficits by building on the multiple capacities, resiliencies, talents, coping abilities, and inherent worth of individuals.

Stress
Stress is the consequence of the failure to adapt to change: the condition that results when person-environment transactions lead someone to perceive a discrepancy, whether real or not, between the demands of a situation, on the one hand and, on the other, the resources of their biological, psychological or social systems. Stressful stimuli can be mental or physical.

Support group leader
A leader of a support group; they may be a professional leading a group or a peer leading a *peer support* group. The leader functions as a facilitator allowing the group self-direction while acting as a moderator for the group.

Support network
A network of systems, professionals, family, friends and peers developed by an individual to provide the individualized support that they require.

Systems of Care (SOC)
A SOC is a coordinated network of community-based services and supports that are organized to meet the challenges of children and youth with serious mental health needs and their families. Families and youth work in partnership with public and private organizations to design mental health services and supports that are effective, that build on the strengths of individuals, and that address each person's cultural and linguistic needs. A SOC helps children, youth and families function better at home, in school, in the community and throughout life.

SOC also refers to a philosophy of how care should be delivered. SOC is an approach to services that recognizes the importance of family, school and community, and seeks to promote the full potential of every child and youth by addressing their physical, emotional, intellectual, cultural and social needs.

Title 33
Title 33 of the Tennessee Code Annotated is the mental health and developmental disability law of the State of Tennessee.

Wellness Plan
A self-directed wellness plan working toward meeting life dreams and goals. The plan identifies issues that provide hope and control over people's lives. Personal wellness plans identify specific problematic issues, as well as the thoughts, feelings, and experiences with the issues. It helps in identifying goals, working on problematic issues and reaching the personal goals.

Wraparound
Wraparound is a team-based planning process intended to provide individualized, coordinated, *family-driven* care to meet the complex needs of children who are involved with several child-

and family-serving systems, who are at risk of placement in institutional settings, and who experience emotional, behavioral, or mental health difficulties. The wraparound process requires that families, providers, and key members of the family's social *support network* collaborate to build a creative plan that responds to the particular needs of the child and family. Team members then implement the plan and continue to meet regularly to monitor progress and make adjustments to the plan as necessary. The team continues its work until members reach a consensus that a formal wraparound process is no longer needed.

Wraparound should be individualized, *family-driven*, culturally competent and community based. Wraparound should increase the "natural support" available to a family by strengthening *interpersonal relationships* and utilizing other resources that are available in the family's network of social and community relationships and should be "strengths based," helping the child and family to recognize, utilize, and build talents, assets, and positive capacities.

Youth-guided

Youth-guided means that young people have the right to be empowered, educated, and given a decision-making role in the care of their own lives. This includes giving young people a sustainable voice, being listened to, and the focus should be towards creating a safe environment enabling a young person to gain self sustainability in accordance to the cultures and believes they abide by.

Training Descriptions

The Family Involvement Center (FIC) offers the trainings, including descriptions and learning objectives, listed below. Training modules are taught through lectures, power point presentations, and experiential learning techniques designed to engage participants in adult-centered learning and to provide them with tools that increase efficacy. FIC trainings can be mixed and matched to meet the specific needs of individuals and/or organizations and are co-facilitated by experienced Parent Trainers from FIC.

GENERAL TRAINING MODULES

Title: ***Parent Involvement vs. Engagement***
Length: 1 hour
Description: This training module explores the difference between parent involvement and parent engagement and lays the foundation for establishing a trusting reciprocal relationship. We explore the mantra "nothing about us without us" and how to support parents by listening to their voice and increasing their participation in planning and decision-making. This requires mutual commitment and respect and results in meaningful parent involvement
Objectives:

- Participants will learn to establish the trusting reciprocal relationship needed to engage families.
- Participants will learn about the difference between involving and engaging parents, who initiates and drives effective engagement, and staff and parent roles.
- Participants will be able to identify three key attributes that are evident when meaningful parent engagement and involvement occurs.

Title*: Family-Friendly Language*
Length: 1 hour
Description: "The difference between the right word and the almost right word is the difference between lightning and the lightning bug" ~Mark Twain
In this training module participants identify language that perpetuates disrespect for family members and/or creates feelings of hurt, punishment, isolation, or diminishment that can hinder the ability to engage in a trusting relationship. Participants will learn family-friendly language that honors the strengths and abilities of families and youth.
Objectives:

- Participants will identify language that preserves respect for family members and youth.
- Participants will discover and practice using family-friendly language that honors the strengths and abilities of families and youth.

