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**PROCEDURAL MANUAL**

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HOME & COMMUNITY SERVICES

Mission Statement

The mission of the Chester County Intermediate Unit’s Home & Community Services (H&CS) program is to provide effective behavioral services to children, adolescents, and their families. H&CS believes that families are the first and best resource for identifying their strengths, challenges and the social and behavioral goals they wish to achieve. To this end, H&CS will assist clients in increasing socially appropriate behaviors that will maximize their potential, facilitate independence and self-advocacy, and promote healthy functional relationships. We will utilize evidence-based behavioral management practices, specialized instruction, and the natural support systems available in the home, school, and community. Our aim is to be recognized as the premier provider of behavioral health services.
What is Home & Community Services?

H&CS is home/community/school-based services, which are utilized to address the increasing complex needs of children. H&CS is not intended to be a replacement for all other mental health services. H&CS offers an alternative to some of the functions clinic/hospital-based services usually performed. These services are delivered in the home/community/school. The types of clinical services usually offered are:

1. Mobile Therapy (MT)
2. Behavior Specialist Consultant (BSC)
3. Therapeutic Staff Support (TSS)
4. Behavioral Health Personal Care Assistant (BHPCA)
5. Respite Worker (RW)
6. Case Manager (CM)
7. Case Specialist (CS)

The purpose for any recommended service must be justified and clearly stated as medically necessary if funded by Medical Assistance (MA) or commercial insurance (Third Party Liability [TPL]), or identified in the Individualized Educational Plan (IEP) for Early Intervention or School District funded cases. Unique and creative services can be provided if they are medically necessary and clinically justifiable. The problem or maladaptive behavior must be clearly identified within the context of where, when, and how the problem occurs. The intervention should clearly indicate how it would address the problem. There should be a multi-system involvement with particular emphasis on identifying and using natural community supports. Service goals may include the following:

- Identifying and utilizing individual and family strengths.
- Fostering independence.
- Promoting family autonomy.
- Assisting the family to develop their own natural community support network and in developing community resources.
- Aiding in the transition from a more restrictive level of treatment (for example hospital/residential to community-based services.)
Helping the client reintegrate after receiving more restrictive services to receiving services in the home, school, and community.

Preventing out-of-home placement.

Assisting and aiding clients in developing personal skills as necessary to enhance parent/child or child/peer relations.

Providing individualized behavioral management or specialized instruction in the school setting to address a child’s behavioral needs and maintain appropriate educational placement.

**Strategy and Services**

H&CS assists clients in increasing socially competent behaviors that will maximize their potential, facilitate independence and self-advocacy, and promote healthy functional relationships. We utilize evidence-based behavioral management practices, specialized instruction, and the natural support systems available in the home, school, and community.

H&CS provides services to clients via behavioral health rehabilitative services (BHRS), specialized instruction, and behavioral health personal care assistant services (BHPCA). Many of our consultants and staff have degrees or certifications in Applied Behavioral Analysis, Special Education, Counseling Psychology, and related fields. Staff are, highly motivated and dedicated professionals with extensive experience in autism and other developmental disorders.

H&CS does not ascribe to only one form of intervention. Clients are viewed holistically and general behavioral principles are followed. The goal of H&CS is to assess each client’s individual needs. Treatment and specialized programming are designed based on the client’s individual needs and are updated on an ongoing basis or as needed. Treatment is provided in the client’s home, school, or community setting using a team approach, which includes parents, clinical staff, community supports and educators.

H&CS is a program of the Chester County Intermediate Unit’s Student Services division. H&CS is offered to those children and families that reside within the school districts and geographical areas served by CCIU and their satellite offices/programs. Primarily, services are provided to residents of Chester, Delaware, Lancaster, and Montgomery Counties. Depending on the funding source, H&CS offers several types of services to meet the client’s individual needs. For example,
Behavior Modification

Functional Behavioral Assessments

School Consultation

Specific ABA Modalities depending upon on the client’s individual needs and funding source

For those behavioral health services that meet the criteria of medical necessity, H&CS will follow the rules and conventions as defined by the federal and state regulations, the contracted agreements of the County Behavioral Health Managed Care Organization (BHMCO), commercial insurance (TPL), and/or the County Office of Mental Health/IDD. CCIU recognizes the benefits of using ‘Wraparound’ philosophy and makes all attempts to adhere to that framework.

