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CCIU HOME & COMMUNITY SERVICES PROCEDURAL MANUAL

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CCIU 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 heath 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 Human Services (DHS) (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 DHS 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 DHS 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 a minimum of 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.
- 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-5
- Adult Protective Services Mandated Reporting

Effective July 12, 2015, each TSS and BHPCA is required to complete 44 hours of training 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 and Intervention-specific training dependent on their client's needs
- Corporate Compliance as stipulated by the Bureau of Program Integrity
- Child Abuse Recognition and Reporting and Adult Protective Services: 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, Lebanon 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 Human Services

(DHS) 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 DHS.

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.
5. Freedom of Choice Statement page 1 and 2.
6. Grievance Procedures page 1 and 2.
7. Copy of Medical Assistance (ACCESS) Card.
8. Private Insurance/Medical Assistance form. (Copies of each card also needed if applicable.)
9. Consent to Release Information forms.
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 Human Services (DHS) 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 (EI/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.
4. Summary of Interagency Review Meeting.
5. Wraparound Services Progress/Change/Continued Need (page 1 and 2).
6. De-Escalation/Crisis Intervention.
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).
12. Comprehensive Psychological Evaluation.
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 4-6 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 Human Services 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 DHS 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 form 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 by 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 DHS 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 Human Services. In addition, the reasons why any BHRS hours were not provided are also reported to the Pennsylvania Department of Human Services. 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.

PROCEDURES FOR COMPLETING THE PSYCHOLOGICAL EVALUATION (MA FUNDED)

The following are the procedures for the H&CS Psychological Evaluation:

1. The H&CS Case Management team contacts the licensed psychologist to schedule a Comprehensive Psychological Evaluation at the earliest possible date.
2. The Case Management team then contacts the client's family, makes certain they sign releases to obtain other pertinent information to the formation of a comprehensive evaluation and contacts the BSC and other clinical staff for updates, etc.
3. The psychologist then makes arrangements to review child's medical chart, copy needed material, and interview the child with his/her legal guardian(s).
4. The psychologist observes the child's behaviors and translates observable behavioral symptoms into DSM IV (DSM V as of May 2014) diagnosis. An emphasis is placed on the child's strengths, family dynamics, goals of service, and recommendations for services. The psychologist in consultation with the team decides the medical necessity of specific services and the hours of services needed.
5. All the information that has been obtained is assessed and composed into a Comprehensive Diagnostic Psychological Evaluation.
6. The evaluation report is completed within seven (7) days and given to the Case Management team assigned to the client.
7. **Psychological Addendum:** When there are significant changes in a child's life that require a change in the recommended hours of service a psychological addendum is prepared, reflecting what the changes are and justifying the need for change in services. A psychological addendum is also necessary when the ISPT disagrees with the recommendation within the original clinical evaluation and negotiates with the clinical evaluator a change in frequency and/or duration or substitutes alternative service. If a child is on an extended authorization (according to the DD Bulletin) a full psychological evaluation may need to be completed to recommend any changes to the current service authorization.

CONFIDENTIALITY OF BEHAVIORAL HEALTH RECORDS

All H&CS staff are bound by the requirements of Health Insurance Portability and Accessibility Act of 1996 (HIPAA) the Commonwealth of Pennsylvania, the Pennsylvania Department of Human Services Regulations and the Chester County Intermediate Unit policy on confidentiality. Persons seeking or receiving services from any of the CCIU H&CS Programs can expect that information about them will be treated with respect and confidentiality.

Limitations of confidentiality would include any information relative to the mandatory reporting of suspected child abuse or reports of intention to harm self or others.

Records

Records include, but are not limited to, all written information related to daily/weekly clinical reports, observations, fiscal documents, case management notes, and any file of material retained by the H&CS. Records received from other agencies become part of the client's records and are subject to the same conditions. Records of a client are the property of Chester County Intermediate Unit's H&CS or any of the H&CS satellite programs. The clients have control of the release of information contained in their personal records.

CONSENSUAL RELEASE OF INFORMATION

- In general, only signed original Authorization for Release of Records or Information form requests are acceptable before information, either verbal or written, is released. If a faxed Authorization for Release of Records or Information form is received requesting records, there must be a statement on the faxed release clearly stating that the faxed release is acceptable in lieu of the original. If it is requested that records be sent by fax, it must be clearly stated on the release that records can be forwarded over a fax transmittal. If records are going to be forwarded by a fax, the cover sheet must be stamped confidential and the sender of the records must call the requester of the records to verify that they were received.
- The Coordinator of H&CS may make exceptions under unusual or extenuating circumstances, but only after careful and thorough review.
- Sufficient time, 5 business days, must be given to allow for adequate review of the request for Release of Information, and to process the request.
- Clients, under the age of 14, require an Authorization for Release of Records or Information form provided by H&CS signed by parent or legal guardian before any verbal or written information is released. This form is to be witnessed, signed, and dated by a responsible party.
- Written records to be released must be approved by the Case Management team of H&CS. Only the H&CS Billing Department, Department Secretary, or Case Management team may do the actual copying of such records. This is to ensure that documentation can be noted in the record file as to what information has been released and to whom it has been released.
- A signed Authorization for Release of Records for Information form must be secured each time information is requested. The Authorization for Release of Records or Information form must contain the following factors:
    - A time limit on its validity, which shows starting and ending dates.
    - Identification of the agency or person to whom the records are to be

released.

- A statement of the specific purposes for which the released records are to be used.
- A statement identifying the specific relevant and timely information to be released.
- A place for the signature of the client or parent/guardian and the date following a statement that the person understands the nature of his release.
- A place for the signature of a staff person obtaining the consent of the client or parent/guardian and the date.
- Indication that the consent is revocable at the written request of the person giving consent.

➢ The following written statement must accompany all records, released or disclosed:

This information has been disclosed to you from records whose confidentiality has been protected by state and federal statute. State and federal regulations limit your right to make any further disclosure of this information without prior written consent of the person to whom it pertains.

➢ If no expiration date is noted, Release of Information Forms will be valid for a one-year period.

NON-CONSENSUAL RELEASE OF INFORMATION

Client records shall be kept confidential and shall not be released without consent of the client except in the following circumstances:

1. CCIU ("The Provider") may disclose Patient Information to another provider without first obtaining a written request if the request is for the purpose of providing emergency treatment to the patient. The Provider may disclose Patient Information to the Patient's family or other person in an emergency circumstance if the disclosure is in the patient's best interest. However, prior to release of a summary under this subsection, it is necessary to obtain approval from the Supervisor or Coordinator of H&CS.
2. To third party payers, both those operated and financed in whole or part, by any government agency and their agents or intermediaries, or those who are identified as payer or co-payer for services and who require information to verify that services were actually provided. Information to be released without consent or court order under this subsection are limited to staff names, dates, types, and costs of therapies or services and a short description of the general purpose of each treatment session or service.
3. To reviewers and inspectors including Commonwealth of Pennsylvania

licensure or certification when necessary to obtain certification as an eligible provider of services.

4. To a county MH/IDD administrator, with his/her duties under applicable statutes and regulations.
5. To a court or mental health review officer in the course of legal proceedings authorized by the mental health act.
6. In response to a court order when production of the documents is ordered by a court
7. To appropriate state and county personnel related to child or patient abuse, including active Children and Youth investigations.
8. In response to an emergency medical situation when release of information is necessary to prevent serious risk or bodily harm or death. Only specific information pertinent to the relief of the emergency may be released on a non-consensual basis.
9. To parents or guardians when necessary to obtain consent to medical treatment.
10. To attorneys assigned to represent the client at a commitment hearing.

Clients or the parents of clients under the age of 14 shall be notified of the specific conditions under which information may be released without their consent.

Information may not, without the client's consent, be released to additional persons or entities or used for additional purposes.

CLIENT'S ACCESS TO RECORDS

Records of a person receiving BHR Services are the property of the CCIU H&CS Program and their satellite offices. The term "access" when used in this subsection, refers to physical examination of the record but does not include nor imply physical possession of the records themselves or a copy thereof. A person who has received or is receiving treatment, may request access to his records, but shall be denied such access if one of the following conditions exists:

1. Upon review of the documentation by the Case Management team of H&CS, he or she determines that disclosure of specific information concerning interventions will constitute a substantial detriment to the client's treatment and/or well-being.
2. When disclosure of specific information will reveal the identity of persons or breech the trust or confidentiality of persons who have provided information upon an agreement to maintain their confidentiality.

If a client wishes to enter a written statement qualifying or rebutting information in their records, which they believe to be erroneous or misleading, they shall have the right to prepare such statement for inclusion as part of their record. The client's written statement should accompany all released records.

The Supervisor of H&CS may require that a mental health professional, who is a member of the clinical team and who has reviewed the record in advance, be present when the client or legal guardian examines the record to aid in the interpretation of documents in the record.

If the person is denied access to all or part of his/her record, this act and the basis for the denial should be noted in the person's record.

A client has the right to receive copies of their own medical records. Clients or parents/guardians, if client is 14 years and younger, must make the request in writing to the Case Management team or the Coordinator of the program. All written requests must specify the exact information being requested, time period of request, and signature of the client (if 14 years and older) and/or the legal parent/guardian. The Coordinator will review the request upon receipt. All approved requests will be processed within 30 days as stipulated by HIPAA. For ongoing copy requests the copies will be processed and sent at the end of each month. Families can be charged a "reasonable" fee based on the costs of materials and staff time spent copying the record.

HIPAA generally allows a parent to have access to the medical records of his or her child. There are three situations when parents would not be the minor's personal representatives under the privacy rule. These exceptions are: (1) when the minor is the one who consents to care and the consent of the parent is not required under state or applicable law; (2) when the minor obtains care at the direction of a court or a person appointed by the court; (3) when, and to the extent that, the parent agrees that the minor and health care provider may have a confidential relationship. However, even in these exceptional situations, the parent may have access to the medical record of the minor related to this treatment when State or other applicable law requires or permits such parental access. Parental access would be denied when State or other law prohibits such access. If State or other applicable law is silent on a parent's right of access in these cases, the licensed health care provider may exercise his or her professional judgment to the extent allowed by law to grant or deny parental access to the minor's medical information.

Finally, as is the case with respect to all personal representatives under the Privacy Rule, a provider may choose not to treat a parent as a personal representative when the provider reasonably believes, in his or her professional judgment, that the child has been or may be subjected to domestic violence, abuse or neglect, or that treating the parent as the child's personal representative could endanger the child.

RELEASE TO COURTS

Whenever a client's records are subpoenaed, other than proceedings authorized by the Mental Health Act, and the client has not consented to release the records, no records should be released in the absence of an additional order of the court.

Clients' records should be released in the absence of such action if they are currently receiving services and their whereabouts are known. In a case of person's no longer receiving services, the Chester County IU H&CS shall send notification by Certified Mail to the last known address.

INTERAGENCY TEAM CONFIDENTIALITY

A BHRS ISPT Sign-In and Concurrence Documentation form is to be filled out and completed at every interagency team meeting, which includes other agency/program personnel. This form must be signed and completed by all persons present at the meeting. Signing of this form guarantees a client's right to privacy and confidentiality. Signing of this form binds all team members to the confidentiality guidelines as mandated by state statute and regulation.

SECURITY OF RECORDS

As Identified by The Health Insurance Portability and Accountability Act of 1996 (HIPAA), H&CS has the responsibility to ensure that all medical records are secured within each program location. Therefore, only authorized personnel may access BHRS clinical records, which are maintained in a secured facility. Approved workforce members/service providers, who are either under the direct control of the covered entity (CCIU H&CS), or an approved business associate entity (CCRES) with a signed HIPAA business associate agreement, may gain access to medical records. Additionally, it is important to note that an "individual" business associate (i.e. contractor or employee from CCRES) must have, at minimum, a formal work/service agreement/contract with the business associate entity (CCRES), as well as have a signed "individual" HIPAA business associate agreement before they may gain access to medical records.

No clinical record may be removed from the central file area except for case review and then only in the possession of a member of the Chester County IU H&CS staff.

At the close of regular business hours, all clinical records must be secured by removal from unsecured offices and cabinets. All records will be kept in a locked secure area. Only authorized personnel, including clinical/clerical H&CS Program staff, will have access to records.

Any material identifying a client may not appear accessible to the general public.

Violations of any of the above policy provisions will subject the staff member to disciplinary action up to and including dismissal. The employee or clinician involved could potentially be subject to civil or criminal liability.

A listing of health information disclosures is required by HIPAA. A listing is not required when records are disclosed to the many individuals who see your health records for treatment, payment, and health care operations.

Date: March 2016

Record Access and Retention Procedure

Access to Records:

1. Records are not accessible to anyone without the written consent of the client, the client's parent/guardian, the person holding the client's power of attorney for health care or health care proxy, or if a court orders disclosure other than the following:
    a. The client
    b. CCIU staff for the purpose of providing services to the client
    c. The Department or Department's designee.
    d. Any entity that is permitted to access records under the law.
2. Up to 1 year of a client's Medical record will remain in a locked area, protecting the client's confidentiality.
3. Once it has been determined that the medical record is full and/or has more than 1 years worth of information in it, the CM/CS will complete an internal audit of all the documents.
4. After the CM/CS has completed their internal audit of a client's chart, it will be sent to ESC via courier to be scanned and made into an electronic record.
5. It will remain in the secured electronic record management system (SERMS) for up to 7 years.
6. This secured electronic record management system (SERMS) complies with the following:
    a. The electronic record must be readable
    b. Conforms to Federal and State requirements
    c. Constitutes a duplicate of the original paper record and has not been altered or if altered shows the original and altered versions, dates of creation and creator.
    d. The electronic record can be converted back into legible paper copies and assessed by an auditing agency.

PROCEDURE FOR SCANNING PAPER CHARTS FOR ELECTRONIC STORAGE

REQUEST A SHIPMENT

1. Make a request for boxes to be shipped to the Educational Service Center (ESC) for electronic storage purposes via courier on demand at http://www.courier.cciu.org
    a. Be sure to indicate an "Item Type" of "Box Large"
    b. Be sure to include the number of boxes

c. In the “Additional Notes” section note that the boxes are for the Document and Imaging department.

Instructions on how to sign up for a courier on demand account can be found at http://www.cciu.org/Page/108

2. Please use this same practice to request, file box return and/or that service to a given location be cancelled, and file storage boxes be returned.

SHIPMENT

Each and every box shipped from any H&CS location (including ESC) will be shipped with 3 forms that are provided by H&CS staff and filled out as indicated on the form. They include:

1. The “Delivery Signature Form”
2. The “Box Content Check Form”
3. The “Scanned File Notification Form”

The “Delivery Signature Form” will be attached to the outside of the box.

1. The procedure for processing the “Delivery Signature From” is:
    a. H&CS staff will
        i. Fill out sections 1-14 on the “Delivery Signature Form.”
        ii. Attach the form to the outside of the box.
    b. On pick up the courier will:
        i. Verify that all information has been correctly filled out by H&CS staff, and that the box is sealed
        ii. Sign and date the “Delivery Signature Form” and transport the box to the Document and Imaging department
        iii. Obtain a signature on the “Delivery Signature Form” from an Office Services staff member to verify delivery
    c. Office Services staff will:
        i. Scan the “Delivery Signature Form” and email it to Document and Imaging staff for electronic storage in a folder named with the file box number (LHCS-1129), in the “H&CS File Boxes” folder on the Reception Common share. The “H&CS File Boxes” folder is a password-protected folder to which only Document and Imaging staff and Kristie Zoltek have access.
        ii. Send the original paper copy to Catherine Scanlon c/o Evelyn Graves in a sealed envelope.

The “Box Content Check Form” and the “Scanned File Notification Form” will be enclosed inside the box in one envelope by H&CS staff.