Title: ***Strengths Extraction***
Length: 2 hours
Description: This interactive training module provides participants with tools and skills they need to engage in an honest conversation with the families they are working with. Participants learn to ask questions that

elicit natural responses, to practice active listening, and to identify strengths hidden within a family's story. Identifying strengths is a key component of engaging families and building trusting relationships. Participants practice extracting strengths through the art of conversation, explore the difference between descriptive and functional strengths, and learn to build on the parent's/primary caregiver's strengths when creating a service plan.

Objectives:

- Participants will discover the art of extracting strengths through conversation and how to use those strengths in service planning.
- Participants will learn ways to involve families in the discovery of their own strengths.
- Participants will be able to differentiate between descriptive and functional strengths and learn how to make descriptive strengths functional.

Title: *Understanding Family Culture from Competence to Humility*

Length: 2 hours

Description: "There is a difference between intellectually knowing another culture ("cultural knowledge" or "cultural competence") and being able to truly relate to it ("cultural humility")." ~Steve Lew

In this training, participants engage in a River of Culture Exercise that sets the stage for discussing the difference between demonstrating cultural competence and practicing cultural humility. Best defined, cultural humility is a commitment to and active engagement in a lifelong process of self-evaluation and critique that we enter into along with the parents/primary caregivers, colleagues and others we work with. This process requires humility in order to recognize and confront power imbalances that exist in our communication dynamics.

Objectives:

- This training will lead participants in the discovery of their own culture and its impact on the families they work with.
- Participants will learn how to embrace and understand culture and its unique relationship in providing support for families.

Title*: Identifying Unmet Needs*

Length: 3 hours

Description: "The biggest unmet need is loneliness." ~Anonymous

In this training module participants learn that meeting needs is both an art and a science. The art is listening and interpreting the narrative of a family's story to determine their needs. The science is testing the precision of fit between what a family needs and what they get in service delivery. Participants will learn the difference between services and needs and practice the "needs egg" technique of identifying needs.

Objectives:

- Participants will learn the difference between services and needs.
- Participants will learn how to utilize the "needs egg" to determine possible unmet needs and to brainstorm options to meet each need.
- Participants will learn how to write good "needs statements" that are built on the family's strengths.

Title: *Suspending Judgment*

Length: 1.5 hours

Description: "Bias and prejudice are attitudes to be kept in hand, not attitudes to be avoided." ~Charles Curtis

This training module addresses the fact that all of us hold biases. Participants learn about bias and conduct a self-reflection exercise to explore their personal biases. They learn strategies to suspend or overcome biases that may interfere with their ability to engage with families.

Note: This is a great follow up to the "Understanding Family Culture" training module.

Objectives:

- Participants will learn that bias is learned and unintentional and often rooted in ignorance and fear.

- Participants will conduct a self-reflection exercise and learn strategies to overcome personal bias.
- Participants will learn how we reinforce stigma and bias and how self-stigma is the prime factor of such reinforcement.
- Participants will discover that words matter and learn the benefit of mindful language as well as strategies to increase public awareness.

Title: ***Listening with All Your Senses, Developing Empathetic Relationships***
Length: 2 hours
Description: Experiencing empathy and giving an empathetic response are not the same. In this interactive training module participants learn the difference between experiencing empathy and giving an empathetic response that also validates feelings. Participants will learn six habits of highly empathetic people and how to create a respectful environment for empathic, non-judgmental listening.
Objectives:

- Participants will learn the skills needed to show empathy and respect for families facing difficult situations.
- Participants will work though their own feelings of empathy in order to gain knowledge about others.

Title: ***Reaching Agreement and Validating the Family Perspective***
Length: 1.5 hours
Description: In this training module participants learn the difference between validation and agreement and why validation is important in building trusting relationships. Participants learn the six levels of validation and practice using skills that successfully validate others, keeping those levels of effective validation in mind.
Objectives:

- Participants will learn why validation is important and a key element in building trusting relationships.
- Participants will discover the difference between validation and agreement.
- Participants will learn to utilize the correct level of validation based on what the person is sharing with them.
- Participants will have the opportunity to practice validation skills in a safe learning environment.