Staff

- **Behavioral Specialist Consultant (BSC)**
  - Qualifications include, but not limited to minimum of Master’s degree with behavioral training in conjunction with the Pennsylvania Behavior Specialist License
  - Provides behavioral treatment plans/consultation as stipulated by the Department of Public Welfare (DPW) (or other primary funding source), or plans/consultation related to specialized instruction when school district/IU funded

- **Mobile Therapist (MT)**
  - Qualifications include, but not limited to a minimum of a Clinical Master’s degree
  - Provides face-to-face psychotherapy

- **Mental Health Specialist (MHS)**
  - Qualifications include, but not limited to a minimum of a Master’s degree in a human service profession
  - Provides face-to-face psychotherapy

- **Therapeutic Staff Support (TSS)**
  - Provided through BHRS
Qualifications include, but are not limited to, a Bachelor's degree

Must provide services in accordance with the regulations and guidelines stipulated by DPW or other funding source

**Behavioral Health Personal Care Assistant (BHPCA)**

- Generally school district/IU funded services
- Qualifications include a Bachelor's degree unless otherwise specified
- Provides behavioral health and specialized instruction services
- Potentially provides some physical care

**Respite Worker (RW)**

- Qualifications include, but are not limited to, a Bachelor's degree
- Must provide services in accordance with the regulations and guidelines stipulated by DPW or other funding source

**Case Manager (CM)**

- Minimum qualifications include a Master's degree in human services field, and qualification as either BSC or MT
- Provides quality assurance and oversight on individual cases
  - Includes attention to case details such as staffing, training, and supervision

**Case Specialist (CS)**

- Minimum qualifications include High School Diploma
- Administrative position requires ability to multitask and demonstrate high attention to detail
- Provides quality assurance and administrative oversight for individual clients

**Training**

Each TSS and BHPCA staff receives 15 hours of training, as required by the Office of Medical Assistance, before being assigned a client. This training includes, but is not limited to:
- Documentation and data collection skills
- Understanding the CASSP principles
- An overview of Autism Spectrum Disorders and other serious emotional and behavioral needs of children and adolescents.
- An introduction to ABA techniques/behavioral management
- Professional ethics, boundaries, fraud, conduct and legal issues including child protective services and mandated reporting and client confidentiality.
- Psychotropic Medications
- The role of the TSS worker in the home, school and community
- Overview of job expectations and requirements
- Treatment/behavioral planning
- Introduction to the DSM-IV or DSM-5
- Childhood Development

Each TSS and BHPCA is required to complete up to 43 hours of training (dependent on the county where services are provided) within the first six months of his or her date of hire. Each year thereafter they are required to complete a minimum of 20 hours of training.

These trainings include, but are not limited to:

- Autism training (within the first six months)
  - 12 hours- Autism training requirements are county-specific
- Non-violent Crisis Intervention (NCI)
  - 6 hours year one
  - 3 hours each year thereafter
- CPR/First Aid (Child and Adult)
- Autism Interventions specific training dependent on their client’s needs
- Corporate Compliance as stipulated by the Bureau of Program Integrity
- Child Abuse Recognition and Reporting: Mandated Reporter
Each TSS and BHPCA is required to attend weekly supervision at one-hour per session. The BSC is also required to observe each BHPCA and/or TSS onsite every other week. The BSC must sign off and review documentation in the office minimally twice per month. Treatment team meetings take place as needed, however ongoing consultation is provided on a weekly, sometimes daily, basis or as authorized.

BSC, MT and Case Managers and Case Specialists attend ongoing training throughout the year, with a minimum of 10 hours required. This training includes any and all trainings listed for BHPCA and TSS staff, but also includes an initial thorough orientation on The Role of the BSC or The Role of the MT. This training includes in depth treatment plan development, effective team communication, topics and interventions related to Autism, and basic ABA principles. BSC and MT staff are required to attend, minimally, one-hour of supervision monthly. Case Managers and Case Specialists attend one hour of supervision weekly. Weekly updates and communication are expected.

**Child Adolescent Service System Program (CASSP)**

A major expectation for H&CS staff is that the philosophy and practice of services adhere to a well-defined set of principles outlined through Pennsylvania's Child and Adolescent Service System Program (CASSP). CASSP is designed for children and adolescents with, or at risk of developing, severe emotional disorders and their families. These principles, expressed in various forms since the beginning of CASSP, can be summarized in six core principles that should followed simultaneously and cohesively.

- Child Centered
- Family Focused
- Community Based
- Multi Systems
- Culturally Competent
- Least Restrictive/Least Intrusive

**Child Centered**

Services are planned to meet the individual needs of the child, rather than fit the child into an existing service. Services consider the child's family and community contexts are developmentally appropriate, child specific and also build on the strengths of the child and family to meet the mental health, social and physical needs of the child.
FAMILY-FOCUSED

Services recognize that the family is the primary support system for the child and help to empower the family to advocate for themselves. The family participates as a full partner in all stages of the decision-making and treatment planning process, including implementation, monitoring and evaluation. A family may include biological, adoptive and foster parents, siblings, grandparents and other relatives, and other adults who are committed to the child. The development of mental health policy at the state and local levels includes family representation.