2. The procedure for processing the “Box Content Check Form” is:
    a. Scanning staff will:
        i. Verify that the box contains an envelope that has enclosed both the “Box Content Check Form” and the “Scanned File Notification Form.” If it does not they will proceed directly to step 2aiv1.
        ii. Remove the “Box Content Check Form” from the envelope in the box and verify (by checking the appropriate boxes on the “Box Content Check Form”) that the client names and file numbers on the “Box Content Check Form” match those on the file folders in the box.
        iii. If the contents, as described in step 2aii, are a match scanning staff will:
            1. Sign and date the “Box Content Check Form”
            2. Scan the form and email it to themselves for electronic storage in the corresponding file box folder in the “H&CS File Boxes” folder on the Reception Common Share
            3. Send the original paper copy to Catherine Scanlon c/o Evelyn Graves in a sealed envelope.
        iv. If the contents are not a match scanning staff will:
            1. Note the discrepancy on the “Box Content Check Form” next to the corresponding client name. If the “Box Content Check Form” and/or “Scanned File Notification Form” aren’t enclosed this will be noted on the “Return Delivery Signature Form.”
            2. Sign and date the “Box Content Check Form”
            3. Email the sender to notify them that the box is being returned due to discrepancy or because the box didn’t have the “Box Content Check Form” and/or “Scanned File Notification Form” enclosed.
            4. Enclose both the “Box Content Check Form” and/or the “Scanned File Notification Form” in the provided envelope (if they exist) and seal the box
            5. Create a courier request for return delivery
            6. Fill out items 1-14 on the “Return Delivery Signature Form”
            7. Attach the “Return Delivery Signature Form” to the outside of the box.
    b. The courier will:
        i. Verify that all information has been correctly filled out by Document and Imaging staff, and that the box is sealed
        ii. Sign and date the “Return Delivery Signature Form” and transport the box to the appropriate H&CS location.
        iii. Obtain a signature on the “Return Delivery Signature Form” from an H&CS staff member to verify delivery

iv. Return the “Return Delivery Signature Form” to the Document Imaging department

c. The Document and Imaging staff will then:
    1. Scan the form and email it to themselves for electronic storage in the corresponding file box folder in the “H&CS File Boxes” folder on the Reception Common Share
    2. Send the original paper copy to Catherine Scanlon c/o Evelyn Graves in a sealed envelope.

3. The procedure for processing the “Scanned File Notification Form” is:
    a. Scanning staff will:
        i. Keep the “Scanned File Notification Form” inside the box until they begin to scan the contents.
        ii. As they scan and complete each respective file or files for each client they will sign and date the “Scanned File Notification Form” as appropriate and return the form to an envelope in the box.
        iii. When the last signature is acquired on the “Scanning Notification Form” scanning staff will:
            1. Scan the form and email it to themselves for electronic storage in the corresponding file box folder in the “H&CS File Boxes” folder on the Reception Common Share
            2. Send the original paper copy to Catherine Scanlon c/o Evelyn Graves in a sealed envelope

FILE AND FILE BOX RETURN

A box will be maintained in the scanning department/cage for each of the three H&CS locations for file folders. When the box for each respective location becomes full the files will be returned via courier. A Document and Imaging staff person will make a request via courier on demand for the files to be returned. A “Return File/File Box Signature Form” will be attached to the outside of the box. When the respective H&CS staff person signs off on receipt, the courier will return the form to the Document and Imaging department. Document and Imaging staff will scan the form and store it in the “H&CS File Boxes”, “Returned.File.Folder.Boxes” folder with one of the following conventions:
Date.Location.Returned.File.Boxes
Date.Location.Returned.File.Folders
Examples:
4.7.14.DelMont.Returned.File.Boxes
4.7.14.Lancaster.Returned.File.Folders

H&CS staff can request the return of file boxes via courier on demand. The same return signature form and process will be used.

TRANSFER BETWEEN H&CS COUNTIES

Occasionally, when an H&CS client moves from one county to another, it is necessary to transfer the client between H&CS offices. In order to complete this transfer:

1. The Case Management team notifies their own Coordinator of impending case transfer.
2. The sending Coordinator contacts the receiving Coordinator.
3. Together, the Coordinators generate dates for move and potential time period for transfer
4. Sending Case Management team will contact receiving Case Management team to confirm necessary documents and forms for packet submission. Sending team must also stay involved until new authorization exists.
5. Receiving Case Management team will put packet together and send to funding source for review.
6. Once County/MCO confirms change to new county, both Counties will meet with family for transfer:
    a. New County do intake
    b. Old County writes up termination note.
7. Ship files to receiving County.

TRANSFER/DISCHARGE CRITERIA

For all clients transferring to another service or provider or being discharged, the following steps are to be carried out:

1. The Clinical leader must write up a discharge summary including reason for discharge and diagnosis upon discharge.
2. The Clinical leader must fill out the appropriate Discharge Planning form.
3. The client/family must sign a release of information.
4. The Case Management team must submit all forms and requested material to the new provider and the BHMCO.

Date: March 2016

ABUSE/INCIDENT REPORTING POLICIES

All H&CS staff are required to complete the "Recognizing and Reporting Child Abuse: Mandated Reporter" training every five years. New staff must complete this training within 30 days of hire. It is available online on Moodle.

Child Abuse

RATIONALE

The CCIU H&CS program believes that the abuse of children by their parents or caretakers is an extremely serious problem. Furthermore, the Pennsylvania Child Protective Service Law (Title 23 Pa. C.S.A. Chapter 63) requires childcare workers/clinicians/educators to report cases of suspected child abuse to the county office of Children and Youth or Child Line. Failure to report suspected child abuse is a summary offense.

TYPES OF ABUSE

Serious physical or mental injury which is not accidental and/or sexual abuse and/or serious physical neglect of children under age 18 caused by the acts or omissions of a perpetrator. Any act or omission that jeopardizes the welfare of the child may be considered abuse.

REPORTING CHILD ABUSE

Within 24 hours, the mandated reporter must make the call to Child Line and/or Children & Youth, and fill out the CY-47 form. This can be done online or via telephone. You must also fill out an H&CS Childline Incident Report (available on Moodle Resources).

You must contact your Case Management team or Coordinator, who can also assist you with your report if needed. Do not discuss with family, school personnel or community activity staff until you have spoken with a member of your Case Management team.

If you are a TSS at school with your client and you have reason to suspect that your client is in imminent danger and shouldn't go home, contact a member of your Case Management team. Unless there are unusual circumstances, s/he will direct you to immediately report your suspicions to the teacher and the designated administrator at school, whether it is the nurse, principal, guidance counselor or mental health specialist. The administrator will contact Child Line or Law Enforcement as needed. You should collaborate with the administrator and teacher in making this report.

If you are a PCA or TSS at school and you suspect that another student (not your client) is a victim of abuse, report this to the teacher and/or designated school personnel with whom you will collaborate in making the report to Child Line. Notify your Case Management team of the situation.

If school does not respond to your suspicions but you believe that your suspicions are reasonable, contact your CM to discuss the situation. S/he may suggest that you immediately report it yourself.

If it is after 4 PM and you are working with your client at home or in the community, and you have reasonable suspicion that your client has been abused, you must make the report and leave an email message for your Case Management team and phone him/her first thing the next morning.

If it is a weekend or holiday, you only have 48 hours in which to send in a CY-47 following your report (which must be made within 24 hours). Call Child Line, follow up with a courtesy call to Children & Youth, and then download, print out and complete a CY-47 form from our Moodle Resources page (Mandated Reporter resources). Send the CY-47 to Children & Youth yourself and report this to your Case Management team on the next workday. Also complete an H&CS Childline Incident Report. Effective in 2015, these reports can be emailed directly to the agency.

You should always feel comfortable following up with the county Children & Youth agency after 30 days to learn whether your report was determined to be unfounded, indicated or founded, and what steps have been taken.

Adult Protective Services (APS)

MANDATED REPORTING OF ABUSE AND NEGLECT FOR ADULTS, AGE 18-59

Home and Community Services provides services to both children and adults. Beginning July 2015, all H&CS Providers will become familiar with the Adult Protective Services Mandated Reporter Law in the Commonwealth of Pennsylvania. They will complete a 23-minute webinar online followed by a quiz, earning a minimum grade of 80%.

H&CS Providers hired after July 10, 2015 will complete this training as part of their TSS Initial Training. All current employees and contractors are required to complete the training during the 2015-16 training year.
New contractors must complete the APS Mandated Reporter training within one year of hire.

This training counts towards annual training requirements, and at this time, staff must complete it one time only.

PROCEDURE FOR REPORTING ADULT ABUSE OR NEGLECT:

- If you have reason to suspect that an adult with a disability is a victim of abuse, neglect, exploitation or abandonment, you are required to make an immediate oral report to the **Protective Services Hotline at 1-800-490-8505**.
- Within 48 hours after the oral report, you must submit a written report to the APS Agency (Liberty Healthcare) for their review at RA PWAPSMandatoryRon@pa.gov or fax it to: **484-434-1590** (a mandatory abuse report form and instructions can be found on the DHS website at: http://www.dhs.state.pa.us under the "report abuse" link). The mandatory abuse report form can be used as the written report.
- Liberty Healthcare will review the reports and determine if an onsite investigation is necessary.
- If you suspect the individual is the victim of sexual abuse, serious injury, serious bodily injury or that a death is suspicious, in addition to contacting the Protective Services Hotline, you must **also** immediately contact local law enforcement **and** make an immediate oral report to the Department of Human Services (DHS) by calling **717- 265-7887 and selecting option #3**.

Client Threats Toward Others

H&CS staff has the obligation to report immediately to the Case Management team any serious threat by a client towards a third party. Procedures to be followed are:

1. The clinician determines that there is a threat and that the client may act on his/her threat.
2. There is a specific target of the threat, i.e., some identified person(s) (and not a generalized group, e.g., all adults, public at large or the whole community.)
3. Tell the client your obligation to report this threat.
4. Report the matter to the Case Management team and make a written note on an Incident Report form for client file. It is then the Case Management team's responsibility to:
    - Inform the targeted person(s) immediately by phone, with a written follow-up.
    - Inform the relevant police force by phone of the perceived threat and with a written follow-up.
    - Inform the client's parent(s)/legal guardian(s).
    - If the location of the person is unknown, or the person cannot be contacted, inform the local police and the police in the area where the person is thought to be.

Document all actions and provide a copy to the Coordinator.

If the Clinician believes the client to be an immediate threat to him/herself or others and in danger of death because of severe mental illness, the Clinicians shall inform the client that a petition for involuntary examination (302) will be made. Clinicians should contact the police and their county MH/IDD crisis intervention office for further direction. The Case Management team must be informed immediately.

CRISIS INTERVENTION NUMBERS:

Chester County	610-918-2100
Delaware County	Crozer Chester Medical Center 610-447-7600 Crisis Connections Team (mobile & phone crisis) 855-889-7827
Lancaster County	717-394-2631
Montgomery County	Children's Crisis Support Team 888-435-7414

Please note any action taken by the Clinicians does not preclude the legal guardians ultimate responsibility for the client's welfare.

Incident Report Procedures

INCIDENT REPORTING PROCEDURES:

An incident is defined as any circumstance, which involves:

1. Physical injury to the child, family member, or staff.
2. Any and every time staff must intervene physically with a child.
3. An unusual circumstance, which may produce adverse reactions for the child either immediately or at a later time.
4. Any and all accidents involving staff and/or child connected in any way to the fulfillment of your job duties.
5. Any and all circumstances resulting in property damage.
6. Any and all suspicions or witness of abuse.
7. Any involvement with emergency medical and/or police personnel.
8. Any instance where the current policies and procedures are not adhered to for any reason.
9. **WHEN IN DOUBT, FILL IT OUT.**

REPORTING PROCEDURES:

1. All incidents need a written Incident Report.
2. The staff member must report, via phone or with the actual Incident Report, to the Case Management team within 24 hours of the incident. If the staff member cannot reach the Case Management team, then they need to contact the program Coordinator. Please do not leave a message. Please speak with someone directly. If it is after hours leave a message for the Case Management team and follow up the next morning.
3. Documentation must clearly state if the client's behavior warranted physical intervention. Clinicians must state why physical intervention was needed to avoid the client being injured by another, or injuring him/herself.
4. The staff member MUST hand in the completed written form to the Case Management team of H&CS within 24 hours of the incident.
5. The Case Management team will sign the incident report with the date and time received and the staff member and client involved.
6. Case Management team must submit a copy of the Incident Report to the Coordinator, State, County, School District or corresponding MCO within 24 hours of receipt.
7. The original report is filed in the client's main record.

For incidents involving injury to client, legal guardian or staff or involving property damage, or suspected abuse follow incidents report procedure as outlined above. With the following exceptions:

1. Seek immediate medical attention if necessary
2. Report to the Case Management team within one (1) hour

HOME AND COMMUNITY HABILITATION

DHS OFFICE of Developmental Programs (ODP)

ODP INCIDENT MANAGEMENT REPORTING PROCEDURE

1. CM/CS will report any of the following incidents in HCSIS within 24 hours of the discovery or occurrence of the incident:
    a. Death
    b. Suicide attempt
    c. Hospitalization
        i. Medical or psychiatric
    d. Emergency room visit

   e. Abuse as follows:
      i. Physical abuse
      ii. Psychological abuse
      iii. Sexual abuse
      iv. Verbal abuse
   f. Individual to individual abuse
   g. Neglect
   h. Missing person
   i. Law enforcement
   j. Injury requiring treatment beyond first aid
   k. Disease reportable to the Department of Health
   l. Fire
   m. Misuse of funds
   n. Participant rights violation
   o. Emergency closure
   p. Crisis event
   q. Restraint
2. CM/CS will report any of the following incidents in HCSIS within 72 hours of discovery or occurrence of incident:
   a. Medication administration error
   b. Restraint unless the restraint falls into the definition of “abuse”
3. If HCSIS is unavailable CM/CS will fax or scan an incident report to ODP and then enter the information into HCSIS once the system is again available.
4. For incidents that are to be reported within 24 hours of discovery or occurrence, CM/CS shall finalize the incident report in HCSIS by including additional information about the incident, results of the required investigation and corrective actions within 30 days of discovery or occurrence of the incident, unless the deadline is extended in HCSIS.
5. CM/CS is to provided a detailed description in HCSIS of the response to the incident, to include:
   a. Prompt action to protect the health and welfare of client
   b. The results of the investigation
   c. Corrective action to be taken
   d. Staff responsible for implementing plan
   e. Specific information regarding disciplinary actions to be taken with staff to ensure the health and welfare of participants.
6. Incidents are to be reviewed quarterly (or more frequently if needed) as required by ODP and must contain information on the incident target.
7. All Certified investigations will occur on all incident categories as outlined on §6000.925 of the ODP Incident management bulletin #6000-04-01.

RISK MANAGEMENT – INCIDENT PROCEDURE FOR ODP

1. All H&CS incident reporting protocols to be used.
2. Staff/CM/CS and Coordinator will review incident to determine the root cause of the incident, if possible, and review and document a corrective action in the incident report to ensure that another incident of that type does not occur again.
    a. To include strategies to address risk factors and risk levels
3. CM/CS will contact client's Support Coordinator (SC) to discuss the incident and potential new strategies so that the ISP can be updated.
    a. Staff would work to integrate new strategies to ensure another incident do not occur. The following strategies would be implemented:
        i. Identify risk factors
        ii. Identify health status, family medical history and medical risks
        iii. Identify behavioral history and risks
        iv. Review incident history
        v. Identify social, environmental and physical needs
        vi. Identify personal safety issues
        vii. Identify strategies to be used to reduce the frequency of incidents or the severity of effects
    4. CM/CS will train staff on client's particular risk factors
    5. CM/CS will ensure that preventative measures are being implemented to reduce potential incidents of risk.
    6. CM/CS will monitor client's risk and work collaboratively to update strategies as needed.

Adult Protective Services (APS)

MANDATED REPORTING OF ABUSE AND NEGLECT FOR ADULTS, AGE 18-59

Home and Community Services provides services to both children and adults. Effective July 2015, all H&CS Providers must be familiar with the Adult Protective Services Mandated Reporter Law in the Commonwealth of Pennsylvania. They will complete a 23-minute webinar online and complete a quiz, with a minimum grade of 80%. H&CS Providers hired after July 15, 2015 will complete this training as part of their TSS Initial Training. All current employees and contractors are required to complete the training during the 2015-16 training year. New contractors must complete the APS training within one year of hire. This training counts towards annual training requirements, and at this time, staff must complete it one time only.

Employee Accident Procedures

Any staff member injured on the job should call the assigned Case Management team and the CCRES office within 24 hours of the incident. If emergency medical attention is required, staff should immediately seek treatment and contact the Case Management team and their staffing agency as soon as possible. Staff

members should consult their Staffing Agency's Policy and Procedures' Manual to determine the appropriate reporting procedure. An H&CS Incident Report and CCRES work related accident form **MUST** be completed within 24 hours and submitted to the Case Management team.