Title: ***Family-Driven/Youth-Guided Care***
Length: 2.5 hours
Description: This training module is designed for a diverse audience (including parents/primary caregivers, youth, community members and professionals) in which we define terms relevant to family-driven, youth-guided care. Participants will gain a greater understanding, knowledge, and appreciate for the value of parent and youth involvement. This knowledge supports the engagement of parents/primary caregivers and youth in leadership roles within organizations where they receive services and within their communities resulting in both system transformation and effective parent and youth/professional partnerships.
Objectives:

- Participants will be able to define terms relevant to family-driven, youth-guided care.
- Participants will gain a better understanding of the knowledge and value base for parent and youth involvement.
- Participants will be able to identify attributes, benefits, barriers, strategies, hallmarks, and steps related to family-driven, youth-guided care.

Title: ***40 Developmental Assets***
Length: 2-hour module OR 4 or 8 hour training (length varies based on the content requested)
Description: Certified FIC Parent Trainers facilitate workshops and/or full day trainings on The 40 Developmental Assets, developed by Search Institute. The Developmental Assets® are 40 research-based, positive qualities that influence young people's development, helping them become caring, responsible, and productive adults. Based on youth development, resiliency, and prevention research, the Developmental

Assets framework is proven to be effective and has become the most widely-used approach to positive youth development in the United States and, increasingly, around the world. The framework has been adapted to be developmentally relevant from early childhood through adolescence. The 40 Developmental Assets is a powerful tool for developing strengths in youth and families and in helping youth avoid delinquency and achieve success in school, in the community, and at home. This skill-based training improves the ability to engage and support families and to build resiliency in young people.

Objectives:

- Participants will learn about Search Institute and the 40 Developmental Assets.
- Participants will discuss "external assets" and will learn activities and strategies so they can assist in the building of "external assets".
- Participants will learn about and explore activities that support the building of "internal Assets".
- Participants will learn about potential asset-building activities for youth programs.

Title: ***Family/Professional Partnership Training: All Aboard***

Length: 8-hour training

Description: The Family/Professional Partnership module is a one-day training utilizing the metaphor of a journey. Experienced parent trainer and system of care professionals take participants through a series of skills-based activities designed to help them turn existing relationships into successful partnerships. System transformation requires committed partnerships between system of care professionals and parents/primary caregivers who have received services on behalf of their child or young adult. This work requires collaboration, honest two-way communication, attention to how power is shared, and a commitment to shared resources. Partnering to bring the professionals authority and power to influence funding decisions and family life expertise together, this effort requires mutual accountability, trust, and collaboration and is fundamental to system change efforts.

Objectives:

- Participants will learn to develop and nurture effective family/professional partnerships through the metaphor of a journey.
- Participants will be able to identify the difference between formal and natural leaders.
- Participants will discover the key ingredients necessary for effective parent-professional partnerships.
- Participants will learn how "power" is shared in effective partnerships.

Title: ***Trauma Informed Care***

Length: 2 hours

Description: This training, for both professionals and parents/primary caregivers, explores the values and principles of a trauma-informed approach to service delivery and introduces tools for professionals and parents that can help minimize traumatic experiences in the workplace and at home. Participants have an opportunity to look at the Adversarial Childhood Experiences (ACE) questionnaire and to discuss the implications of its results on the lives of children and families.

Objectives:

- Participants will learn the values and principles of a trauma-informed approach to establishing and building trusting relationships with children and families.
- Participants will learn tools and techniques for decreasing traumatic experiences in the workplace and at home.
- Participants will learn about the ACE Study and its findings about the lives of the children and families**.**

Title: ***Compassion Fatigue***

Length: 2 hours

Description: This training module explores the many demands parents/ caregivers face and the frustrating reality that often, through service delivery alone; we are unable to make a significant impact that positively

benefits the outcomes of those we serve. Participants learn about compassion fatigue and complete a self-assessment to determine where they are currently on that spectrum. Participants also learn the importance of balance, self-care, and building resources for resilience.

Objectives:

- Participants will discover the symptoms of compassion fatigue and their impact on caregivers.
- Participants will learn the value of self-care and its ability to minimize the effects of compassion fatigue.