COMMUNITY BASED

Whenever possible, services are delivered in the child's home community, drawing on formal and informal resources to promote the child's successful participation in the community. Community resources include not only mental health professionals and provider agencies, but also social, religious and cultural organizations and other natural community support networks.

MULTI-SYSTEMS

Services are planned in collaboration with all the child-serving systems involved in the child's life. Representatives from all these systems and the family collaborate to define the goals for the child, develop a service plan, develop the necessary resources to implement the plan, provide appropriate support to the child and family, and evaluate progress.

CULTURALLY COMPETENT

Culture determines our worldview and provides a general design for living and patterns for interpreting reality that are reflected in our behavior. Therefore, services that are culturally competent are provided by individuals who have the skills to recognize and respect the behavior, ideas, attitudes, values, beliefs, customs, language, rituals, practices, and characteristics of a particular group of people.

LEAST RESTRICTIVE/LEAST INTRUSIVE

Services take place in settings that are the most appropriate and natural for the child and family and are the least restrictive and intrusive available to meet the needs of the child and family.
Determining When H&CS Behavioral Services are Appropriate

MA/TPL FUNDED:

BHR services are generally regarded as the least restrictive service options for children who need intensive mental health services. However, by delivering services to children in their homes and communities these services may potentially be highly intrusive. Many factors are considered besides a mental/behavioral health diagnosis before H&CS are deemed appropriate. The following are examples of some of the factors, which are taken into account to assist in the decision making process when initially determining the appropriateness of H&CS:

- Multiple client serving systems are involved (for example, child welfare, juvenile justice, education, mental health/mental retardation, and drug and alcohol).
- The client may be dually diagnosed.
- The client’s current environment (home or school) is deteriorating.
- The client’s behaviors are negatively impacting functioning in the home, school or community setting.
- The family, school or county, has referred the client for services.
- The client is at risk of separation from his/her family.
- The client’s disabilities are severe.
- The client is medically fragile.
- The other children in the family are considered to be at risk also.
- The client is returning from an out-of-home placement.

After the client, family, and interagency team determine that BHR services are needed a decision must also be made on the need for greater or lesser intensity of service. Greater or lesser intensity must be adjusted to the individual’s need for active intervention as reflected in the psychiatric/psychological evaluation and the treatment plan. Typically, the severity of the behaviors that the child exhibits is the primary criteria that the evaluators use to determine the intensity of service.

It is understood, and may be asserted that H&CS in the lives of children and families are not "natural", but a necessary intervention intended to be time limited.
Reducing levels of intervention is a necessary element of therapy directed toward fostering and developing independence in the relationship formations of children with their families, peers, and functioning in normalized settings in the community.

**EARLY INTERVENTION OR SCHOOL DISTRICT FUNDED:**

School District and Early Intervention programs can request service directly from H&CS. In these cases, H&CS will provide individualized behavior management, specialized instruction, or special designed instruction in accordance with the client’s IEP, behavioral needs and SD/EI request.
REFERRAL AND ADMISSION OVERVIEW

The Chester County Intermediate Unit H&CS are offered to those clients and families that reside within the school districts and geographical areas served by CCIU and their satellite offices/programs. Primarily services are provided to residents of Chester, Delaware, Lancaster and Montgomery Counties.

The goal of the H&CS Program is to help children and adolescents, who are experiencing psychological distress and/or emotional and/or behavioral difficulties, overcome self-defeating behavior, interact age appropriately, interface positively with family members, and maximize their potential. Family, school, and community members are enlisted to move the child in this positive direction. All interventions are done in the client’s home, school or other community settings.

Treatment Components (MA/TPL funded)

A multidisciplinary team of helping professionals provides the client’s clinical services. Team members may include a consulting licensed Clinical Psychologist, Case Manager, Case Specialist, BSC, MT, and TSS. Also enlisted at times to aid in the team’s efforts are guidance counselors, teachers, school psychologist and other responsible adults that may have a positive impact on the child and family. Parents and/or guardians are always included on the treatment team. Each client receives a comprehensive psychological evaluation and an individual Treatment Plan is developed to work on areas the child needs to improve in order to attain a higher level of functioning.

Treatment Components (EI-SD funded)

A multidisciplinary team of helping professionals provides the clinical services. Team members may include the Case Manager, Case Specialist, BSC, TSS/BHPCA, school personnel and family members. Each client receives an individualized treatment plan based on the child’s IEP or EI/SD request.