PERSONAL PROPERTY DAMAGE

The CCIU will hold the providing Staffing Agency responsible for property damage and/or theft.

Date: March 2016

RESTRAINT POLICY

NON-VIOLENT CRISIS INTERVENTION TRAINING

It is a requirement that all CCIU H&CS TSSs, BHPCAs, and Respite Workers be trained in Non-violent Crisis Intervention (NCI). All staff members are required to receive training from an instructor who has been certified by the Crisis Prevention Institute (CPI) for 6 hours the first year and up to 3 hours in subsequent years. All employees will adhere to the NCI principles of providing for the health, welfare, safety and security for oneself, others, and the client. Staff members will receive a card documenting the completion of the training. Please note that even though NCI training does include information on manual restraints, no staff member may restrain clients solely based on taking this training. BHPCAs may be asked to follow different parameters when implementing physical restraints, and must consult with their Case Management team in advance.

According to CCIU H&CS procedures, no other certificate is acceptable unless it is specifically the Crisis Prevention Institute, Inc. certificate in Non-violent Crisis Intervention.

In accordance with NCI training philosophy, any and all physical intervention is to be **used as a last resort only**. Physical restraints should not be a behavioral intervention on the treatment plan. Physical intervention is used only to prevent the immediate physical harm to client, self or others. If a client is at risk of needing physical restraining on a continual basis, an ISPT meeting should be held to discuss possible change to level of care, and ALL involved staff must have specific training in manual holds.

Caregivers (i.e. teacher or parent) are the lead and/or responsible party to implement restraining of a client. Clinicians will only become involved when the caregiver needs assistance and/or when the client is in imminent danger and the caregiver is not in close proximity.

Any and all events that require the use of therapeutic physical intervention should be documented on an Incident Report Form. The Case Management team and Program Coordinator must be notified within 24 hours. (See Incident Reporting Procedures)

DHS REGULATIONS REGARDING MANUAL RESTRAINING

Manual restraint should only be used in an emergency as a safety measure, when there is imminent danger of bodily harm to the consumer or others, and only after appropriate less restrictive behavioral techniques have been tried. Less restrictive behavioral and physical interventions include the use of de-escalation techniques by trained staff, such as reducing environmental stimuli, escorting the client to a quiet room and permitting time for the client to verbalize his/her concerns. The clinical staff may not be the lead provider of restraint, unless specifically requested by the contracted funding source. The caregiver is the lead and/or responsible party.

According to DHS, a Physician and/or Registered Nurse are the only professionals qualified to order a manual restraint. BHRS staff is not to be part of the prescription. Restraint and seclusion are emergency safety interventions, not therapeutic techniques.

PHYSICAL REDIRECTION

Physical restraining should not be confused with physical redirection. If the client needs to be redirected by using a hand-over-hand approach, this is considered physical redirection.

Prompting, escorting or guiding a client who does resist assistance in the activities of daily living is not a manual restraint. Physical redirection, if used, must be included in the treatment plan.

Date: March 2016

GUIDELINES FOR BEST PRACTICE

Transportation of Clients

It is the policy of CCIU H&CS that staff members may not transport a client in their own or anyone else's vehicle, unless it is part of a behavioral intervention clearly delineated within an approved treatment plan and the staff is cleared by their staffing agency. Clearance is granted once the proper insurance agreements, waivers, and driving records are signed and approved.

Field Trip Pre-Approval Policy

All of the interventions implemented by the CCIU H&CS staff should be dictated by the treatment plan. Therefore, all staff participation in field trips must be clinically indicated and approved by the Case Management team and Coordinator. The treatment plan should provide an outline of the therapeutic roles and functions of any staff participating in the field trip, including a detailed description of the activities and accompanying specific interventions that are to be followed while on the field trip. These activities and interventions must be documented with achievable, measurable objectives and goals.

Prior approval of the activity/field trip must be obtained from the Case Management team and Coordinator **at least two weeks prior to the planned trip.**

Approval is obtained by submitting the Pre-Approval for Field Trip form.

All activities involving costs to the client must be provided and paid for by the legal guardian. The costs of field trip activities for the H&CS staff should be paid by one of the following:

1. Legal guardian.
2. School district.
3. Other appropriate funding sources.

Guidelines for the Prevention of Disease Transmission

1. Gloves should be worn when handling soiled items, body fluids, excretions and secretions, as well as surfaces, materials and objects exposed to them. **ALWAYS WASH HANDS AFTER REMOVING GLOVES.**
2. Wash hands immediately if they become contaminated with blood or body fluids. Blood and other body fluids — Flush down toilet or place in a plastic bag until it can be disposed of. Examples: Urine, Bowel Movements, Tissues
3. Other items for disposal that are contaminated with blood or other body fluids that cannot be flushed down the toilet should be wrapped securely in a plastic bag (baggie, garbage bag) and placed in a second plastic bag, then closed tightly and discarded as household trash.
4. Any spills of body fluids or waste (blood, urine, stool, vomit, etc.) should be

cleaned promptly as follows:

- Put on gloves.
- Clean with soap and water.
- Then clean with a freshly prepared solution of (5.25°/o) household bleach (Clorox) diluted 1:10 with water.
- (1 part bleach - 1 cup bleach) (9 parts water - 9 cups water)

5. Protect open wounds or skin lesions from direct contact with blood and body fluids.
6. Avoid accidental wounds from sharp instruments - razor, etc.

The guidelines for the prevention of disease are to be used as a guide in the event of an emergency. H&CS staff is not responsible for the "physical care" of any client on a daily basis. It is the responsibility of the caregiver to attend such daily needs.

Court Involvement & Subpoenas

On occasion, H&CS staff may be asked to appear in court to give professional testimony. In the event this should occur, the following procedures must be adhered to:

1. **NO TESTIMONY OF ANY KIND WILL BE PRESENTED WITHOUT A COURT ORDER**. The court order should be sent to the appropriate H&CS office and filed in the client's record. Under no circumstances will H&CS staff and Clinicians home addresses be given out. The Coordinator must approve all requests for a clinician's testimony.
2. If requested to appear in court, immediately notify the Case Management team who will communicate this information to the Program Coordinator. A subpoena orders an individual/clinician to attend the hearing and a court order orders the individual /clinician to testify.
3. According the CASSP principles and DHS regulations, TSS should not have to give testimony in court. If the court is insistent on the testimony of a TSS, legal counsel will be sought.
4. The Coordinator of H&CS will direct staff on how to proceed.

Procedure for providing BHRS outside of Pennsylvania

Requests to provide clinical BHR services outside of Pennsylvania will be reviewed for approval. The following procedure will need to occur:

1. BHRS services are to be provided in the client's home, school and/or local community. The following are some of the parameters to be considered when requesting/considering serve provision outside of the state of PA.

a. Is the location local to the client's home or school?
b. Is the destination a structured, licensed and/or certified program?
c. Family vacations will not be considered.

2. Clinical justification for the request will need to be submitted by the BSC. This justification will need to include (but not limited to) the following information:
    a. What is the Behavioral work that will be provided? Please provide specifics.
    b. Why this location? What is it about this location specifically that necessitates BHR services to be provided at this site.
    c. The above information will need to be documented in the following areas:
        i. Treatment plan
        ii. PCCN
        iii. Evaluation

.

3. The clinical team will need to review any safety concerns. A safety plan and protocol, that includes interventions up to and including calling 911 or other authorities if needed, should be developed and reviewed by the clinical team, and all team members should sign off on such plan.

4. Should there be sufficient justification for the service in the requested location, written confirmation from the funding agent that they are in agreement and approve the service and location will need to be acquired. H&CS staff will request the approval from the funding agent. This approval is required as there is no Reciprocal Agreement to provide BHRS between states.

PROFESSIONAL BEHAVIOR

Privacy/Confidentiality

H&CS Staff have a primary responsibility to respect the privacy and confidentiality of the family and client. Staff members are responsible for stating the limits of this confidentiality to the client and family. Staff members need to learn to recognize situations where the right to confidentiality is waived as in instances of child abuse or the imminent danger to self or others.

1. **Never share or disclose any information regarding the family, including the identity of the family, without an Authorization for Release of Records or Information form signed by the guardian for a specific reason.** This would include not disclosing information to school staff. However, in EI and SD cases please refer to the Case Management team or Coordinator for specific confidentiality guidelines.
2. Therapeutic activities should only include the immediate family members. Never engage in interventions with the client in the company of **unauthorized** individuals including neighbors, friends of the staff, relatives of the staff, other clients, etc.
3. Never discuss client's personal information with unauthorized individuals, including spouses, relatives, school personnel, and colleagues.

Clients 14 and older

As per Pennsylvania State law, any child, age 14 years and older, is required to sign an Authorization for Release of Records, prior to any information exchange.

Ethical and Professional Considerations

Behavioral Health providers, school districts, and other public agencies are responsible for developing and coordinating treatment/educational services for individuals with Autism Spectrum Disorders (ASD) and/or other Mental Health diagnoses. Families that receive Mental Health/Behavioral Health intervention services expect high-quality, professional consideration from the professionals and paraprofessionals serving their children. Staff members need to be aware of how their conduct and attitude could affect the child's functioning and provision of service to the family.

The following practices, in addition to the standing ethical requirements of districts and providers, promote professional and ethical conduct by persons providing services to the families of individuals with ASD and/or other Mental Health diagnoses.

RESPONSIBILITY FOR CONFIDENTIALITY

Staff members who come to the parent's home will have access to confidential information about a child and his/her family. The following principles are vital to the roles of an H&CS Clinician (BSC, MT, TSS, and/or BHPCA):

- The client's right to privacy is paramount and must be respected.
- Case discussions are conducted in a professional manner and in an appropriate place. All assessment data (such as psychological reports, Daily/Weekly reports, Treatment Plans, correspondence, etc.) are kept in a locked, confidential file, and all data are safeguarded against loss at all times.
- The client's name, address, school placement, case history, or unusual incidents are only discussed with individuals who are professionally involved with the client's case.
- Photographs or videotapes of the client or client's family for therapeutic purposes may be taken only after the Case Management team obtains written consent from the parents. No other reasons are allowed or acceptable.
- Clinicians do not and may not speak for any agency, parent, or other party.

PARENT RELATIONSHIPS

Parents are consumers of the services offered by the provider. Clinicians must always maintain a professional relationship and preserve professional boundaries at all times.

- Clinicians should not discuss their personal life with parents. Contact with the child's family should be limited to the context of the Mental Health/ Behavioral Health program/services. All client contact must be treatment plan oriented.
- The treatment team should avoid having case discussions about the family while in their home.
- It is not professionally appropriate for clinicians to socialize with, babysit for, or establish a relationship with their clients or families outside of their professional role.
- Clinicians should not discuss any other clients with whom they work.
- Clinicians should avoid comparing one client's level of development, progress, or program to that of another client.
- Clinicians should always speak with parents in a professional manner. ***Avoid judgmental language. Focus on the family's strengths.***
- Clinicians should listen to what the parent has to say regarding the treatment and services. Some parents may have more extensive experience with behavior management than their clinicians do, and even if they do not know technical terms, parents are certainly more familiar with their children.
- As much as possible, clinicians should always attempt to involve parents in the treatment. If the parent has ideas or questions about the program as a whole or about specific therapeutic procedures, encourage him or her to ask

questions at team meetings or write down questions to discuss at the next consultation.

AVERSIVE INTERVENTIONS

Under no circumstances should any form of aversive stimulation be used, even if the parents request its usage. MA regulations prohibit the use of aversive behavioral interventions. (Aversive stimulation examples: physical discipline, locking children in a room, withholding nourishment)

If abuse of any kind is suspected, clinicians are expected to follow the mandated procedures for reporting abuse.

LIMITATIONS OF TSS ACTIVITIES

TSSs and BHPCAs are hired by a behavioral health provider or school district to provide one-on-one interventions to individuals in the home, school, and/or community setting. TSSs and BHPCAs are not trained, qualified, or legally supervised to be therapists to a parent or family member. The role of "therapist" should be courteously avoided. Parents may ask for advice, or they may wish to discuss their own problems, however, staff should refer to the following best practice protocol:

- Refer matters that suggest the need for therapeutic intervention to the child's BSC, MT and/or Case Management team.
- TSS/ BHPCA training is limited to implementing the treatment plan and/or IEP depending on the funding source (i.e. conducting behaviorally-based interventions with clients).
- If parents ask about their child's diagnosis, prognosis, progress, medical status, or other children's in-home/educational programs, refer those questions to the appropriate source (e.g., Case Management team, BSC, pediatrician, psychologist, school psychologist, speech and language specialist).

IN THE SCHOOL SETTING

- The TSS may have occasion to visit or work in a child's school. This must be approved by the Case Management team. The child's parent should always be consulted prior to contacting the school personnel or visiting a classroom setting. The parent will obtain permission from the child's teacher and explain the purpose of the TSS's activities.

USE OF ELECTRONICS

- All cell phones, tablets, PDAs, and any electronic equipment **must be turned off** while on school property, even in the classroom.
- Staff should not utilize the schools, clients or personal computer/laptop during work hours or on work site unless approved by a Case Management team.

USE OF SOCIAL MEDIA

- Staff should be aware of the communal nature of social media, which prevents anyone who posts, uploads, or otherwise permits content to be disseminated via social media from protecting any confidential information. For this reason, staff should never post, write, upload, tweet, text, email, or otherwise submit any information about clients or services to any social media site or via any social media format. Additionally, any email addresses that you are using for work purposes must be professional in nature.

DRESS CODE

Staff should always dress in a professional manner. Staff assigned to provide services in the school setting should follow the school's approved dress code. It is understandable that, in the home or community setting, staff want and need to dress both comfortably and casually, however, the following attire is strictly prohibited:

- Flip flops or sandals
- Sneakers in the school setting
- Shirts that expose excessive cleavage (i.e. belly tops, tank tops and halter tops.)
- Mini skirts, cut-off shorts, low rise jeans that expose undergarments
- T-shirts with slogans, advertisements, and/or with "offensive" messages
- Any clothing that is soiled or ripped.
- Denim (Jeans) in the school setting (unless it is an approved school staff dress down day or it's the approved school staff attire).

ATTENDANCE

TSS workers are expected to be on time for all scheduled appointments. If the TSS is going to be late, or anticipates missing a session, he or she must inform the Case Management team, parent, and the school 24 hours in advance. All absences may also need to be reported to the appropriate staffing provider and/or electronic sub system such as AESOP.

The TSS should exercise self-discipline related to missing scheduled appointments. The families rely on staff to provide consistent services according to the authorized prescription. The TSS worker is there to help support the caretaker and works with the child and parent together.

DATA COLLECTION AND ANALYSIS

Data collection is the basis for any behavioral intervention. Data ensures objectivity and supplies a basis of comparison between procedures and programs. Data also provides accountability in treatment planning and interventions, showing clearly whether or not progress is occurring. There are many procedures/methods/interventions, the use of which cannot be justified, without

clear data based improvement in the child. Data is also a vital aspect of the early intervention concept as a whole.

- Data should be used to evaluate the TSS's interventions/strategies on a day-to-day basis.
- The TSS is expected to keep clear and careful records of all sessions.
- It is very important that the TSS be as careful and scientific in data collection as possible. Avoid judgmental jargon, personal opinions, and subjective language. It is critical that all daily reports and other documentation are legible.

LIMITATIONS OF TSS TRAINING

The training that TSS workers receive will be valuable and beneficial and it will prepare him or her for more advanced professional responsibilities, but it does not qualify the TSS, legally or professionally, as a behavior analyst or behavior therapist. The TSS is not permitted, by law, to engage in unsupervised private therapy of any type (see Laws and Regulations Relating to the Practice of Psychology, issued by the Board of Psychology). TSS workers must always defer to the Lead clinician with all treatment questions or issues.

Relationships

- Staff should never use their professional relationship to further their own personal interests or endeavors.
- Staff should be are aware of how their own personal needs can influence the client or family.
- Staff should clearly define their role with the client and family at the initiation of services. Staff should never take on a dual relationship where it may impair their professional judgment, reduce their objectivity, or increase the risk of exploiting the client or family (for examples, please see Situations to Avoid # 4, 6, 17, 18, 19, and 25 below).