Title: ***Self-Care***

Length: 1.5 hours

Description: This training module begins with an opening exercise modeling self-care strategies. Participants take a self-assessment followed by a group discussion. Participants identify and discuss common workplace stressors, best practices of a supportive supervisor, signs of overload, and the importance of being resiliency-focused.

Objectives:

- Participants will learn the importance of self-care.
- Participants will discover simple self-care strategies they can implement on a daily basis.

Title: ***Natural-Supports***

Length: 2 hours

Description: "It takes a village to raise a child." ~African proverb

Natural supports are a key ingredient in a solid support system for children and families. Natural supports foster empowerment, interdependence, growth, and accountability and decrease reliance on formal services systems. Participants take part in an experiential exercise regarding natural supports in their own lives and the difference they feel when connected vs. disconnected to those networks. Participants share personal experiences about developing natural supports within their community and the impact this had on their lives.

Objectives:

- Participants will learn to identify natural and informal supports and about the importance of these supports in the lives of children and families.
- Participants will gain the skills needed to engage natural and informal community supports in the child and family team process.

Title: ***Where You Begin and I End***

Length: 2 hours

Description: Participants identify sources of emotional stress, define boundaries, and identify patterns of behaviors that indicate weak personal boundaries. Through self-reflection, participants explore opportunities to establish or reinforce personal boundaries in the workplace and at home. Participants learn what it means to be interdependent rather than independent and that setting boundaries is a starting place for negotiation, rather than a sophisticated form of manipulation. Participants identify ten steps for establishing healthy boundaries, learn a formula for honest, healthy communication that sets the stage for creating healthy boundaries, and review limit-setting language that is counterproductive. Participants also discuss the choices, consequences, and negotiations that take place when implementing healthy boundaries.

Objectives:

- Participants will learn the definition of boundaries, to recognize signs of weak boundaries, and the six categories of boundaries.
- Participants will identify ten steps needed for forming healthy boundaries and practice a formula for honest, healthy communication that is productive.

Title: ***Interest-Based Negotiation***
Length: 2 hours
Description: Participants discover the art of interest-based negotiation, focused on interests rather than position. This is an excellent technique for negotiating conflicts and creating win-win situations. Participants learn to move beyond their own position in a conflict and to create common ground where parties can negotiate, create options for mutual gain, and promote communication and collaboration.
Objectives:

- Participants will learn the basic principles of interest-based negotiation.
- Participants will learn the difference between focusing on interests vs. positions.
- Participants will engage in experiential learning and practice these skills.

PARENT/FAMILY EDUCATION SERIES

Title: ***Salsa, Salud, y Sabor (Food, Fun, and Fitness) - Family Education Series for Latinos***
Length: 8 weeks, 2 hours per session
Description: This evidence-based family education program focuses on healthy living by paying attention to food portions and nutritional values and physical activity. The goal of the series for participants is to increase their physical activity and to build habits that lead to a healthy lifestyle. Latino families and children attend this program together, eat a healthy meal, attend break-out sessions by age group, and participate in traditional Hispanic games. Family Involvement Center is a La Promessa Partner with the National Latino Children's Institute and has certified, experienced parent trainers who facilitate the classes.
Objectives:

- Participants will learn about healthy food portions and nutritional values specific to the Latino culture.
- Participants will engage in physical activity as a family utilizing traditional Latino games.

Title: ***Birth to Five - Parent Education Series***
Length: 4 weeks, 2 hours per week
Description: Parents/caregivers learn skills and techniques to strengthen the parent/child relationship with their infants and toddlers. Topics include the importance of establishing good parent/child relationships, early brain development; social and emotional development of infants and toddlers, and early childhood mental health. The program also emphasizes the importance of reading and increasing literacy in our children. Reading resources are provided in class.
Objectives:

- Participants will discover the importance of establishing a positive parent/child relationship with infants and toddlers.
- Participants will learn about social and emotional development in infants and toddlers and why the parent/child relationship is vital to healthy development.
- Participants will learn about early brain development and stages of growth for infants and toddlers.
- Participants will learn techniques to enhance the relationship with their infant or child and about resources available to them.