Admission Criteria (MA/TPL funded)

- Client must be under the age of 21.
- The client must have a primary mental health diagnosis (according to DSM-IV or DSM-5)
- The client must be currently enrolled with medical assistance and have a valid Access card.
The client must be approved for services by the local county Mental Health/IDD office and/or the county Behavioral Health Managed Care Organization.

**Referral Process**

A referral may be made by contacting the CCIU H&CS Program. Referrals may also be made directly to the office of MH/IDD and/or County Behavioral Health Care Organization. If the client is covered by medical assistance, the client must be registered with the local county Mental Health/IDD office and/or county Behavioral Health Managed Care Organization (BHMCO).

Some Counties may require the initial prescription for Wraparound Services to come from a Core provider. Other counties may require initial prescriptions be made by approved prescribers (Psychologists/Psychiatrists) identified by the County Department of MH/IDD or BHMCO.

**Referral/Admission Protocol**

All referrals must be made by a legal guardian or client 14 years of age or older and will be forwarded to an H&CS Coordinator. At the time of referral H&CS will adhere to all the regulations mandated by the Department of Public Welfare (DPW) and the County Office of MH/IDD. H&CS will also follow the CASSP Principles and the guidelines of the county BHMCO. The BHMCO and Core providers can also initiate referrals. These referral sources should contact the appropriate H&CS office by email or phone to inquire as to staff availability.

In the case of Early Intervention (EI) referrals, an EI Case Manager faxes or emails a referral form along with the IEP and staff is assigned once available. Coordinators have the decision-making responsibility of accepting or declining clients based on a variety of criteria for consideration:

- Number of clients on caseloads.
- Staff availability to appropriately service client.
- Staff expertise to appropriately address client’s presenting issues.

**Intake Procedure (MA/TPL Funded)**

Although specific intake procedures differ by County, when the identified licensed psychologist or Core Provider completes the initial evaluation, an Interagency Service Plan Team (ISPT) meeting will be scheduled to review the recommendations/prescription, discuss goals of treatment and choose a provider, and discuss staff assignment. The participants of the ISPT should include but not be limited to, client (if 14 years of age or older), legal guardians, BHMCO.
representative, school representatives, the Case Management team and/or Coordinator, and any other important treatment team members.

At the ISPT, the team will discuss the evaluation and clearly define a strength-based behavioral plan/treatment plan. The team will also discuss the appropriateness and medical necessity of services. The roles of each type of service recommended will be clearly defined. An application for the authorization of services will be generated at the ISPT. This application, with all the appropriate documentation and signatures, will then be sent to the BHMCO and/or DPW.

When a parent calls to transfer services from another provider agency, they are instructed to notify their current provider of their intent to transfer. If staff is available, the Coordinator or Case Management team coordinates a transfer date with the current provider.

When a client is accepted for BHR Services, the H&CS Coordinator immediately schedules an intake session. It is the responsibility of the Case Management team to ensure that all of the necessary paperwork is completed before a psychological evaluation is scheduled and/or prescribed services commence. This paperwork includes, but is not limited to the following:

1. Referral for Services.
2. CASSP Core Principles.
3. Client Rights.
4. Consent for evaluation.
7. Copy of Medical Assistance (ACCESS) Card.
8. Private Insurance/Medical Assistance form. (Copies of each card also needed if applicable.)
10. HIPPA form
11. Parent Contract
12. Consent to Treat
13. Physician Communicator
14. Obtain any and all pertinent information related to the child that could be helpful in the assignment of and treatment of the client. This would include previous evaluations, Individual Education Plans (IEP), medical records, etc.

All forms must be signed by a legal guardian and client if they are 14 years of age or older. Court documents must be requested when legal guardianship is in question. Once all necessary paperwork is completed, it is the responsibility of the Case Management team to ensure all the proper authorizations have been obtained and that the client is eligible for services.

However, it should be noted that no further steps would be taken until all required paperwork has been signed and returned by the legal guardian. Failure of the legal guardian to return paperwork within 5 business days may result in the loss or termination of services.

From the day the legal guardian makes an inquiry regarding BHR Services, the Department of Public Welfare (DPW) has 60 days to deliver any services deemed as eligible through medical necessity. Services include the completion of a psychological evaluation and the commencement of prescribed services. If the psychological evaluation is not completed and/or an identified provider cannot provide services within 60 days, then the legal guardian may make the decision to wait for services with that identified provider or, request to be referred back to the State or BHMCO to locate another provider of BHR Services.

The BHMCO is responsible for authorizing services within 48 hours of their receipt of the application. In the event services are questioned the BHMCO may request more information delaying authorization another 4 to 6 days. Denial of services would lead to the legal filing for a level 1 grievance. This could continue to delay the authorization of services indefinitely.