SITUATIONS TO AVOID

1. Staff should never be left unsupervised with the client.
2. Staff should never bring contraband into the home/school/community setting, including their own personal medications. In addition, personal items, such as medications or firearms, should not be kept anywhere that clients would be able to access.
3. Never take, borrow, or loan money to the client or family.
4. Never engage in personal/intimate relationships with the client or family.
5. Never use foul language in the presence of the client or family.
6. Never use client or family to clean or work for staff.

7. Never compete with legal guardians for the client's affection.
8. Never allow the client or family to drive the staff's car.
9. Never share personal history without prior consultation with a supervisor.
10. Never consume alcohol before or during contact with client or family. Never buy, provide, or share alcohol with the client or family.
11. Never take client or family to staff's home for activity.
12. Never allow client or family to stay overnight at staff's home.
13. Never bring friends or family members along on therapeutic activities or to the family's house.
14. Never engage in illegal acts in the presence of the client or family, or discuss such acts.
15. Never engage in conversation and/or activities with other minors/students. Make sure all interactions are in the behavioral plan, documented in a Daily Report, and, most importantly, are therapeutically and medically necessary for the client.
16. Never provide, share, nor buy tobacco products for the client or family.
17. Never attempt to sell the client or family any products or services (Mary Kay, raffle tickets, etc.)
18. Never form personal relationships with the client or family within one year of completing treatment.
19. Never accept employment from a client or family during or within one year of completing treatment.
20. Never accept gifts or give gifts to the client or family.
21. Never work with the client without the caregiver present and participating.
22. Never work in a school, home, or school setting without the client being present.
23. Never eat meals with the family unless it is part of the service plan goals.
24. Never engage in fraudulent activities while working with the client or family.
25. Never take on the role as a babysitter or caregiver. This caregiver role would include being a client's teacher, tutor, coach, scout leader, etc.
26. Never promote dependency on services with the client or family. Do not enable the client or family.
27. Never participate in collusive behaviors with the client or family (EX: Asking the family to sign off on hours not provided).
28. Never engage in financial conversations with the client or family including, but not limited to, personal earnings.

29. Never engage in personal phone calls or text messages while working with a client. Cell phones, tablets, and PDAs must be turned off during any therapeutic sessions.

EMOTIONALLY CHARGED SITUATIONS TO AVOID

1. Never judge guardians.
2. Never be rigid or uncompromising in conversations with the client or family.
3. Never yell or become confrontational when working with the client or family.
4. Never use physical force with the client except to prevent the client from physical harm. Any physical restraint or force must be reported to the Case Management team immediately.
5. Never force a client to do an activity he/she does not want to do unless accompanied by the legal guardian and specifically agreed upon in the treatment plan.
6. Never talk down to a client or family or be demeaning in any way.
7. Never lie to a client or family (however, it is appropriate to evade personal questions.)
8. Never allow the client or family to provoke you into a defensive or angry posture.
9. Always seek supervisory consultation before confronting family violence or family drug and alcohol use.
10. Always seek supervisory consultation for any case/client situations that are found to be concerning.

Date: March 2016

TSS IN THE SCHOOL

Issues, Guidelines, & Resolutions

TSS services can be offered in three basic settings: child's home, school, or community. On occasion, the role of the TSS may be referred to as a Behavioral Health Personal Care Assistant (Please see BHPCA job description). When staff is assigned as a BHPCA and not as a TSS, they must defer to their Case Management team to clarify their role in the classroom.

Roles and responsibilities will be thoroughly defined through the Guidelines for Provision of In-School Wraparound (BHRS) Services form.

- The TSS's role in a classroom is to assist and support, not to instruct the client or evaluate the teacher.
- The TSS should, at all times, respect and follow the teacher's guidelines, instructions, programs, and routine. If the TSS is in disagreement with school procedure, speak to the Case Management team. Do not try to "fix it" yourself.
- Under no circumstances should the TSS/BHPCA be a disruptive influence in a classroom or home.
- Staff should adhere to the dress code of the school setting.
    - See Dress Code for additional directives.

When it is determined at the inter-agency review meeting that TSS service is needed in the school setting, school personnel must be represented at the meeting, along with legal guardians, the MCO and other mental health professionals. The following essential guidelines must be considered prior to a TSS placement in school:

1. Medical necessity criteria must be met for the services.
2. The school, parent, and the child must agree to mental health treatment of the child and must actively participate in treatment.
3. School personnel must be represented at the inter-agency team meeting to accurately represent the child's progress in school with particular emphasis on the child's emotional and behavioral issues.
4. It is essential that there be a clear understanding on the part of all parties that the TSS does not take the place of the teacher and/or the educational program, but that he/she is there to address those mental/behavioral health needs encountered by the child until such time that those issues can be handled by the educational staff.
5. It is the school's responsibility to teach the child, enforce classroom/school rules, make sure the child is receiving functionally appropriate public education, and ensure that IEP goals are met.

Date: March 2016

Roles of Behavioral Health Program Staff In The Classroom

SUPERVISION OF TSS AND TREATMENT PROGRAM

It is the responsibility of the BSC or the MT to oversee the implementation of the behavioral program, monitor the effectiveness of the behavioral program, and to consult with the TSS to see that the program is effective. It is the job of the TSS to implement the treatment plan interventions as developed by the BSC or MT assigned to the child. The plan is developed with the child, his/her family, and relevant school personnel, where appropriate, to address those behavioral areas that are causing the most difficulties.

When a TSS is in the classroom setting, it is essential that the input of the teacher or other significant adults in the classroom be obtained during the treatment planning process. Their input should address issues of concern in the classroom setting, and should result in a mutually agreed upon behavioral modification program. This collaborative approach should be individualized to the child, address their unique behavioral and emotional concerns, and may be different than the behavioral plan used for the other children in the classroom.

The BSC should refer to and complete *Guidelines for Provision of In-School Wraparound (BHRS) Services form.* This form must be completed and included in the clinical file. It is the responsibility of the Case Management team to ensure effective collaboration and clear communication.

GUIDELINES FOR PROVISION OF IN-SCHOOL WRAPAROUND (BHRS) SERVICES FORM

The Guidelines for Provision of In-School Wraparound (BHRS) Services form is to be completed prior to the beginning of every school year and in the event of a change in school placement or staff during a school year for any client receiving Therapeutic Support Staff in the school setting. This form reviews roles and responsibilities of wraparound staff and school personnel as well as the schedule of the TSS worker within the school setting. It reviews the purpose/goals of the TSS worker in the school. The BSC or the Case Management team will contact the school to set up a meeting to complete the form. The TSS and a school representative must participate in the meeting and the school representative must sign the form indicating agreement with the topics discussed.

TSS-TEACHER-CHILD COMMUNICATION

Teachers need to interact with our client the same as they do with other children in their class. The TSS is there to support the child in following the direction of the teacher. The teacher should communicate directly with the client, so it is important that the TSS avoid situations in which the teacher communicates with the TSS who in turn communicates with child.

It is essential for the child to learn to deal directly with the people in charge of the classroom and decrease dependence on the TSS. It is appropriate, in turn, for

the TSS to remind the child what the teacher has said, or to redirect the child if they are off task, not following directions, not obeying rules, etc.

Role of the TSS in the classroom

The role a TSS plays in the classroom is dependent upon the individual needs of the child. When a child is in need of continual redirection or interventions to prevent disruptive behaviors, it is appropriate for a TSS to be located right next to or behind the child. As the child becomes more "stable" in his/her behaviors, the location of the TSS in the classroom setting can be adjusted. Although the TSS is assigned to a particular child, it is desirable to make his/her role in the classroom as natural as possible. It is not acceptable for the TSS to discipline other children or to take over the responsibilities of the teacher or the aide in the classroom as they pertain to other students in the class.

The TSS can talk to other children, but they should try to be as unobtrusive as possible. Although the adults in the classroom know that the TSS is there for a particular child, it is not necessary for all the other children to know this. There is nothing more stigmatizing than having an adult follow you around all day and the stigma can be somewhat lessened by having the TSS blend in to the classroom setting.

The TSS is not a Classroom Aide

Whenever there is an extra set of hands helping out in the classroom, others take notice. Questions arise from other people in the building as to who the person is and how to go about getting this extra help. It needs to be clear to all concerned that the TSS is not an aide for the class, and is not expected to function as one. The TSS's presence in the classroom is based solely on the mental/behavioral health needs of their client. As such, TSS should not be addressing any educational needs that their client may present. Additionally, the TSS is not a permanent position in the classroom, thus the goal is always to decrease the need for "one-on-one" support in all settings. Included in the treatment plan at some point should be a specific plan to address fading the TSS support in direct relation to the ability of the child to manage his/her own behaviors and/or the classroom personnel to manage the child's emotional and behavioral issues.

Treatment Plan

Every child who has a TSS has a treatment plan. In order for the child to improve in his/her behaviors or emotional state, he/she should have a comprehensive plan or method of dealing with the behaviors that is implemented in all domains. In order for treatment to be most effective, the significant adults in the client's life must agree upon the plan. Issues relevant to the school setting must be addressed in the plan when a TSS is assigned to a particular child in school. The teacher, aide, principal, and any other significant adults in the child's school environment must agree to and support the implementation of the plan, with the TSS being in charge of carrying out the plan and collecting data to monitor progress as it is related to the child's behavior. Any changes in the plan should

occur only with the agreement of significant team members, including educational staff, mental health staff, and parents. In order to determine its effectiveness, the plan is reviewed at least every six (6) months, more often if the need arises. It is also fluid in that it can be changed at any time in response to changes in the child's progress.

Fading support in the Classroom Setting

At some point, as the child's behaviors in the classroom setting stabilizes, the need for “one-on-one” support will be decreased. Fading TSS support should be addressed in the treatment plan. Some important considerations should be taken into account when decreasing TSS support, including the rate of fading, the time at which the support is withdrawn, and the methodology used to fade the support. For example, as the child stabilizes, the intensity of the TSS support within the classroom setting can be relaxed. Initially, a TSS may need to be located next to or directly behind the child, as the child may require constant reinforcement or redirection. As the child adjusts to the classroom, the proximity of the TSS can be changed. He/she may be located in the back of the classroom or might circulate through the class when appropriate. The subsequent step would be to test the child at varying intervals, without the TSS present. As the child becomes more successful, the TSS services should be withdrawn. Looking at a child's school day, support should be withdrawn first in the periods during which the child does his/her best. It is imperative that the TSS collects data concerning the client’s performance relative to target behaviors so that decisions can be objectively based. All decisions concerning the continuation, increase, or decrease in levels of service, should be substantiated with objective data that describes frequency, intensity, and duration of problematic behaviors exhibited by the client.

De-Escalation/Crisis Intervention Plan

Each child should have a De-Escalation/Crisis Intervention plan. This plan should include the names and phone numbers of those people present in the school who are responsible for intervening in the event of a crisis. Additionally, the plan should specify the order in which the people should be contacted. Parents or guardians should be the first listed in the event of a crisis. Secondly, contact people listed should include Case Management team, behavioral specialists, psychologists, intensive Case Management teams, treating physicians, crisis intervention specialists, relatives, or friends who have knowledge of a potential for intervening to help resolve the crisis. This plan should be agreed upon and signed by the parents. The role of the TSS is to provide crisis intervention assistance and to implement the crisis plan. It is the responsibility of identified school personnel to assist the TSS in alleviating the situation until resolution. Roles and responsibilities should be clearly defined in the form *Guidelines for Provision of In-School Services.*

Curriculum Design

It is the responsibility of the teacher to design the curriculum and to teach the child. The TSS is not able to provide any academic instruction. Close consultation

and collaboration between the BSC and the teacher is mandatory in planning for behavioral/mental health treatment programming. In such cases, it is essential that the skills that are being taught in the child's program be reinforced in the classroom. However, the BSC is not responsible to write the behavioral plan for the IEP.

In other situations, we cannot ignore the fact that the level of difficulty of the subjects being taught can impact on the child's behavioral/emotional state. If work is too easy and the child is not challenged, he/she may react with boredom or disinterest. Conversely, if the schoolwork is too difficult, the child may react with frustration, agitation, or give up before even trying. Thus the importance of being appropriately placed in the curriculum is evident.

Collaborative Approach

The TSS is placed in the classroom to work collaboratively with the teacher and other school personnel. They are not there to judge the teaching style, personality, or performance of that teacher. They have been placed in the classroom because of the behavioral/mental health needs of a particular child, not to critique the teacher. It is a desirable outcome if the TSS can assist the teacher to the point that the teacher can focus their energies on teaching and less on the disruptive behaviors of one particular child.

The TSS, BSC and MT should never undermine the authority of the teacher or school staff. All clinicians, TSS included, must first meet with the teacher and school staff to discuss concerns or specific interventions. H&CS clinicians are considered professionals when it comes to behavior related issues. Clinicians should not make educational related recommendations, nor should they judge the academic interventions of the school staff. Additionally, the school staff should not undermine the behavioral related interventions of the H&CS staff. Effective collaboration requires mutual respect and open communication.

If the behavioral staff and educational staff find it difficult to communicate, then each team should consult their respective supervisors. At no time should the client or family be apprised of any difficulties in the collaborative effort. This would only cause the client and the family to lose focus on the real issues.

To prevent communication issue from occurring, it is **mandatory** that the BSC implement the *Guidelines for Provisions of In-School Wraparound (BHR) Services* form. This form should be filled out in a team meeting and should be repeated as necessary (i.e. change in school placement or staff). Once completed, the original should be kept on file in the client's H&CS file.

Confidentiality Issues

As discussed previously, when a TSS is providing service within a school setting, it is readily apparent that there is an extra adult in a particular classroom, and other teachers or school personnel will notice and question staff about who they are and why they are in the school. It is important that the TSS maintains the client's confidentiality by not discussing information related to the

mental/behavioral health issues of the child with school personnel not directly involved with the client. The laws pertaining to confidentiality surrounding educational issues are vastly different from the laws that apply to behavioral and mental health services. These differences become highlighted when a TSS is assigned to a child in a school setting. It is impossible to hide the fact that this person has been assigned to a particular child. However, beyond that, issues regarding the mental health of the child must be kept in the utmost confidence. Access to files and information regarding the child is strictly limited, and verbal exchange of information, psychological reports, psychiatric reports, etc. are released to school or other third parties only when an authorization for the release of information is signed by the parents/legal guardians and the child if he or she is 14 or older. This release must also specify the particular document that is being requested. In addition, the services at home, as well as the challenges and successes in this environment, may not be shared with the school.

When services are prescribed in school, a copy of the treatment plan related to interventions in school must be kept on file with the child's teacher. Any information in the treatment plan unrelated to school may only be released to the school with the legal guardians written consent. Therefore, the BSC should provide two (2) versions of the treatment plan-one that includes only school goals and interventions, and one, for the family, that includes the goals and interventions across all contexts.

However, there are some documents that may be given to the school without this express written consent provided by parents/legal guardians and the client him or herself. Specifically, TSS Daily reports and **school** treatment plans, but not home treatment plans, may be given to a designated person at the school when they refer to and cover the behaviors that our services are addressing within that context. Even though specific written consent is not required for the release of TSS Daily reports and **school** treatment plans, this process should still be reviewed by the treatment team and should be documented within the client's chart.

It is possible that BSC weekly reports and incident reports may also be released to a designated person at the school, without express written permission from parent/legal guardian or client him or herself, but this practice would need to be reviewed in detail by a Case Management team in advance.

MEDICATION ISSUES

School districts must deal with the issue of dispensing medication to children during the course of a school day, and every district has a policy that applies to all children. It is essential that this policy be adhered to stringently, and the fact that a TSS is in place does not change that policy. In order for psychopharmacology treatment to be effective, it must be adhered to as prescribed by the attending physician. It is often the role of the TSS to monitor the effectiveness, as well as observed side effects, of various medications, and to report back to the attending physician. But, **it is not the role of the BHRS staff to administer the**

medication. It should be noted that children on psychotropic medication are often very sensitive about having to take this medication, especially during school hours. All staff should be sensitive to this fact and take all necessary steps to ensure confidentiality around these issues.