Title: ***Behavior Building - Parent Education Series***
Length: 8 Weeks, 2 hours each week
Description: Behavior Building is an eight module course that focuses on working with individuals with disabilities (developmental and behavioral health) using a positive, person-centered approach. Participants learn the major reasons why disabled individuals display undesirable behaviors, how the environment positively and negatively impacts their behavior, and techniques that foster healthy and successful relationships.
Objectives:

- Participants will understand the definition of Behavior Building and its eleven important principles.
- Participants will recognize and analyze cues, prompts, and antecedents to undesirable behaviors.
- Participants will learn how to reinforce and influence positive behavior.
- Participants will learn techniques for Behavior Building, including Active Training (acquiring new skills while preventing the deterioration of skills already learned).
- Participants will learn non-aversive Behavior Building techniques.

Title: ***Sib-Shops: Workshops for siblings of youth who have special health and developmental needs***
Length: Series of workshops, length determined by needs
Description: Sessions focus on a sibling's view of living with a brother or sister who has special needs. Workshops are designed to help siblings connect with their feeling**,** hopes, and aspirations.
Objectives:

- Participants will connect with peers who have siblings diagnosed with special needs.
- Participants will learn about special needs in a fun, recreational context.

Title: ***Strengthening Families and Communities, A parent program promoting peace***
Length: 13 weeks, includes an orientation and 12, 3- hour sessions
Description: This program uses a culturally-sensitive framework to tackle the needs of a variety of different ethnic/cultural groups - namely violence against one's self and others. There are five curriculum areas: Culture, Relationships, Discipline, Rites of Passage, and Community. All components are designed to help parents and children develop strong cultural roots, strengthen the parent-child relationship, and learn life skills necessary to function in today's society. As a vehicle for fostering high self-esteem, self-discipline, social competence, and social consciousness; anger management and positive discipline techniques are integrated to help parents model for and teach their children. This program also includes an evaluation used to assess the efficacy of individual participants and/or agencies and communities.
Objectives:

- Participants will learn the core building blocks for success that promote peace and violence-free, healthy lifestyles.
- Participants will discover that mentoring and modeling are the most effective teaching tools - parents are the most important teachers of their children.
- Participants will learn activities and language they can use to teach their children "rites of passage" that will help them transition from childhood to adulthood successfully.
- Participants will learn positive parenting techniques that keep the parent-child relationship intact.
- Participants will be introduced to the developmental and thinking stages of children.

Title: ***CASII (Adolescent Service Intensity Instrument) Orientation***
Length: 3 hours
Description: This training provides families with knowledge about the CASII tool, its implementation, and the various domains it examines to determine the intensity of need and resources needed to meet the needs of a youth/family in the behavioral health service system in Arizona.
Objectives:

- Participants will learn the History and Overview of the CASII instrument.
- Participants will learn about the goals of implementation in Arizona.
- Participants will learn about the different domains examined to determine CASII scores.
- Participants will learn how the CASII is scored and how to apply the score in child and family team decision-making.
- Participants will discover the importance of family voice in scoring the CASII tool.

TRAININGS OFFERED TO THE COMMUNITY

Title: ***Mental Health First Aid Training***
Length: 8 hours
Description: Mental Health First Aid is a groundbreaking public education program that helps the public identify, understand, and respond to signs of mental illnesses and substance use disorders. Mental Health First Aid is offered in the form of an interactive 8-hour course that presents an overview of mental illness and substance use disorders in the U.S., introduces risk factors and warning signs of mental health problems, and reviews common treatments. Those who take the 8-hour course to certify as Mental Health First Aiders learn a 5-step action plan encompassing skills, resources, and knowledge to help individuals in crisis connect with appropriate professional, peer, social, and self-help care.
Objectives:

- Participants will increase their mental health literacy.
- Participants will learn the Mental Health First Aiders 5-step action plan to help individuals in crisis.
- Participants will discover the importance of prevention of and early intervention in mental health problems.
- Participants will learn the importance of decreasing stigma associated with mental health.

Title: ***Youth Mental Health First Aid Training***
Length: 8 hours
Description: Youth Mental Health First Aid USA is an extension of Mental Health First Aid. It is specifically targeted to those who work with young people between the ages of 12 and 18. Youth Mental Health First Aid is an interactive program that relies on participation from attendees.
Objectives:

- Participants will increase their mental health literacy.
- Participants will learn the Mental Health First Aiders 5-step action plan to help individuals in crisis.
- Participants will discover the importance of prevention of and early intervention in mental health problems.
- Participants will learn the importance of decreasing stigma associated with mental health.