The Case Management team will assign all staff once services have been authorized by the BHMCO.

**Intake Procedure (El/SD)**

School Districts and Early Intervention Programs can make direct referrals to the Coordinator of the appropriate office. In the case of Early Intervention (EI) referrals, an EI Case Manager faxes or emails a referral form along with the IEP, and staff is assigned once available. Coordinators have the decision-making responsibility of accepting or declining clients based on a variety of criteria for consideration:

- Number of clients on caseloads.
- Staff availability to appropriately service client.
Staff expertise to appropriately address client’s presenting issues.

**Assignment of Cases**

The H&CS will make every effort to assign cases based upon the staff member’s level of skill. All attempts will also be made to match the client with a staff member with whom he/she is compatible.

1. Work may be assigned during the daytime or evening. Working hours may also include holidays and/or weekends. **Please note, hours assigned depend on medical necessity and/or may be limited to EI calendar days.**

2. CCRES staff must use the CCRES scheduling website (there is a link on CCRES’s website) to update their personal information and to keep their availability updated as follows:
   - Log onto http://providerschedule.ccres.org/
   - Log in using your email address as username and your lowercase initials and the last 6 digits of your SSN as your password
   - Update any information relevant to provider contact for case assignment
   - Update your schedule (TSS) or requested hours (BSC/MT)
   - If you are willing to substitute click on the willing to sub box

Once assigned to a case, it is the staff’s (BSC, MT, TSS, BHPCA) responsibility to inform their Case Management team of any changes to his/her availability to work. The Case Management team must be made aware of this as soon as the staff member has this knowledge.

All staff interested in acquiring a case must request a case through the Staff Information System.

1. Based upon the availability, interest and experience as well as availability of cases, the Case Management team will schedule staff members with an assignment.

2. Before each assignment, it is the staff member’s responsibility to know the location of service, obtain information about the child, and know the other team members.

3. It is the Case Management team’s responsibility to make sure the team members are aware of each staff member’s role and responsibility.
4. The clinical leader will be responsible for providing a course of intervention as well as a treatment plan within 30 days to all team members, especially the TSS/BHPCA. If a BSC is assigned to a case, then they are designated as the clinical leader. In the absence of a BSC, the MT will assume the clinical leadership.

The H&CS program will attempt to identify staff as soon as the recommendations are made. Staffing assignments are only finalized once services are authorized. Certain hours, assignments and availability of work cannot be guaranteed to the staff. Specific clinicians or, unauthorized hours/services cannot be guaranteed to the client or family.

Staff members assigned to ongoing cases will be expected to complete that assignment as prescribed. If a staff member is unable to continue with the case as prescribed, best practice dictates that the staff member should give reasonable notice (4 weeks) of their anticipated termination date to ensure adequate time for therapeutic closure and satisfactory transition. In circumstances where families have referred staff, not currently working in the H&CS program, specifically to work with their child/family, such staff must give 4 months notice before being reassigned to a new case. Please note, that notice of 4 weeks or 4 months must not include sick time or vacation to be considered for reassignment.

Staff members may refuse any work assignment. Persistent refusal of assignments may result in a limited number of assignments offered. If a staff member has concerns regarding a case assignment, he/she should discuss such concerns with his/her Case Management team.

Clients or families may refuse services and/or staff. Persistent refusal of services or staff may cause a delay of appropriate medical interventions. If MA services cannot be delivered in an appropriate and timely manner the Case Management team may refer the family back to the BHMCO to find another provider of BHR Services.

For EI cases, staff or client refusals may necessitate that the Case Management team refer the case back to the funding source. If a family has concerns regarding any part of the services delivered, they should discuss such concerns first with the Case Management team. If the family’s concerns go unresolved, then they should consult with the Coordinator of H&CS.

Assignment of Work Hours

Scheduled Hours

Staff members are expected to schedule services with the client, family, and/or school prior to the arrival at the work location. All staff members must make every
effort to schedule follow-up appointments. Staff must make their schedules clear to all involved. The exact time of arrival and departure must be documented and verified with a signature of a guardian or teacher on the daily/weekly report. It is expected that staff members schedule their sessions based on the client’s needs rather than their own needs.

Any deviation from the established schedule must be reported to the Case Management team, family, and school personnel prior to the change. Changes include early/late arrival or departure and client/family requested changes. Staff members who cannot start work when scheduled must notify the Case Management team /family/school prior to the scheduled start. Changes resulting from unexpected circumstances (i.e., getting lost, weather related, etc.) must be reported to your Case Management team as soon as it is reasonably possible, but within 24 hours. If a staff member works six hours or more, with the same client in the same location, a 30-minute break must be taken and documented on the daily report and time sheet. Staff members will not receive pay for that break time.