THE ROLE OF THE EDUCATIONAL SYSTEM IN INTERAGENCY TEAM MEETINGS AND SERVICE DELIVERY

In order to access BHR Services in a school setting, all of the following supports should have been considered or already be in place:

- Guidance Counseling.
- IST (Instructional Support Team)/ RTI (Response to Intervention), grades K through 5.
- SAP (Student Assistance Program), grades 6 through 12.
- Intake/referral to outpatient Mental Health services.
- Multi-disciplinary team meeting.
- Psychological/Multi-disciplinary evaluation.
- Behavior Modification plans within a regular education classroom.
- Special Education (if applicable).

The list is not intended to be sequential or exhaustive, but used as a guide for all professionals to recognize the school's effort in serving the needs of the child.

If a child is receiving special education services and there are ongoing emotional/behavioral concerns, the following should be addressed:

- When was the most recent evaluation or re-evaluation?
- Has the school completed the required functional behavioral assessment to determine if the child's behavior is due to a disability?
- When did the multi-disciplinary team last meet?
- What is the date of the most recent Individualized Education Plan (IEP)? Were changes made to the IEP? If so, why are the supports not working?

Again, if the child is receiving special education services and the treatment plan is to include BHR Services delivered in the school, the rationale for these services must be provided. The school must be a part of any decision to provide BHR Services in a school setting, and ongoing communication between school personnel and the Wraparound staff is essential.

The schools should be aware of the following eligibility criteria for BHR Services. An interagency team meeting must be held and one or more of the following conditions below must be met before a child can be considered for BHRS-funded services:

1. The child is returning home from inpatient or RTF.

2. The child has a GAF below 60 with significant impairment.
3. The child has persistent impairment of developmental progression and/or psychosocial functioning due to a mental health diagnosis.
4. Prior treatments indicate the need for these services
5. The child is at high-risk of out-of-home placement due to mental health/behavioral health issues.

SCHOOL DISTRICT FUNDED SERVICES

When BHR services are not found to be "medically necessary", the School District may opt to fund necessary IEP related services through the H&CS program. The purpose of this section is to detail the job descriptions that our contracted staff will be performing as agreed upon in the Student Service Agreement. Please be advised that the job descriptions noted below may differ from services funded through BHRS/Wraparound Services.

1. **Behavioral Health PCA (BHPCA):** The person filling this position will provide one to one behavioral/academic support to clients and serve as an appropriate model for positive self-management. If placed in an academic environment the BHPCA will follow the direction of the educational plan / IEP for that child.
2. **BSC:** The BSC will be responsible to support the BHPCA when necessary. The BSC will assist the BHPCA and other involved professionals in addressing problem behaviors and replacing them with more socially appropriate and productive behaviors. In many cases, the BSC will develop and monitor a treatment plan based upon the behavioral goals and objectives in the child's IEP.
3. **Case Management team:** The Case Management team will be responsible for the management of staffing issues, logistical concerns, relations with the school district and the general orchestration of the assigned staff's efforts.

Date: March 2016

ISPT and the IMPLEMETATION OF SERVICES

Wraparound and ISPT Meetings:

The ISPT meeting is a vital component in the service planning process for children and their families. The ISP team consists of the parents/legal guardians, client if 14 years or older, BSC, MT, school personnel (if services are provided in the school setting), any other community professionals or involved agencies, as needed. The goal of the ISPT meeting is to review treatment recommendations and progress, and update the treatment plan for continued authorization of services.

Suggested format for Facilitating ISPT Meetings:

1. INTRODUCTIONS
2. CONFIDENTIALITY AND ATTENDANCE SHEET – ISPT Meeting Summary form.
3. REVIEW THE CASSP PRINCIPLES
4. STATEMENT OF PURPOSE **-** What are the objectives of the meeting? The team may choose to identify or visualize with the child and family what success looks like for the child in the future (months or a year from now). The team may then discuss the specific steps to achieve success. Natural supports should be discussed before professional supports.
5. SUMMARY OF THE PSYCHOLOGICAL EVALUATION - The psychological evaluation should be completed prior to the meeting. Notes should also be taken on this sheet that may reflect any updates since the evaluation.
6. STRENGTHS - What strengths do the child and family have and how can the team build on these strengths to help this child and family?
7. NEEDS – What behaviors are self-defeating and interfere with the client's quality of life?
8. PRIOR INTERVENTIONS / EFFORTS AND OUTCOMES - What interventions have been tried and to what effect? What interventions will maximize the client's potential, and to move the client in a positive direction?
9. REVIEW AND DISCUSS RECOMMENDATIONS FROM THE PRESCRIPTION – Identify strengths, barriers, and current services and resources. Identify and list discharge criteria that are measurable and realistic, and include recommendations for aftercare services.
10. REVIEW OF RECOMMENDED HOURS – What hours are medically necessary to help the client reach his/her recommended goal?
11. ROLES **/** RESPONSIBILITIES AND TIMELINES - The facilitator is responsible for clarifying roles and responsibilities of team members. The Case Management team is responsible for assuring that the application for

authorization is completed and mailed to the BHMCO or DHS.

It is suggested that an effective ISPT meeting will not exceed 1-1/2 to 2 hours. It is up to the team facilitator to keep the group focused on the outcomes of the meeting.

THE ISPT PROTOCOL

1. **Envision the child and family in a year. What do we want to see?**
   - Discuss medical, behavioral, emotional, cognitive/learning, interpersonal, leisure or other domains specific to the child and family.
2. **What do we need to do to get there?**
   - What child and family strengths, interests, and resources can we use to get there?
   - What community resources can we use?
   - What school resources can we use? Consider school support groups, school clubs, athletic activities, music, dance, and drama, before and after school-organized activities, etc.
3. **Who can contribute? And How?**
   - For client themselves, and each family member or interested adult: List specific activities or goals.
   - Whom do we need to contact in the community to access the community resources?
   - Whom do we need to contact in the school to access the school resources?
   - Do other members of the team have resources?
   - Who will do the contacting?
4. **What needs does the child and family still have that cannot be filled by home and community resources?**
   - What resource(s) need to be developed?
   - Who can help with this?
   - List professional services that the child and family need.

Commitment to Cultural Competency

In adherence to the CASSP principle of cultural competence, the Chester County Intermediate Unit H&CS recognizes that children and their families may come from varying cultural backgrounds. Clinical staff is responsible for acknowledging that the family is the primary system of support, that families may have cultural differences, and that these differences can influence the relationship between

consumers and providers of mental health services.

Therefore, clinical staff will need to be familiar with cultural differences to assure that cross-cultural interactions are integrated into the services and the relationships with other helping individuals. Every effort will be made to provide each child the appropriate support based on his/her own cultural background and to make staff available that can provide an understanding of these cultural differences.

EVIDENCE THAT THE SERVICE IS CONSISTENT WITH ALL CASSP PRINCIPLES:

BHR Services provided by H&CS and its satellite programs will abide by all CASSP principles including the following:

- Children and adolescents deserve to live and grow in nurturing families.
- Communities should develop a rich array of services for children and their families to preclude out-of-home placements, including, but not limited to, home-based services, parent support groups, day treatment facilities, crisis centers, and respite care.
- Parents and children should participate fully in all service planning decisions.
- The community service systems, which are involved with the child and family, should participate and share placement, program, funding, and discharge responsibilities.
- The primary responsibility for the children or adolescent should remain with the family and community. Pre-placement planning will include a discharge plan.

DESIGNATION OF RESPONSIBLE PARTY TO MONITOR AND ASSESS PROPOSED SERVICES:

The County Coordinators of H&CS for the Chester County Intermediate Unit will be responsible for assessing and monitoring the proposed services. These administrators will be responsible for ensuring that all guidelines regulated by the Office of Medical Assistance Programs (OMAP) are followed. These administrators will also oversee the operations of the H&C Services Unit in the following areas:

- Evaluate the quality of services to the children and their families
- Maintain successful uninterrupted family treatment services to clients
- Ensure that services follow the principles of the CASSP system
- Subcontracting of Services:

  The H&CS program will subcontract for BHR Service clinicians as needed, and primarily to CCRES or to approved providers that meet the same standards and qualifications as H&CS.

TREATMENT PLANS

Guidelines for Treatment Plan Formulation

- The Treatment Plan identifies the long-term goals to be achieved by the child during the course of treatment. In addition, the plan addresses a client's strengths, needs, medical concerns, emotional/behavioral challenges, educational issues, family strengths and needs, and community supports. Following CASSP principles, it is imperative that both the child and the family participate in the formulation of the Treatment Plan.
- The formulation of the treatment plan should also involve the participation and perspective of the remaining members of the treatment team. The treatment team consists of, but is not limited to, the parent/legal guardian, client, other family members, BSC, MT, TSS, and the Case Management team. Adjunct team members would include those members who are key people in assisting with the client's treatment. They can include school personnel, other agency personnel, worksite supervisors, day care staff, etc. (**School personnel must be present when services are in school.**)
- The treatment team must discuss a prioritized list of common problems/needs and the family **needs** to be part of the intervention and concur with intervention strategies. Additionally, the treatment plan needs to clearly document how skills and interventions will be transferred from professional clinical staff to the adult caregivers. This documentation should also include data on the success of this skill transfer or barriers to such. As part of BHPCA services, family involvement is at the discretion of the school.
- The treatment goals that are specific, observable, and measurable should be discussed at the ISPT meeting. It is a vital part of the TSS role to collect data on these goals, so that a client's progress or regression can be accurately recorded. The BSC is responsible for interpreting the data collected by the TSS or other treatment team members, and then making a determination of whether treatment goals should be continued or modified based on their effectiveness as measured by data collected.
- Every Treatment Plan should also include a De-Escalation/Crisis Intervention Plan. This crisis plan needs to be individualized for the client so that it can be meaningful and effective if ever used. This plan should be handled the same way as the Treatment Plan in that the BSC sits down with the family and makes a very clear, step- by-step, concise, and meaningful plan in case there is an emergency. It is often very difficult for people to be calm and collected during an emergency, and having a well-structured crisis plan could be a very meaningful tool for the client as well as treatment team member. A significant number of crises can be averted by effective collaboration between the BSC and family regarding the client's needs and triggers. However, crises do occur sometimes, and these events may require emergency services or interventions that fall outside the scope of H&CS staff.

It may be appropriate for staff to be involved in some level but the primary crisis intervention will have to be done by another service such as a family doctor, the County Crisis Intervention Unit, the police, the local ER, or by utilizing 911.

- It is important to document significant medical issues, such as allergies, asthma, rare blood type, medications, seizure disorders, diabetes, etc. on the crisis plan. Staff, when with the child/adolescent, should carry the crisis plan at all times.

COMMITMENT TO PROVIDE AN INDIVIDUALIZED TREATMENT PLAN:

H&CS Wraparound staff will adhere to a comprehensive treatment plan based on the strengths and needs of the child or adolescent and the family. The treatment plan will be prepared with the involvement of the interagency services planning team staff and include the following:

- The DSM-IV TR or DSM-5 diagnosis and current mental status of the child resulting from an evaluation by a licensed physician, psychiatrist, or licensed clinical psychologist.
- A psychosocial assessment of the family including the family dynamics, psychological, social, educational, and vocational factors important to the family.
- The treatment plan will establish specific goals for the child or adolescent and participating members of the family, which directly reflect the interests, strengths, goals, and needs of the child. These goals will include:
    1. Short-term, realistic, specific objectives related to each goal and described in terms of specific and measurable outcomes and timelines
    2. The identification of the person or persons responsible for carrying out each part of the plan, including parents, clinical staff, school personnel and/or other relevant caregivers
    3. The activities and modalities to be employed
    4. Objectives that are evaluated and redefined periodically, documenting the progress that has been made
    5. A client's parents or legal guardians, as well as the client him or herself when appropriate, will be involved in the preparation and revision of treatment plans and progress reports. The parent or legal guardian, and the adolescent if over the age of 14 will sign and approve the treatment plan and updates.
    6. Daily/Weekly reports will clearly record the delivery of services and how the services relate to the attainment of the goals set forth in the treatment plan.
    7. Daily/Weekly reports should indicate the family/caregiver's participation in the interventions and strategies.

STAFF POLICIES AND PROFESSIONAL CONDUCT

Staffing Provisions

All staff must qualify for the positions for which they seek employment. All staff must provide the following documentation before they are hired:

- Completed application to their staffing agencies.
- Copy of degree and/or transcripts.
- Current-valid Childline, Criminal Check, and FBI clearances.
- Resume.
- Driver's license and Social Security card.
- Any other documentation required by their staffing agency, DHS, or the PA Department of Labor.
    - For individuals who are applying for BSC positions, you must also submit a copy of your Behavior Specialist License.

Staff Availability

All staff are responsible to report and update their staffing availability on the CCRES Provider Schedule System. This up-to-date information is essential in order for the staff to be assigned to available cases.

Absence from Work

Staff who are unable to make their regularly scheduled appointments with a client should adhere the following procedures:

1. H&CS requires a minimum of 24 hours notice when a staff is not able to complete a scheduled assignment.
2. It is the responsibility of the staff to report an absence to the family, school (if applicable), and Case Management team (if applicable, the Case Management team will find a substitute).
3. For TSSs and BHPCAs:

   An H&CS Request for Absence must be completed and returned to the assigned Case Management team, prior to any planned absences. If the situation requires a substitute, then it is the staff's responsibility to also submit an H&CS Substitute Request form to the Case Management team.

4. **<u>Note:</u> It is important to note that if there is no TSS/BHPCA substitute to be found, a back up plan should exist.**
5. TSS/BHPCA should always inform the BSC or MT and Case Management team of the fact that they are unable to work when scheduled.
6. A copy of each of these forms will be kept in the staff's personnel file with H&CS.

7. Persistent practice of giving less than 24 hours notice will lead to disciplinary action. Failure to report a cancellation may result in an automatic dismissal.

H&CS INCLEMENT WEATHER PROCEDURE

FOR MEETINGS OR EVENTS HELD AT H&CS OFFICES:

In the event of inclement weather, staff should consult the CCIU website at www.cciu.org for information regarding office closings or delays. The H&C program will do their best to provide early notification of any decision, which may result in the cancellation or delay of scheduled H&CS sponsored events. However, as a guide, morning and weekend cancellations and delays should be posted by 7AM, while evening cancellations and delay should be posted by 4PM on the day of the scheduled event. As weather can be unpredictable, a staff's decision regarding travel in inclement weather is a personal one, and should be based upon individual circumstances. The H&CS program asks staff to use both their judgment and caution if scheduled events are not cancelled during the time of inclement weather.

FOR SESSIONS SCHEDULED WITH CLIENTS:

In the event of inclement weather, staff assigned to work with clients in a school or daycare setting should consult the school district and/or individual school policy for any closings or delays. Staff assigned to work with clients in a home or community setting should consult with the parents or legal guardians about weather and travel conditions.

In all circumstances, staff should use their judgment and caution when deciding whether to keep scheduled appointments.

Termination of Cases or Services

H&CS cannot guarantee the indefinite disposition of case hours. A staff (TSS, MT, BSC) may be removed from an assignment at the sole discretion of H&CS or the client/family using our service. If the client or family terminates services, the assigned Case Management team will inform the clinician. All H&CS are immediately put on hold when a child is placed in a psychiatric facility, partial program, or hospital. Services may be resumed the day of discharge or upon approval of the State or BHMCO.

Staff given ongoing cases will be expected to complete the assignment as scheduled. If staff is unable to continue with the case, best practice dictates that the staff should give reasonable notice (at least 4 weeks) of their anticipated termination or request for reassignment date, in order to ensure adequate time for therapeutic closure and satisfactory transition.

The exception to the 4-week notice policy for reassignment is for staff who are brought into H&CS with the intent to work with a specific family. In such cases, a minimum of 4 months notice must be given to the Case Management team and Staffing Agency before reassignment is considered.

STAFF DISMISSAL

A staff may be dismissed from H&CS **immediately** or receive a disciplinary action for any of the following reasons, including, but not limited to:

- Theft or Fraud.
- Non-compliance with any IU policy or procedure.
- Behavior that is documented as unprofessional and/or in opposition to the policies, procedures, and/or mission of H&CS
- Not fulfilling work obligations, such as not providing all prescribed hours.
- Falsifying documentation.
- Incomplete, inaccurate, or unacceptable documentation.
- “No show” to an appointment with a client or team member.
- Violation of client confidentiality.

All disciplinary actions will be at the discretion of the staff’s contracted agency. H&CS reserves the right to dismiss a staff despite the actions of their contracting agency if any the above-mentioned acts are substantiated.