Title: ***ASIST 11 - Applied Suicide Intervention Skills Training, Pathways for Assisting Life***
Length: 16 hours
Description: The ASIST 11 workshop is for caregivers who want to feel more comfortable, confident, and competent in helping prevent the immediate risk of suicide. Over one million caregivers have participated in this two-day, highly-interactive, practical, practice-oriented workshop. Pathways for Assisting Life (PAL) training equips participants with language and techniques that make it easier for a person at risk to talk about suicide, a skill for helping a person at risk discover life connections, and a talent for turning those connections into reasons for working on safety-for-now.
Objectives:

- Participants will recognize that caregivers and persons at risk are affected by personal and societal attitudes about suicide.
- Participants will learn to discuss suicide with a person at risk in a direct manner.
- Participants will learn to identify risk alerts and develop safe plans related to them.
- Participants will learn skills required to intervene with a person at risk of suicide.
- Participants will be able to list the resources available to a person at risk of suicide, including themselves.
- Participants will make a commitment to improving community resources around suicide prevention.
- Participants will recognize that suicide prevention is broader than suicide first-aid and includes life promotion and self-care for caregivers.

TRAININGS FOR PARENT-TO-PARENT SUPPORT ROLES

Title: ***Eight Core Skills, Code of Ethics Training designed for parent –to-parent support roles working in the behavioral health system*** **Length**: 2 days
Description This training provides Parent Partners and Family Support Partners and other positions providing parent-to-parent support with the 8 core competency skills identified by the National Certification for Parent Partners and Family Support Partner Roles as the code of ethics for parent support roles.
Objectives:

- Participants will learn how to communicate their own story when it can help other parents?
- Participants will learn how to support other parents as peers with a common background and history rather than as experts.
- Participants will learn how to provide support to parents while acknowledging that each parent's answers may be different from their own.
- Participants will learn how to take responsibility for clarifying their role as Parent Partners and as a parent of a child with emotional, behavioral, and/or mental health needs.
- Participants will learn how to build partnerships with other professionals who are involved in the care of our children and influence them to see parents in a positive light.
- Participants will learn the importance of making and honoring mutual commitments to honesty with every party involved in the care of children.
- Participants will demonstrate a non-judgmental, respectful attitude in their work and in discussions with both parents and professionals.
- Participants will demonstrate a commitment to non-adversarial advocacy in their roles and interactions with other stake-holders.

Title: ***Core Skills Training, Designed for parent –to-parent support roles working in the behavioral health system 20 skills*** **Length:** 4 days, 32 hours. (Can be offered in 2-day increments over a 2 week period rather than 4 consecutive days.)
Description: This training teaches 20 foundational skills designed specifically for the unique role of the Parent Partner and Family Support Partner role. Skills are organized around the four phases of the cycle of help: engagement, planning, implementation, and transition. In each of the four phases, five specific skills (for a total of 20) that support efficacy in our work with parents and/or caregivers are taught through lectures, power point presentations, and experiential learning. This training is most effective within the first six months of hire.
Note: Trainings for each of the 20 core skills were designed as individual modules that can be mixed and matched for individual staff needs or as a booster for an entire agency.
Objectives:

- Participants will learn how to share their life experience in a way that is concise, uses common experience to form a connection, and inspires realistic hope for both parents/primary caregivers and professionals.
- Participants will learn foundational skills in the four phases of the help cycle specific to the-parent-to-parent support role.
- Participants will learn to communicate effectively with parents/primary caregivers and professionals.
- Participants will learn core skills for empowering the parents/primary caregivers they work with.
- Participants will learn solution-building techniques.

Title: ***Essentials Training, 20 skills designed for parent-to-parent support roles working in the behavioral health system*** **Length:** 4 days, 32 hours (Can be offered in 2-day increments over a 2 week period rather than 4 consecutive days.)
Description: The Essentials Training is comprised of 20 essential/advanced skills designed specifically for the unique role of the Parent Partner and Family Support Partner that build on the core skills. Skills are organized around the four phases of the cycle of help: engagement, planning, implementation, and transition. In each of the four phases, five specific skills (for a total of 20) that support efficacy in our work with parents and/or caregivers are taught through lectures, power point presentations, and experiential learning. This training is most effective within six months to one year of hire.
Note: Trainings for each of the 20 essential skills were designed as individual modules that can be mixed and matched for individual staff needs or as a booster for an entire agency.
Objectives:

- Participants will learn how to share their life experience in a way that is concise, uses common experience to form a connection, and inspires realistic hope for both parents/primary caregivers and professionals
- Participants will learn enhanced skills in the four phases of the help cycle specific to-the parent-to parent support roles.
- Participants will learn advanced skills for communicating effectively with families and professionals.
- Participants will learn advanced skills for empowering the parents/primary caregivers they work with.
- Participants will learn advanced solution-building skills.