The Case Management team will provide a TSS or BHPCA with their assigned work schedule, and the Case Management team must approve any changes to that schedule. However, BSCs and MTs are responsible for clarifying their own schedules with the client/family, etc. No two staff may work at the same time performing overlapping or identical services (e.g. two TSS) unless approved by the program Coordinator. Scheduling unauthorized overlapping time may lead to disciplinary action.

CANCELLATION OF ASSIGNMENTS BY STAFF MEMBERS

H&CS requires a minimum of 24 hours notice when a staff member is not able to complete a scheduled assignment. The staff member must contact the Case Management team and BSC then the client/family/school. H&CS is responsible for finding a replacement staff person when necessary. Persistent practice of giving less than 24 hours notice will lead to disciplinary action. Failure to report a cancellation to the family or Case Management team may result in an automatic dismissal.

Families should call the Case Management team if a staff member is not providing appropriate services due to cancellations.

CANCELLATION OF ASSIGNMENTS BY CLIENTS/FAMILIES

H&CS requires a minimum of 24 hours notice when a client/family needs to cancel a scheduled appointment, including psychological evaluations. The client/family must contact the assigned staff member and then the Case Management team. Persistent practice of giving fewer than 24 hours notice may lead to the delay or cancellation in services. The staff member must document each cancellation on a Daily/Weekly Report Sheet. Specific reasons for cancellation must be
documented.

**TERMINATION OF ASSIGNMENT**

A staff member may be removed from an assignment at the discretion of H&CS or at the request of the client or family. No reason needs to be given to the staff member. If the client or family terminates services, the Case Management team will inform the staff member. All MA Wraparound services are put on hold immediately when a child is placed in a psychiatric facility, partial program, or hospital. MA Services may be resumed the day of discharge or upon approval of the Office of Medical Assistance Programs (OMAP) or BHMCO. Services (BSC/MT/TSS) may also be put on hold if the family becomes ineligible for Medical Assistance.

**EMERGENCIES**

Emergencies can be defined as a client behavioral health crisis, injury to staff, client or other, and/or other problems. If an emergency occurs, the Case Management team or Coordinator must be notified immediately. It is the clinical staff’s responsibility to document such an emergency on a Daily/Weekly Report Sheet and an Incident Report. Incident Reports are physically due into the H&CS program within 24 hours.

It is the legal guardians responsibility to contact the appropriate authorities in all emergency situations at home and in the community. BHR Services are not considered or authorized as emergency services. If the emergency is at school, it is the school’s responsibility to deal with the situation and call the appropriate authorities including the legal guardians. Staff members may provide support via a crisis plan and refer the family to appropriate community crisis intervention services. The offices of CCIU H&CS staff (Case Management team / Coordinators) are not available after work hours and do not provide crisis intervention services.

**Contacting Medical Director**

If, after the above crisis protocol is followed, there needs to be additional contact with the Medical Director, Dr. Robert Newbrough, he can be reached by contacting the H&CS Program Supervisor, Catherine Scanlon, at 484-237-5192 or catherines@cciu.org.

**BOUNDARIES**

It is important that each staff member remain within the boundaries of their job description. Staff members are neither expected nor allowed to be all things for the child/family with whom they work. Any request outside of the job description should be directed to the appropriate treatment team member/Case Management
team/ Coordinator. It is important that staff members maintain appropriate boundaries in all aspects of their services. H&CS’ goal is to empower the families to whom we are providing services. Therefore, it is each team member’s responsibility to foster independence and the gradual reduction of services as deemed medically appropriate.

HOSPITALIZATION/PARTIAL HOSPITALIZATION

If a child is hospitalized for mental health reasons, the BHRS Team must immediately, due to reimbursement constraints, cease all services for that client and family. Medical Assistance could consider any BHRS billing as “double billing” while the child is hospitalized. Therefore, the Coordinator of H&CS must approve any BHR Service delivery while the child is hospitalized. The BHRS team may resume services after the child is discharged from the hospital and with the approval of the Coordinator of H&CS.

FEE FOR SERVICE VS MANAGED HEALTH CARE

A client who receives “fee for service” Medical Assistance does not have their BHR Services reviewed by a Behavioral Health Managed Care Organization (BHMCO). Authorizations for services are granted directly by the Office of Medical Assistance Programs (OMAP). All applications for authorization and concerns are sent directly to the OMAP.

A client with Managed Health Care must deal directly with a BHMCO. The BHMCO “oversees” mental health services for the State and reviews all ISPT packets sent by the provider for the client. If the client disagrees with the BHMCO/MA over an issue then the client may file a grievance.