Date: March 2016

FRAUD, WASTE AND ABUSE POLICY

FWA POLICIES AND DEFINITIONS

Fraud is the crime of obtaining money **or** some other benefit by deliberate deception, with the intention of deceiving people. Fraud includes such actions as (but not limited to):

- Billing for services not rendered.
- Over billing or adding time.
- Misrepresenting services rendered.
- Poor or inadequate documentation.
- Forged/Created/Altered records.
- Providing one service and billing for another.
- Billing for services not approved as a billable service as per DHS regulations

CCIU H&CS is subject to both federal and state laws designed to prevent fraud and abuse in government programs (such as Medicare and Medicaid) and private insurance. In addition to preventing fraud and abuse, these laws are designed to ensure that health care providers exercise their best, independent judgment when deciding which services to recommend for their consumers, and also prevent situations that could lead the provider to providing goods or services that are not medically necessary.

CCIU H&CS, in conjunction with appropriate government agencies and managed care organizations, actively pursues all suspected cases of fraud and abuse.

CCIU H&CS complies with all state and federal billing requirements for government-sponsored programs and other payers, including the Federal False Claims Act and State False Claims laws.

To comply with this policy, staff is responsible to:

- Bill only for medically necessary services delivered to members, in accordance with CCRES and CCIU H&CS policies and procedures;
- Comply with the Federal False Claims Act and any applicable State False Claims Laws.

To ensure H&CS is in compliance with all State and Federal regulations regarding fraud and abuse, the program is committed to providing ongoing audits, and providing mandatory in-depth training on Corporate Compliance and Ethics.

Additionally, all daily reports will contain the following statement:

"Submission of any false claims, statements, documents or concealment of materials/information is a Federal offense and punishable by law."

CCIU H&CS has a zero tolerance policy for fraud, so providing false claims and/or not adhering to the billing policy and practices of the program will result in disciplinary action up to and including legal actions by the State or local authorities.

As per the Office of the Inspector General, the CCIU performs comprehensive sanction screening on all staff due to Federal/State Medical Assistance funding.

H&CS Administrative and Billing Oversight for Fraud, Waste and Abuse

1. H&CS has instituted utilization reviews in which parents/guardians are mailed or emailed monthly utilization reports regarding service hours that have been used or not used. These hours are coded as to whether or not the family canceled, staff canceled, school is closed, etc. The parent/guardian is asked to review the information and send a signed copy back to the office. The Case Management Team will contact the family directly by telephone if no response is received.
2. All H&CS Providers (BSC, MT, TSS) must complete Corporate Compliance and Ethics trainings.
3. All H&CS Providers have ready access to the H&CS Policies and Procedures Manual in which fraud, waste and abuse are discussed in detail.
4. All H&CS Providers' paperwork and documentation are reviewed by the H&CS Case Management Teams. Although specifics of the procedure may vary between our county offices, this review consists of:
    - Managing paperwork that comes back from Billing for corrections.
    - If the CM/CS encounters a note that has errors, for example--- not all times filled in or filled in inconsistently, there are overlapping times, there are no

data or no signatures collected, etc., the paperwork is pulled and Case Management follows up with the provider.

- Case Management completes a 2-week "snapshot" of their clients' notes (to include BSC, MT, TSS and treatment plan) every six weeks.
- The CM must enter a note into database stating the following:
    - CM reviewed BSC, MT, TSS notes from (enter timeframe) for quality assurance and to ensure adherence to treatment planning.
- If an issue or discrepancy arose from the review – it must be documented that the issue has been addressed with the provider. This is to include safety issues, lack of follow through with tx plan interventions, if documentation is not reflecting tx plan interventions, parental concerns/lack of involvement, etc.
- If in the 2-week snapshot the CM finds concerns or lack of coherence amongst the services (BSC, TSS, etc) the CM will need to make the clinical decision to review more notes to ensure quality assurance.
- The CM Is responsible for addressing any and all clinical concerns found within any note. This includes following up and bringing the provider in for a meeting to address concerns, as needed.

5. Paperwork is reviewed for accuracy and adherence to the Treatment Plan as well as to address administrative concerns, issues, or problems.
6. The H&CS Billing Department receives the hardcopy of the paperwork documentation and must reconcile times, dates, services provided and signatures for accuracy, integrity, compliance and consistency with the providers' online timesheet.
7. All H&CS Providers are required to attend weekly (TSS) or monthly (BSC/MT) Supervision, where issues and concerns are addressed, as well as topics such as fraud, waste and abuse.

PROCEDURES FOR REPORTING FRAUD, WASTE OR ABUSE

If you suspect fraud or feel that your actions may be misinterpreted as fraudulent you must:

- Document the incident in question.
- Report to your supervisor immediately.
- Be willing to learn from your mistakes and the mistakes of others.

The following information for our current staff regarding the H&CS Fraud, Waste and Abuse policies can be found on the homepage of H&CS Moodle, our online training and program resource location: http://hcsmoodle.cciu.org/

If you encounter issues of Fraud, Waste or (Administrative/Clinical) Abuse, contact the H&CS Program Supervisor/Medical Assistance Compliance Officer for Chester County Intermediate Unit.

The Program Supervisor/Medical Assistance Compliance Officer will contact or report directly to the following:

1. The insuring agency—BHMCO or TPL
2. The Bureau of Program Integrity at DHS
3. The Office of Inspector General
4. The CCIU Board of Directors

From the website of PA DHS, Bureau of Program Integrity:
http://www.dhs.state.pa.us/dhsorganization/officeofadministration/bpi/
Identifying and eliminating welfare fraud requires dedicated teamwork between the Department of Human Services and the Office of Inspector General. The department is responsible for overseeing its programs for any suspected waste, fraud, and abuse and sends suspicious data to the Office of Inspector General for review and potentially an investigation. Individuals who suspect welfare fraud or abuse in Pennsylvania should call the welfare fraud hot line at ***1.844.DHS.TIPS.***

Office of Inspector General:
http://www.oig.state.pa.us/portal/server.pt/community/oig_home/3772

- OIG Bureau of Special Investigations Complaint Form
- *OR* call telephone number (717) 772-2644 or toll free at (877) 888-7927

ALL WRITTEN COMPLAINTS SHOULD BE MAILED TO:

Office of Inspector General
555 Walnut Street, 7th Floor
Harrisburg, PA 17101

Date: March 2016

Billing Policy

The billable workweek begins on a Saturday and ends on a Friday. The term "billable hours" refers to hours authorized by the client's funding source (i.e. Medical Assistance or School District). The H&CS program only has between 45 and 60 days, depending upon funding source, to bill from the date services were rendered.

Each staff is responsible to submit their paperwork on time according to the following schedule:

Drop off paperwork by 4:00 p.m. Tuesday at all offices.

Mail paperwork to: CCIU H&CS, 455 Boot Road, Downingtown, PA 19335 to the attention of "H&CS Billing" and received on Tuesdays by 4:00 p.m.

Paperwork submitted through interoffice mail will be date stamped when it is received in H&CS billing, not when it is dropped off in the interoffice bin. Please note, that delays in courier scheduling or drop off/pick up times may result in paperwork being marked late.

Billable time submitted after the scheduled due dates will be considered late, and may cause late payments or be subjected to a reduced payment or no payment.

Billable hours should include, but not be limited to the following:

BSCs

- May bill in **quarter** hour increments.
- Must bill for time as it is **prescribed and authorized**, such as per week or per month. School District (SD) funded cases must bill per contract (ie: monthly)
- May bill for all consultation time within the prescribed allotment of hours.
- Must document all billable hours precisely as utilized (i.e. no "bulk" billing)
    - Bulk Billing is subject to all policies pertaining to fraudulent billing practices.
- May bill for time spent with client, family, school staff, community programs, MT and TSS worker, as long as BSC is providing consultative services to these individuals. SD/EI funded cases may have variations of this list depending on the contract.
- Billing for treatment plan development and all behavioral interventions is dependent on the client's funding and county of origin. Please consult with the assigned Case Management team and the specific Policies and Procedures of the applicable County for clarification.
- May **not** bill for personnel meetings, supervision, or time spent communicating with the Case Management team.

- May **not** bill for emails or text messages, even if they include clinical content.

MTs

- May bill in **30**-minute increments only.
- May bill for **only** face-to-face psychotherapy, unless the MT is the lead clinician (Lancaster County).
- May bill for up to 1 hour per month (per authorization) of Mandatory Meeting (i.e. participating in the ISPT) above the normally weekly-prescribed hours if approved by the funding source. This time must be documented appropriately on the weekly report.
    - **All Mandatory Meetings must be approved in advance by the assigned Case Management team (See Emergency Mandatory Meeting Policy).**
    - **In Lancaster County, the MT is permitted to bill the MCO for attendance at client specific meetings even if the BSC is also in attendance.**
- Must bill for time as it is **prescribed and authorized**, such as per week or per month.
- May bill for treatment planning only when working face-to-face with the client.
- May **not** bill for telephone contacts (except in Lancaster Co. if lead clinician)
- May **not** bill for time spent consulting with the BSC.
- May **not** bill for any paperwork.
- May **not** bill for personnel meetings, supervision, or time spent communicating with the Case Management team.
- May **not** bill for emails or text messages, even if they include clinical content.

TSS

- May bill in **30**-minute increments only, unless otherwise specifically stated by Case Management team and/or Coordinator.
- May bill for all prescribed hours working one-to-one with the client.
- Must bill for time **prescribed** within the workweek.
- May bill for time consulting with the BSC in the presence of the client.
    - Please consult with the Case Management team regarding specific billing requirements and consultation.
- May **not** bill for telephone contacts.
- May bill for paperwork as it relates to data collection and if paperwork is being completed in the course of the TSS working with their client.

- May **not** bill for time spent with other TSS workers.
- May **not** bill for personnel meetings, supervision, or time spent communicating with the Case Management team.
- May **not** bill for emails or text messages, even if they include clinical content.

BEHAVIORAL HEALTH PERSONAL CARE ASSISTANT

- May bill in **15**-minute increments only.
- May bill for all prescribed hours working one-to-one with the client.
- May bill for time consulting with the BSC in the presence of the client.
    - Please consult with the Case Management team regarding specific billing requirements and consultation.
- May **not** bill for telephone contacts.
- May bill for paperwork as it relates to data collection and if paperwork is being completed in the course of the BHPCA working with their client.
- May **not** bill for personnel meetings, supervision, or time spent communicating with the Case Management team.
- May **not** bill for emails or text messages, even if they include clinical content.
- BHPCAs may bill according to contract.

Please note, that any time not prescribed/authorized will not be paid for.

No two clinicians in the same position may bill at the same time unless it is pre-approved by the Coordinator. If the Coordinator does pre-approve two staff billing at the same time, one staff may receive a reduce rate.

****Special Billing/Documentation procedure for Lancaster County MT and TSS staff for PerformCare clients ONLY:**
The initial minimum amount of billable time that MTs and TSS can bill is 30 minutes. Anything less than that is not billable. After the initial 30-minutes of billable time, MTs and TSS can bill in 15 minutes increments.
For example:

1. 8:00 – 8:45 am – billable as 45 minutes
2. 3:30 – 5:30 pm – billable as 2 hours
3. 4:00 – 4:25 pm – NOT billable because it is less than 30 minutes
4. 8:15 – 8:30 am – NOT billable because it is less than 30 minutes

Team Meetings and Consultations

Requests for all team meetings, other than ISPT and extended/review ISPT meetings, must be made to the Case Management team.

BILLING FOR MEETINGS

- The BSC may bill for attendance at team meetings as a part of their regularly authorized hours for the week.
- The MT may bill at his/her regular rate, however, the hours billed are to be billed as an "Emergency Mandatory Meeting" (except in Lancaster Co.) and may not be used as part of the regularly authorized client hours. The maximum time allowed to bill under this heading is determined by the authorization provided by the funding source. All invoices and Weekly Reports must note this exception.
- The TSS may bill at his/her regular rate as long as the client is present, and as long as the TSS's attendance at the team meeting has been approved, in advance, by the Case Management team for clinical reasons. The exception would be if two or more TSS workers were present, as **no two TSS workers may bill at the same time.** In the cases where more than one TSS is present, some or all of the TSS workers may be paid at the non-billable stipend rate.

EMERGENCY MANDATORY MEETINGS FOR MTS

In addition to their weekly-prescribed mobile therapy hours, a MT may bill for Emergency Mandatory Meeting time. When mobile therapy is recommended for a client, the prescriber of the services (psychologist/psychiatrist) will also recommend the Mandatory Meeting time in the evaluation. The amount of hours prescribed will depend on the authorization. The Case Management team will then request an authorization for the hours from the Managed Care Organization (MCO) on the Plan of Care Form. These hours are to be billed in 30-minute increments.

These hours are above the normally prescribed hours and therefore, should be documented appropriately on the MT weekly report and electronic time sheet. The expectation is that these hours will be used in addition to the weekly hours that are approved for mobile therapy during that particular week. The MT may bill at his/her regular rate.

Approval of the use of these hours must be obtained, **prior to their use**, from the Case Management team. This time may be used for face-to-face meetings only, no phone contacts. The meeting may only be used to participate in ISPT Meetings. A meeting qualifies as an ISPT if the family and client (if over 14 years old) are present and a representative from the MCO has been invited. MTs cannot bill for attending psychological evaluations, psychiatric appointments or IEP meetings. (Lancaster County is the exception).

MT ROLE CLARIFICATION

An MT can bill for therapy with any family member, as long as the session is focused on the identified client. For example, an MT can work with a child's

parents or siblings with regard to stress they are experiencing due to having a family member with a mental health diagnosis.

An MT needs to write his or her own treatment plan.

Travel Time

In general, TSS, BHPCA, and part time MTs, may receive a stipend for travel time. It is the responsibility of the staff member to verify, with their staffing agency, whether or not they are eligible for this stipend. If eligible for this stipend:

- Staff will be paid for travel time between H&CS clients or locations of clients only.
- Staff will not be reimbursed for travel time from their home to client's home, or from the client's home to their home.
- Travel time must be listed on both the electronic time sheet and the Daily/Weekly report in order to be reimbursed.
- Travel time must be recorded in 15-minute increments.
- Rates and reimbursement for travel are dependent on the contracted staffing agency.

Date: March 2016

Electronic Time Sheets

How to access

- Visit www.ccres.org.
- Click on Staff.
- Click on “Staff Information System”.
- Click on “Enter the Site”.
- Enter your email address in the first box then your password (last 6 characters of your Soc. Number) in the second box.
- The “Time sheets” button is the fifth one down on the left. Please click that button.
- Click on the “Click Here” to add a new entry.

How to enter

Enter all the fields as follows:

- Service date.
- Start time (hours and minutes in separate boxes, we do not need an end time)
- Click AM or PM.
- Type in the number of hours you are billing for that day. **If you are working for 6 or more hours with the same client in the same location, you must take a ½ hour break during the day.**
- If you have provided more than one session for a client in the same day, you must complete a separate time sheet entry for each session you provided. For example, a TSS who worked with a client at school from 8am-12pm, took a ½ hour lunch break, and then worked from 12:30pm to 3:30pm must enter one session with a start time of 8am and total of four hours, and then a separate session on the same day with start time of 12:30pm and total of 3 hours. Similarly, if a BSC provides consultation at school from 9am-10am, and then sees the client and mom at home that same afternoon from 3:30-4:45, the BSC would enter one session with start time of 9am and total of 1 hour and a separate session for the same day with a start time of 3:30pm and a total of 1 and ¾ hours.
- Each session must be documented accurately on the daily or weekly progress note and on the electronic time sheet. It is the TSS’s responsibility to make sure that each of their sessions is provided in 30-minute increments. If a client’s schedule does not easily permit this breakdown of TSS hours (client needs services at school between 8am and 12:15pm, and then 12:30pm and 3:20pm), the TSS should discuss possible solutions with their BSC and Case Management team.
- Enter travel if you traveled from another client or location.
- Select your client.

- Select your position on the case.
- Select Home or School
- Click on the service you are billing CCRES for.
- Enter the hours you are authorized for the week and the reason code if you have unfulfilled hours. If you did not complete any of your authorized hours for the week, **you must still submit** an electronic time sheet and a progress note that indicates hours authorized, zero (0) hours provided, and the reason code.
- Click submit. It will tell you if any fields were not completed or if it was successfully submitted and will instruct you what to do next. You can duplicate from prior services as long as you change appropriate information (service dates, times, hours worked and etc.)