ARIZONA SPECIFIC TRAININGS

Title: ***DBHS Practice Protocol Family and Youth Involvement in the Children's Behavioral Health System***
Length: 2 hours
Description: This training familiarizes parents/primary caregivers, youth, and provider organizations with the guiding principles for meaningful parent and youth involvement at the individual, program, and system level within Arizona's Behavioral Health System and emphasizes the value of parent-to-parent support roles within our system. Participants review videos about effective parent professional partnerships, the role of family organizations, and the importance of family leadership within the system.
Objectives:

- Participants will learn the key attributes of meaningful parent involvement and its importance in the Arizona Behavioral Health System.
- Participants will learn about the unique roles for parent-to-parent support and youth mentor roles.
- Participants will discover the roles that family-run organizations play in optimizing meaningful parent and youth involvement.
- Participants will learn strategies to build and sustain an infrastructure that supports and involves family members in transformation efforts at all levels of the system.

Title: ***DBHS Practice Protocol on Youth Involvement in the Children's Behavioral Health System***
Length: 2 hours
Description: This training familiarizes parents/primary caregivers, youth, and provider organizations with the guiding principles for meaningful youth involvement in the Arizona Behavioral Health System and the value of youth peer support roles within our system.
Objectives:

- Participants will discover the elements of meaningful youth involvement.
- Participants will be introduced to the importance of establishing and facilitating youth participation at all levels of the system.

- Participants will learn the value of utilizing formal and informal peer support services.

Title: ***AZ Vision and 12 Principles***
Length: 2 hours
Description: The AZ Visions and 12 Principles Training shares the Arizona journey to develop and implement a new way of serving children and their families in Arizona in response to the JK Lawsuit settlement.
Objectives:

- Participants will understand the Arizona Vision and 12 Principles.
- Participants will learn how Arizona's 12 Principles serve as the organizing framework for the child and family team practice.
- Participants will learn how these 12 Principles are universally applied to all enrolled youth and families through the use of child and family teams.

Title: ***Child and Family Teams***
Length: 1.5 hours
Description: This training introduces the concept of the Child and Family Team (CFT) and reviews the history and purpose of CFTs. In addition, the module highlights the importance of engaging parents and youth in the decision making process of CFTs as well as the importance of establishing effective parent/professional partnerships.
Objectives:

- Participants will become familiar with the nine activities of the CFT process.
- Participants will understand the formation of the CFT process.
- Participants will recognize the value your "lived" experience brings to the CFT process.
- Participants will understand the meaning behind the word "collaboration" in CFTs.

Title: ***FIC Overview***
Length: 2 hours
Description: This training explores the development of Family Involvement Center (FIC) and the foundation of its mission, values, and core beliefs.
Objectives:

- Participants will be familiar with FIC and understand the role of family-run organizations.
- Participants will become familiar with FIC's approach to supporting families and professionals in the behavioral health system.
- Participants will understand the supports and services provided at FIC.
- Participants will know that the vast majority of families raising children with mental health needs are healthy families who are experiencing a particularly stressful challenge.
- Participants will understand that "good parenting" skills don't usually work when a child has mental health needs.
- Participants will learn how mental health problems present themselves as "behavior problems" and why disciplinary strategies that work with our "typically developing" children may not be effective.

Title: ***DDD Services Training***
Length: 2 hours
Description: This training reviews services and supports provided by the Arizona Department of Economic Security/ Division of Developmental Disabilities for people who meet certain eligibility requirements. The course covers both the requirements to receive services from DES/DDD as well as the programs and services they offer for those who are eligible.
Objectives: Participants will cover the following about DES/DDD:

- An overview of available services through DDD.

• What DDD covers. • Who is eligible for DDD services. • Information on how to access services. • How to apply for DDD services. • An overview of costs. • Arizona's Long Term Care System (ALTCS).