MEDICAL ASSISTANCE (MA) ELIGIBILITY

In order for BHR services to continue, MA eligibility must be maintained. It is the responsibility of the parent/legal guardian to make sure that the client’s eligibility is renewed annually. If client ‘s MA eligibility becomes inactive, then services are halted immediately, and will remain on hold until MA is reinstated. The county Coordinator may be able to restore some services while MA eligibility is worked out depending upon alternative funding sources. After 30 days of MA ineligibility, H&CS reserves the right to end services permanently and discharge the client.
AUTHORIZATION PROCESS

Request for Authorization (MA funded)

Case Management teams are responsible for compiling the client's request for authorization packets and obtaining authorization for services from the respective OMAP representative or BHMCO representative. The request for authorization packet may include the following information:

1. Interagency Service Planning Team (ISPT) Meeting Sign-In Concurrence Form.
2. Enhanced Services Signature Page.
3. Family Choice Notification form.
5. Wraparound Services Progress/Change/Continued Need (page 1 and 2).
7. Behavioral Treatment Plan (with signatures of the legal guardian and client if he/she is 14 years of age or older).
8. Guidelines for Provision of In-School Wraparound (BHRS) Services form.
9. Plan of Care Summary.
10. In School Collaboration Form (with signatures of school representatives, used for requesting services in school).
11. MA97 Form (if needed, with signatures of the legal guardian and client if they are 14 years of age or older).
13. Transfer of Services Form (when required).
14. Any other information requested by the OMAP or BHMCO.
15. Chester and Lancaster Counties require a TSS schedule.
Once the application for authorization is complete, the Case Management team will send it to the BHMCO or the OMAP for review. From the date of receipt, OMAP has 21 days and the BHMCO has 48 hours to approve or deny the application or request more information from the service provider. If the BHMCO does not respond within 48 hours, then services are typically approved by default. All denials may be sent to a level 1 grievance if the parent or legal guardian chooses to do so.

AUTHORIZATIONS AND RE-EVALUATIONS

Traditionally, services are authorized for a 6-month period of time, although children diagnosed with a developmental disability may qualify to be authorized for up to one year at a time. If services are to continue beyond the approved time span, a new clinical evaluation (re-evaluation) must be completed any time after the final 45 days of the current authorization period. The BSC and/or MT will provide the consulting licensed psychologist with a behavioral update from the team. This update is in the form of the Progress Change Continued Need Form (PCCN) that both the BSC and MT should complete. In addition to providing a thorough clinical case summary, detailing the progress, or lack thereof, on goals during the current authorization period, this PCCN will also be used to document the transfer of skills to adult caregivers. Without clear documentation that intervention and behavior management skills have been transferred to an adult caregiver(s), the clinical rationale for services is significantly weakened and H&CS may not be able to justify a request for reauthorization of a client’s services. These forms must be returned to the Case Management team 10 days prior to the evaluation. The psychologist will then ensure that the evaluation report is completed within seven (7) calendar days of the date of the evaluation. Psychological evaluations have a “lifespan” of between 45 to 59 days, depending upon funding source, thus the ISPT and packet must be submitted to the BHMCO within 45-59 days of the psychological evaluation date and prior to the expiration of the authorization period.

A client must have a re-evaluation prior to the end of the authorized period to continue services.

Request for Authorization (EI/SD funded)

Services will commence upon receiving the funding source formal request and/or signed service contract.
Interagency Service Planning Teams (ISPT)

H&CS Policy dictates that ISPTs are held every authorization period, and at least every 4 months with an extended authorization period. It should be noted that the client or legal guardian might request a meeting at any time.

The BSC, MT or Case Management team may lead the assembled ISPT meeting. The BSC or MT is responsible for bringing a complete updated Treatment/Behavioral Plan to the meeting. The team must review the current recommendations by the clinical psychologist and come to a decision about services. If the team disagrees then the Case Management team must go back to the psychologist to ask for an addendum to the evaluation. If the Psychologist disagrees with the team, then the client may request a second opinion from an outside psychologist. Assuming all agree, the Case Management team submits the completed packet to the BHMCO or the State Department of Public Welfare for authorization of services.

If the clinical psychologist’s prescription does not recommend BHR Services, then the client is referred to the appropriate service or level of care. An ISPT may be held to discuss the prescription inviting the new provider of service.

The Case Management team is responsible for scheduling the ISPT within the allotted time frames. The Case Management team may delegate responsibilities to the BSC or MT, however, the ultimate responsibility for the process lies with the Case Management team. This does not mean a BSC or MT can refuse to take part in an ISPT or fill out packets. Members of the clinical team should be sure all documents in a packet are complete and accurate in order to ensure reauthorization of services.