Time Sheet Deadlines

- All time sheets are to be filled out on-line.
- All electronic time sheets entries hold the same deadlines as the corresponding paperwork submission time frames.

PAPERWORK

Daily/Weekly Reports

- Fill out in full all requested information on the Daily/Weekly Report form that has been developed by the BSC or Clinical Lead on your case. Certifying Signatures are extremely important, and failure to obtain appropriate signatures will hold up the billing process. Obtain parent signatures whenever possible or as indicated. If the services are provided in the school rather than the home, obtain the teacher's signature.
- BHPCAs may be asked to enter daily reports into an electronic data system (Itinerant Time Tracking)
- The start and end times for services provided on all daily/weekly reports must be complete before obtaining the certifying signature at the end of the session. **Do not have the parents or teachers sign blank forms**.
- Parent/Caretaker involvement must be noted on each form.
- BSCs & MTs must use the GDAP (Goal, Data, Assessment, Plan) format for their weekly reports.
- All notations must be written in **black or blue ink on white paper**. Notations, entries, and signature must be original and not photocopied.
- Do not use white correction fluid or scribble out a mistake. If an error is made, put a line through the error, initial it, and make the correction.
- All Daily/Weekly Reports must be submitted to the designated location on a weekly basis. No exceptions allowed.

- If your Staffing agency requires that you submit your time sheets and Daily/Weekly Reports directly to one of H&CS' satellite offices or directly to the H&CS Billing Department, then paperwork will not be processed if it is incomplete (i.e. missing time sheets, Daily/Weekly Reports, and/or missing information).
- All paperwork needing more information or edits must be corrected prior the given deadline to receive/keep payments for the work.

- All clients and legal guardians have the right to understand and be informed of Daily/Weekly Report entries. However, all requests to obtain information relating to Daily Report entries, other than service time and goals, must first be referred to the Case Management team.
- Daily/Weekly Reports are medical records and may not be shared with anyone other then to have the report signed to verify work/therapy time.
- If you have questions regarding the Daily Report format, please contact the Case Management team.

Date: March 2016

SUPERVISION

TSS/BHPCA Weekly Supervision

- Weekly supervision is TSS specific not client specific. Supervision should not be confused with case consultation provided by the BSC.
- Supervision will be provided by a Master's level TSS Supervisor, primarily a Case Manger
- Each TSS MUST receive 1 hour per week of supervision.
- Supervision is non-reimbursable by MA. The TSS will receive a non-billable stipend to attend supervision.
- The TSS Supervisor must document supervision in the database under "Supervision Meeting Tracking" and provide a summary of the supervision session. The summary should include information about the administrative, ethical, and clinical case issues that are discussed. This database documentation will be used to pay the TSS/BHPCA.
- Supervision may take place in an individual or group format.
- The TSS Supervisor is responsible to communicate supervision times as well as any new information relevant to the TSS and the position.
- TSS will receive a supervision stipend at regularly scheduled payroll dates.
- The TSS Supervisor must submit all documentation of supervision on a weekly basis. Missed supervision on the part of any TSS worker should be noted.

*On line supervision credit/payment procedur*e:

1. Credit/Payment will be offered for attempts to join onto the online supervision groups if:
    a. the server is down and you have made numerous attempts to join/connect into the session. This would mean no one would be able to join, including the moderator.
    b. you are experiencing technical difficulty such as being kicked off frequently during the on line supervision hour. The moderator is able to see that you are having difficulty.

2. Credit/Payment will NOT be offered if:
    a. You send an email stating you could not enter the session. The moderator will send you Blackboard Collaborate Quick reference.
    b. Moderator will give you an excused absence.

3. You will be paid for the actual time present; unless you correspond with the moderator about technical difficulties you are experiencing. It would be the moderator's discretion to allow for full payment. (i.e. if you arrive at 5:15pm – 6pm, you will receive .75hours payment).

4. If your moderator never shows up for a scheduled supervision, contact them and/or H&CS@cciu.org and full credit should be awarded.

5. The only way to receive credit/payment/an excused absence is to email the moderator of the on line supervision (if it is a weekly supervision) or by emailing H&CS@cciu.org if difficulties occur during Saturday supervision.

6. Please remember that you must pre-register for Saturday supervision by Friday at 12 noon in order to be able to attend. You will be asked to leave the session if you join

BSC and MT Monthly Supervision

- Monthly supervision is BSC and MT specific, not client specific. Supervision should not be confused with case consultation provided by the Case Management team or Coordinator.

- Supervision will be provided by a Master's level Clinical Supervisor, primarily a County Coordinator

- Each BSC or MT MUST receive 1 hour per month of supervision.

- MA does not reimburse for Supervision but staff will receive a non-billable stipend to attend supervision.

- The BSC/MT Supervisor must document supervision in the database under "Supervision Meeting Tracking" and provide a summary of the supervision session.

- Supervision may take place in an individual or group format.

- The BSC/MT Supervisor is responsible to communicate supervision times as well as any new information relevant to the BSC or MT and their position.

- The BSC/MT Supervisor must submit all documentation of supervision on a monthly basis.

On-site Supervision

- Each new TSS worker, whether they are new to the role of TSS, new to the agency, or both, is required to receive on-site supervision before they may work independently with the client/family/school.

  - TSS workers with no previous experience as a TSS must receive on-site supervision for their initial 6 scheduled hours.
  - TSS workers with previous experience, but who are new to H&CS must receive on-site supervision for their initial first 3 scheduled hours.

- The clinical leader (i.e. MT or BSC) will provide the on-site supervision.

  - If the clinical leader is unavailable to provide the on-site supervision required, the Case Management team must be notified immediately.
  - On-site Clinical Supervision should not be confused with case consultation. The BSC is still responsible for weekly individual case consultation with the TSS.

- For the BSC/MT, the on-site TSS supervision hours are to be considered above and beyond the regular hours authorized. **Additionally, on-site supervision must be provided in 1-hour increments only.** The BSC/MT will receive a reduced rate stipend in lieu of their regular hourly rate.

- For the TSS, the on-site TSS supervision hours are to be considered as part of the hours currently authorized. The TSS will receive a reduce rate stipend in lieu of their regular hourly rate.

- **Both the BSC and TSS worker must document on-site supervision on their electronic time sheets**. Additionally, the BSC must include the corresponding On-site Supervision Report form and the TSS must complete their required Daily Report Form. The amount of on-site hours received must be documented on the TSS Daily Report. For MA funded cases, the BSC does not complete a regular BSC weekly note.
- **For SD/EI cases only, the BSC must complete the on-site form and a weekly report and can bill at their regular BSC rate.**

1. The BSC/MT is responsible for all their on-site supervision notes.
2. The BSC/MT is responsible to coordinate supervision times with the TSS worker.
3. The BSC/MT must return all documentation of on-site supervision weekly with their time sheets and Daily/Weekly Report.

Date: March 2016

Training Requirements

PROBATIONARY TSS/BHPCA:

- **Within 2 weeks after sign-in at CCRES:**
  - Complete all 6 sections of the TSS Initial Training (12 credit hours)
- **Email H&CSTraining@cciu.org** to request an audit of your Initial Training.

- **Attend H&CS Provider Orientation** (4 credit hours).

Within thirty (30) days from date of hire:

- Complete CPR/First Aid (Child and Adult--4 credit hours).
- Mandated Reporter Training (3 credit hours in-person or on Moodle)

Within Six Months from date of hire, new TSS/PCAs must complete:

- NCI Initial Training (6 credit hours--*MyLearningPlan*)
- Corporate Compliance (3 credit hours--Moodle)
- County Autism Training

Additional county specific trainings-

Chester County

44 training credit hours during first six months

Completion of all trainings listed above, plus:

- Chester County Autism Training (12 credit hours)

Delaware, Lancaster, Lebanon and Montgomery Counties

- **44 training credit hours during first six months**
- ***Completion of all trainings listed above, plus 12 additional credit hours consisting of:***

- *H&CS Autism Overview (6 credit hours)—Moodle*

Plus any three trainings from the list below.

- ADHD (2 credit hours)--*Moodle*
- Pivotal Response Training (2 credit hours)--*Moodle*
- *Disruptive Behavior Disorders* (2 credit hours)--*Moodle*
- *Verbal Behavior I* (2 credit hours in person)– *My Learning Plan—District Catalog*
- *Verbal Behavior II* (2 credit hours in person)– *My Learning Plan—District Catalog*

Please remember that the in-person trainings (Verbal Behavior) for this Autism requirement are not offered during the summer, so plan your training schedules accordingly.

REGULAR TSS/BHPCA: 20 TRAINING CREDIT HOURS PER YEAR, INCLUDING:

- Corporate Compliance [required annually)
- NCI Refresher (required annually)
- CPR/First Aid (required every two years)
- Child Abuse Mandated Reporter Training must be taken every five years.
- Adult Protective Services Mandated Reporter training must be taken one time only

Additional trainings electives adding up to the 20 credit hours required by DHS, either taken through H&CS, from outside providers, or graduate coursework. Documentation of attendance will be required and sent to H&CSTraining@cciu.org

WHEN A PCA IS REQUIRED BY THEIR SCHOOL DISTRICT TO TAKE SPECIFIC TRAININGS:

1. H&CS Training must receive certain information, including the name of the staff, name of the training, the date, the location and the number of hours within the week prior to the training.

2. H&CS Training will then send the pertinent information to MLP for training credits and to CCRES for payment. Staff do not enter any trainings on their ETS.

3. When a PCA is required to take some type of Orientation within a school district it is considered unrelated to Training. The Coordinator will determine how the staff is paid.

BSC/CLINICAL LEAD MT: 10 TRAINING CREDIT HOURS PER YEAR REQUIRED

The First Year:

- BSC/Clinical Lead MT Orientation with Coordinator prior to accepting assignments.
- Attend the H&CS Provider Orientation- 4 hours in-person
- The Role of the BSC Orientation - taken one time only by BSCs and clinical lead MTs: 7 hours
- The 2-day FBA training (BSC/BSA-taken one time only-required by DHS and BAS). *
- Child Abuse Mandated Reporter Training (3 credit hours on Moodle) must be taken every five years.
- Adult Protective Services Mandated Reporter training (one credit hour on Moodle) must be taken one time
- Corporate Compliance (3 credit hours, required annually by DHS/BHRS)
- The 2-day, 12 credit Chester County Autism Training is required by DHS for MT/BSA/BSCs working in Chester County (taken one time only)

***BSCs/Clinical Lead MTs: Must complete the 2-day BAS FBA training prior to completing an FBA with clients on the Autism Spectrum**

***Exception:** Staff is a Board Certified Behavior Analyst

Subsequent Years:

- Corporate Compliance is required annually by DHS/BHRS
- Electives including outside coursework, or conferences/trainings may comprise the remaining 7 hours of annual training

Date: March 2016

MT: 10 TRAINING CREDIT HOURS REQUIRED ANNUALLY

The First Year:
Required by DHS/BHRS:

- MT Orientation with Coordinator prior to accepting assignments.
- Complete Role of the MT Orientation (3 credit hours-Moodle)
- Corporate Compliance (3 credit hours- Moodle)
- Child Abuse Mandated Reporter Training (3 credit hours on Moodle) must be taken every five years.
- Adult Protective Services Mandated Reporter training (one credit hour on Moodle) must be taken one time

Subsequent Training Years:

- 10 training credit hours per year minimum
- Corporate Compliance (3 credits hours- required annually by DHS/BHRS)
- 7 to 10 credit hours of elective trainings per training year, which may be provided by H&CS or by universities or outside providers.

Please note:
Trainings listed on My Learning Plan under the District catalog and labeled CCRES or H&CS are the only ones that staff can take.

HOME AND COMMUNITY HABILITATION

REQUIRED H&CS TRAININGS

-NCI-Initial—MyLearningPlan, District Catalog
-CPR/First Aid---MyLearningPlan, District Catalog
-Child Abuse Mandated Reporter Training—Moodle
-Corporate Compliance--Moodle
-Ethics—Moodle
-Adult Protective Services Mandated Reporter Training-
Moodle

ADDITIONAL REQUIRED ODP TRAININGS

- Foundations of Recognizing and Mitigating Risk
- Risk Management Roles for Adnministrative Entities and Providers
- SC Role in Mitigating Risk

- Foundation of Incident Management and Risk Management
- Understanding Incident Management
- The Supposrts Coordinator's Role in Incident Management
- The Core Functions of Risk Management
- ID principles/Everyday

Respite Trainings (LANCASTER/LEBANON COUNTIES)

Two hours of required trainings prior to case assignment—Moodle Resources (Lancaster/Lebanon)

Date: March 2016

STAFFING AND PERSONNEL

Position Description: TSS

Position Title: **Therapeutic Staff Support**
Reports To: Case Management team
Assignment: BHR Services
Department: Home and Community Services
Labor Relationship: CCRES Employee

Position Definition: The person filling this position will provide one-to-one behavioral interventions and modeling to children/adolescents in need of Mental/Behavioral Health support. Travel to and from client's home, school, and community is required.

Relationship: Therapeutic Staff Support shall be responsible to directly report to the Case Management team.

QUALIFICATIONS:

Education/Experience:

Minimum qualifications for the Therapeutic Staff Support include:

- Bachelor's degree in a human services field, psychology, social work, sociology, education, or criminal justice with no previous work experience.
  OR
- Bachelor's degree in any field, with the equivalent of at least one year of full-time paid work experience in a job that involved direct contact with children or adolescents.
  OR
- Licensed registered nurses, with the equivalent of at least one year of full-time paid work experience in a job that involved direct contact with children or adolescents.
  OR
- Associate's Degree, or 60 credits towards a Bachelor's degree, with the equivalent of at least 3 years of full-time paid work experience in a job that involved direct contact with children and adolescents.
  OR
- Licensed practical nurse, with the equivalent of at least 3 years of full-time paid work experience in a job that involved direct contact with children and adolescents.
  AND
- Training in the CASSP principles.
- Experience with behavior modification and social skill development and instruction.
- Training by the supervisor to provide the appropriate intervention or treatment as outlined in the individual treatment plan.
- Current and valid Act 33/34 and FBI clearances.
- CPR and first aid certification.

- Non-violent Crisis Intervention (NCI) training and certification.

Skills/Knowledge:

- Strong communication and collaboration skills.
- Ability to use positive support in a strength-based intervention model.
- Ability to adhere to mandated guidelines and timelines in providing services to clients and families.

Physical:

- Ability to physically manage children/adolescents.
- Due to itinerant nature of position, must have a valid driver's license.

Authority: The **Therapeutic Staff Support Worker** will have the authority to perform all functions listed above in accordance with established policies and procedures.

Functions/Duties/Responsibilities:

To perform this job successfully, an individual must be able to perform each essential function/duty/responsibility at acceptable standards. In accordance with both state and/or federal law, reasonable accommodations will be considered upon employee request.

Essential:

- Assist with team members in the development, implementation, and evaluation of treatment plans for individual clients.
- Empower the parents/guardians in their roles as primary caretakers.
- Provide one-to-one direct interventions, modeling for the child, parents, family members, school personnel, and others, appropriate behaviors necessary for successful adjustment.
- Provide services during school hours, evening and/or weekend hours.
- Provide behavior management, including helping clients practice or improve skills with conflict resolution, anger management, and peer interaction.
- Work with clients and families to provide stabilization of the child in the home, school, and community.
- Collect data and document progress in a prescribed format for each and every session with the child and/or family.
- Travel to and from clients' home/school/community program to perform duties.
- Attend weekly supervision groups
- Complete annual training requirements

Secondary:

- Collaborate with BSC and/or MT and other TSS workers to ensure effectiveness of treatment plans.
- Complete and submit appropriate paperwork and documentation within required timelines. (I.e. Daily Reports, data collection, etc.)
- Assist in the development of interagency coordination efforts.
- Perform other duties as required.