- The BHMCO and DPW require 10-day notice of any scheduled ISPT meetings (no exceptions). Clinical leaders will be given a date range by the Case Management team in which the ISPT is to be scheduled; it is the responsibility of the team leader to notify the Case Management team at least 12 days prior to the ISPT to comply with BHMCO regulations.

The necessary participants are to be contacted and invited to the ISPT. They include, but are not limited to:

1. Legal Guardians.
2. Child (if 14 years of age or older).
3. County Mental Health Representative.
4. BHMCO Care Manager.
5. BHRS Clinician(s) (BSC, MT, TSS only in the presence of the client or with permission from the Case Management team).

6. Psychologist.

7. CCIU Case Management team.

8. School Personnel (when appropriate).

9. Other public agency personnel involved with family.

The original copy of the application of authorization packet is kept in the client’s file. The team leader and parents also receive a copy. The BSC is responsible for supplying the team with the new Treatment Plan. If there is no BSC, then the MT is responsible.

The completed reauthorization packet must be submitted to the Case Management team within two business days from the ISPT meeting. Case Management team must submit the ISPT reauthorization packet to BHMCO 10 business days prior to the end of the service authorization (Fee for service packets must be submitted 21 days from the expiration date).

GRIEVANCES

The OMAP or the BHMCO reviews the entire packet and makes a determination whether to:

1. Approve the services as requested.

2. Approve the services, but authorize a reduction in the amount of service.

3. Refuse to authorize the service.

If services are denied by the BHMCO or OMAP a denial notice is sent to:

1. The provider.

2. The prescriber.

3. The legal guardian.

The client may disagree with the BHMCO or OMAP. A formal disagreement can be made by the family calling or filing, in writing, a first level grievance. The grievance must be filed within 45 days from the date of the denial. If the grievance is filed within 10 days of the date of the denial the client may continue to receive services at the same level as approved by the previous authorization.
If this is the initial application for authorization packet then the client must wait for authorization before services may begin. The BHMCO must render a decision with 30 days of receiving the grievance. It is possible to request that the grievance be reviewed more quickly by calling the BHMCO. When the BHMCO renders its decision for the first level grievance, and the client still disagrees they may file a second level grievance.

If an appeal is not filed within 10 days, the client is subjected to the hours authorized by the BHMCO after the first appeal.

Parents may also request a fair hearing from DPW within 30 days of the date of denial.

BHRS PROCEDURES FOR DAILY/WEEKLY REPORTS

The number of BHRS hours authorized and provided is reported to the Pennsylvania Department of Public Welfare. In addition, the reasons why any BHRS hours were not provided are also reported to the Pennsylvania Department of Public Welfare. It is important to have BHRS reporting submitted accurately and on a timely basis.

Every TSS, BSC and MT must report the following information on his or her daily and/or weekly reports:

- The number of hours authorized (assigned).
- The number of hours provided.
- The number of hours not provided.
- Reason code(s) for the number of hours not provided and an explanation(s) of the reason code.

This information must also be documented on the weekly electronic time sheets.

On the daily report, the number of hours authorized refers to the hours each particular person is assigned to work, not the number of hours the child is authorized to receive. For example, if a child is authorized for 20 TSS hours per week and the Staff Person is assigned to work 15 hours per week, with 3 hours per day being the norm, the Staff Person will indicate that they are authorized to work 3 hours each day. If the Staff Person works 3 hours per day for the first 2 days that week, on each daily report they will indicate that they are authorized for 3 hours and that they provided 3 hours with a Reason Code of 0 (meaning that all hours were provided as authorized). If on the third day, the staff person is sick and only able to provide 1 hour of service, they will indicate that they are authorized for 3 hours and that they provided 1 hour and did not provide 2 hours with a reason code of 3 and an explanation that they were sick. If on the fourth
day and fifth days the client is on a trip, the staff person will send in one report indicating that they are authorized to provide the 6 remaining hours and did not provide any hours with a reason code of 2, and an explanation that the client was unavailable due to a trip.

Multiple reason codes may be used. To use multiple codes, a specific reason code and explanation must be given for specific hours not provided. For example, if 3 hours are authorized for a particular day and the staff person is one half-hour late, and one hour into the session, the client gets sick and the session must be ended, BHRS reporting would be as follows: 3 hours authorized, 1 hour provided with reason code 0, one half-hour not provided with reason code 3 and an explanation that staff was late; one and one-half hours not provided with reason code 2 and an explanation that the client was sick.

Staff should consult the list of utilization codes on the CCRES website. Any questions should be directed to the Case Management team.

All absences must be reported to the Case Management team in advance. All absences should also be reported as soon as possible and should be reported on the CCRES Provider Schedule System.