Service Description: Therapeutic Staff Support

PURPOSE OF PROGRAM SERVICE:

TSS provides one-to-one interventions to a child or adolescent in a variety of

settings, which include home, school, and other areas of the community. This person will also model the behavioral interventions and pro-social behaviors for parents, teachers, and community members to assist the client in being a successful family member, school student, and community member. These services are included in a written treatment plan developed by a team of mental/behavioral health professionals. Services can include, but are not limited to:

1. Psychosocial rehabilitation activities
2. Implementation of a behavior modification plan
3. Time-structured activities
4. Conflict resolution techniques
5. Anger management techniques
6. Modeling pro-social behavior
7. Other interventions, as defined by the treatment plan, which would contribute to the child's stabilization within the home, school, and community.

This service provides the support necessary to prevent the need for a more restrictive service or placement, while the child or adolescent continues to progress in treatment. This service also provides the therapeutic intervention necessary to introduce the child or adolescent to mainstream community activities while the child continues in more conventional treatment. An important role of the TSS is to empower the parent(s) or guardian in their role as the primary caretaker for their child. The TSS also empowers and/or provides support for other responsible adults as they supervise a child in either the educational or community setting.

IDENTIFICATION OF CLINICAL NEED:

The counties have a wide diversity of mental health needs. Many children are put on waiting lists to receive the services of a TSS. There are few options open to children who do not require the intensity of services that are offered in residential settings, but because of the lack of other interventions find themselves in a residential setting. These children may be able to be served in a less restrictive setting with the assistance of a TSS. TSS services fulfill the missing link in a continuum of services designed to focus on less restrictive, less costly services for children in need of support and intervention.

SPECIFIC DESIGN OF SERVICES:

TSS services offered by the H&CS will provide care to the highest standards based upon CASSP principles, Federal, and/or State regulatory acts. TSS will model one-to-one interventions for parents, family members, school personnel, and other significant individuals, so that the behavioral interventions can be transferred from the professional staff to the adult caregivers. Once these adult caregivers have mastered the interventions modeled by the TSS, they will use them to reinforce the child for appropriate pro-social behaviors necessary for successful adjustment within the appropriate setting. TSS services will be provided during school hours if

necessary and/or during evening and weekend hours based upon the team's recommendations and medical necessity. The specific design of services will be delivered on a weekly basis.

SPECIFIC SERVICES INCLUDE:

- Providing immediate behavioral reinforcement
- Implementing activities to redirect challenging behaviors
- Supporting time-structuring activities
- Providing psychosocial rehabilitative activities as prescribed in the individual treatment plan
- Utilizing time-out strategies
- Assisting the parent or caretaker in providing therapeutic structure and limits for the child or adolescent
- Supporting child and family interactions
- Reinforcing appropriate social behavior within the child's own peer group, family, or other social settings
- Supporting parents, or other responsible adults in providing direct supervision of the child or adolescent
- Assisting the child or adolescent in developing age-appropriate activities of daily living skills as required and described in the treatment plan
- Providing crisis intervention if needed

STAFF SUPERVISION:

- Weekly supervision is TSS specific not client specific. Supervision should not be confused with case consultation provided by the BSC
- Supervision will be provided by a Master's level TSS Supervisor, primarily a Case Manger
- Each TSS MUST receive 1 hour per week of supervision
- Supervision is non-reimbursable by MA. The TSS will receive a non-billable stipend to attend supervision.
- The TSS Supervisor must document supervision in the database under "Supervision Meeting Tracking" and provide a summary of the supervision session. This database documentation will be used to pay the TSS/BHPCA.
- Supervision may take place in an individual or group format.
- The TSS Supervisor is responsible to communicate supervision times as well as any new information relevant to the TSS and the position.
- TSS will receive a supervision stipend at regularly scheduled payroll dates.
- The TSS Supervisor must submit all documentation of supervision on a weekly basis.
- Frequent absence from weekly supervision will be noted.

Date: March 2016

TRAINING REQUIREMENTS:

For **ALL** counties**-**
Within 2 weeks of sign-in at CCRES:

- Complete all 6 sections of the TSS Initial Training on Moodle –
  12 credit hours, including Autism Interventions, Applied Behavior Analysis, Documentation, DSM-5, Ethics and Adult Protective Services Mandated Reporter Training

Upon completion of 12-credit TSS Initial Training (earning 80% or higher in each section)

- Attend H&CS Provider Orientation - 4 credit hours

Within thirty (30) days from date of hire:

- Complete CPR/First Aid - 4 credit hours
- Recognizing and Reporting Child Abuse: Mandated Reporter (3 credit hours)

Within six (6) months from date of hire:

- NCI Initial Training - 6 credit hours
- Corporate Compliance - 3 credit hours
- County Autism Training

Additional county specific trainings-

Chester County- a total of 44 training credit hours during first six months, including:

- Completion of all trainings listed above **plus**:
- Chester County Autism Training - 12 credit hours (scheduled as a 2-day 14 hour training)

Delaware, Lancaster, Lebanon and Montgomery Counties- a total of 44 training credit hours during first six months, including:
Completion of all trainings listed above **plus 12 additional credits, including**:

- H&CS Autism Overview (6 credit hours on Moodle)

Then any three (3) of the following:

- Verbal Behavior I- 2 credit hours *(My Learning Plan)*
- Verbal Behavior II- 2 credit hours *(My Learning Plan)*
- Pivotal Response Training -2 credit hours *(Moodle)*
- ADHD- 2 credit hours *(Moodle)*
- Disruptive Behavior Disorders- 2 credit hours *(Moodle)*

Date: March 2016

REGULAR TSS/BHPCA/TSS-A: 20 TRAINING CREDIT HOURS PER YEAR, INCLUDING:

- Corporate Compliance (required annually) – 3 credit hours
- NCI Refresher (required annually) – 3 credit hours
- CPR/First Aid (required every two years) – 4 credit hours
- Elective trainings – 10 to 14 credit hours as needed to fulfill 20 hour annual requirement
- Child Abuse Mandated Reporter Training (required every 5 years)
- Adult Protective Services Mandated Reporting Training (required one time)

Position Description: BHPCA

Position Title: **Behavioral Health Personal Care Assistant**
Reports To: Case Manager/Case Specialist
Assignment: BHR Services
Department: Home and Community Services
Labor Relationship: CCRES Employee

Position Definition: BHPCA services are rendered to students with physical, educational and mental health needs. In collaboration with LEA, it is H&CS's responsibility to ensure that all BHPCAs are qualified and adequately trained to perform activities assigned to them. Specific training may need to be provided by the school district/funding agent for special needs of the student. There is a supervisory chain of command, and the BHPCA must be fully cognizant of the person to contact should assistance be needed. Behavioral Health Personal Care Assistant is considered a one-on-one service; but their skills may be used within the classroom as needed. BHPCAs encourage and support students by utilizing behavioral interventions necessary for the student's successful progress throughout the school day.

Relationship: Behavioral Health Personal Care Assistants report directly to the Case Management team.

Examples of BHPCA Responsibilities:

- Assisting the student to use equipment.
- Assisting the student to use and maintain augmentative communication devices.
- Monitoring the incidence and prevalence of designated health problems or medical conditions, e.g., seizure precautions or extreme lethargy.
- Observing and intervening to redirect behavior.
- Assisting, monitoring and guiding the student to pay attention, participate in activities, and complete tasks in order to master skills previously taught.
- Accompanying students on school buses or other vehicles.

QUALIFICATIONS:

Education/Experience:

Minimum qualifications for the Behavioral Health Personal Care Assistant include:

- Bachelor's degree in a human services field, psychology, social work, sociology, education, or criminal justice with no previous work experience.
  OR
- Bachelor's degree in any field, with the equivalent of at least one year of full-time paid work experience in a job that involved direct contact with children or adolescents.
  OR
- Licensed registered nurses, with the equivalent of at least one year of full-time paid work experience in a job that involved direct contact with children or adolescents.
  OR
- Associate's Degree, or 60 credits towards a Bachelor's degree, with the equivalent of at least 3 years of full-time paid work experience in a job that involved direct contact with children and adolescents.
  OR
- Licensed practical nurse, with the equivalent of at least 3 years of full-time paid work experience in a job that involved direct contact with children and adolescents.
  AND
- Training in the CASSP principles.
- Experience with behavior modification and social skill development and instruction.
- Training by the supervisor to provide the appropriate intervention or treatment as outlined in the individual treatment plan.
- Must possess current /valid Act 33/34 and FBI clearances.
- CPR and first aid certification.
- Crisis Prevention Intervention (CPI) training and certification.

Skills/Knowledge:

- Strong communication and collaboration skills.
- Ability to use positive support in a strength-based intervention model.
- Ability to adhere to mandated timelines in providing services to clients and families.

Physical:

- Ability to physically manage children/adolescents, when required in the treatment plan.
- Due to itinerant nature of position, must have a valid driver's license.

FUNCTIONS/DUTIES/RESPONSIBILITIES:

To perform this job successfully, an individual must be able to perform each essential function/duty/responsibility at acceptable standards. In accordance with both state and/or federal law, reasonable accommodations will be considered upon employee request.

Essential:

- Assist with team members in the implementation treatment plan for student.
- Provide one-to-one direct interventions, modeling for the student and school personnel, and others, appropriate behaviors necessary for successful adjustment.
- Provide services during the school day.
- Provide behavior management, conflict resolution, anger management, and peer interaction.
- Collect data and document progress in a prescribed format for every session with the student.

Secondary:

- Collaborate with BSC to ensure effectiveness of treatment plan.
- Complete and submit appropriate paperwork and documentation within required timelines. (i.e. daily reports, data collection, etc.)
- Perform other duties as required.

STAFF SUPERVISION AND QUALIFICATIONS:

The BHPCA will be supervised by a Mental/Behavioral Health Specialist with a minimum of a Master's degree in a human service field and at least one-year's experience in a CASSP system.

- BHPCA must attend 1 hour of supervision weekly**.**

TRAINING REQUIREMENTS:

- All newly hired BHPCAs must receive 16 hours of training before they may be assigned a client.
- All BHPCAs must attend an additional 28 hours of training within their first 6 months of hire.
- All BHPCAs must complete twenty (20) hours of training annually after their first year.

Position Description: Respite Worker

Position Title: **Respite Worker**
Reports To: Case Management team
Assignment: BHR Services
Department: Home and Community Services
Labor Relationship: CCRES Employee

SUMMARY OF POSITION:

H&CS provider staff will provide emotional support and in-home respite care to children/adolescents/adults/families in need of utilizing the Respite Management Program. H&CS provider staff will provide rest and relief to the parent/guardian/caregivers of children and adults with behavioral health challenges,

specifically in the home and community setting. An H&CS provider staff will supervise and interact with the identified family member (s) while the parent/guardian/caregivers are afforded time to rest and offered relief for caring for their family member(s) with behavioral challenges, complex conditions and disabilities. Respite services will be provided during day, evening and weekend hours based upon the identified client(s) having an emotional/behavioral history that has required special supports or supervision.

Relationship: Respite worker shall be responsible to directly report to the Case Management team.

QUALIFICATIONS:

Education/Experience:

Minimum qualifications for the Respite Worker include:

- Bachelor's degree in a human services field, psychology, social work, sociology, education, or criminal justice with no previous work experience.
  OR
- Bachelor's degree in any field, with the equivalent of at least one year of full-time paid work experience in a job that involved direct contact with children or adolescents.
  OR
- Associate's Degree, or 60 credits towards a Bachelor's degree, with the equivalent of at least 3 years of full-time paid work experience in a job that involved direct contact with children and adolescents.
  AND
- Training in the CASSP principles.
- Experience with behavior modification and social skill development and instruction.
- Current and valid Act 33/34 and FBI clearances.
- CPR and first aid certification.
- Non-violent Crisis Intervention (NCI) training and certification.

Skills/Knowledge:

- Strong communication and collaboration skills.
- Ability to use positive support in a strength-based intervention model.
- Ability to adhere to mandated guidelines and timelines in providing services to clients and families.

Physical:

- Ability to physically manage children/adolescents.
- Due to itinerant nature of position, must have a valid driver's license.

Authority: The **TSS Worker** will have the authority to perform all functions listed above in accordance with established policies and procedures.

Functions/Duties/Responsibilities:

To perform this job successfully, an individual must be able to perform each essential function/duty/responsibility at acceptable standards. In accordance with both state and/or federal law, reasonable accommodations will be considered upon employee request.

Essential:

- Provide documentation of the care the client receives during the respite placement including daily progress notes, incident reports, medication administration logs and other information deemed necessary to assure that client treatment is consistent with established standards.
- Utilize knowledge about human development and developmentally appropriate activities.
- Provide direct care, modeling for the child, parents, family members, and others, to demonstrate appropriate behaviors necessary for successful adjustm
- Provide behavior management, conflict resolution, anger management, and peer interaction.
- Ensure safety of the client and identified siblings while under your supervision.
- Ensure and assist with appropriate social interactions and leisure activities.
- Assist with homework or other chores the client may need to complete.
- Work with families to provide a supportive home environment.
- Address basic childcare needs to include toileting, diaper change, and feeding.
- Report any strange or unusual behaviors in accordance with procedures.
- Collect data and document progress when requested and in the proper format for each and every session with the child and/or family.
- Complete paper work and electronic documentation as required and in a timely fashion.
- Actively seek work assignments through the use of the Staff Information System.
- Comply with all HIPAA guidelines regarding confidentiality.
- Provide services during day, evening and/or weekend hours.
- Travel to and from clients' home and/or community locations to perform duties.
- Attend ½ an hour of monthly supervision.
- Complete annual training requirements for position.
- Perform other duties as required.

Secondary:

- Complete and submit appropriate paperwork and documentation within required timelines. (I.e. Daily Reports, data collection, etc.)
- Perform other duties as required.

Service Description: Respite worker

PURPOSE OF PROGRAM SERVICE:

Respite services are designed to provide a temporary relief for caregivers. These services can help parents and caregivers by giving them a rest or a break from caring for children and/or adults with behavioral health concerns and mental health diagnoses.

The CCIU H&CS program provides In-Home respite services**,** provided in the clients home or out in the community. Parents/Guardians do NOT need to be present in the home during this time. **Authorizations are 15 hours over a 3 month period** – the

only exception to this is a medical emergency or death in the family If requesting for more hours, the family MUST provide some type of documentation to receive any extra hours.

IDENTIFICATION OF CLINICAL NEED:
Who we serve: ***Children*** must be members of CBHNP and not affiliated with a CRR Host Home or the identified client in Family-Based services (however, siblings of a client who is the identified client may be eligible provided there are behavioral health concerns or a mental health diagnosis in place for that sibling). ***Adults*** must be members of PerformCare.

SPECIFIC SERVICES INCLUDE:

- Providing immediate behavioral reinforcement
- Implementing activities to redirect challenging behaviors
- Supporting time-structuring activities
- Providing psychosocial rehabilitative activities as prescribed in the individual treatment plan
- Utilizing time-out strategies
- Assisting the parent or caretaker in providing therapeutic structure and limits for the child or adolescent
- Supporting child and family interactions
- Reinforcing appropriate social behavior within the child's own peer group, family, or other social settings
- Assisting the child or adolescent in developing age-appropriate activities of daily living skills as required and described in the treatment plan
- Providing crisis intervention if needed

STAFF SUPERVISION:

- Half hour monthly supervision is Respite worker specific not client specific.
- Supervision will be provided by a Master's level Respite worker Supervisor, primarily a Case Manger
- Each Respite worker MUST receive 1/2 of supervision per month.
- Supervision is non-reimbursable by MA. The Respite worker will receive a non-billable stipend to attend supervision.
- The Respite worker Supervisor must document supervision in the database under "Supervision Meeting Tracking" and provide a summary of the supervision session. This database documentation will be used to pay the Respite worker.
- Supervision may take place in an individual or group format.
- The Respite worker Supervisor is responsible to communicate supervision times as well as any new information relevant to the TSS and the position.
- Respite worker will receive a supervision stipend at regularly scheduled payroll dates.
- Frequent absence from monthly supervision will be noted.

Date: March 2016

TRAINING REQUIREMENTS:

For **ALL** counties**-**
Within 2 weeks of sign-in at CCRES:

- Complete all 6 sections of the TSS Initial Training on Moodle –
  12 credit hours, including Autism Interventions, Applied Behavior Analysis, Documentation, DSM-5, Ethics and APS Mandated Reporter)

Upon completion of 12-credit TSS Initial Training (earning 80% or higher in each section)

- Attend H&CS Provider Orientation - 4 credit hours

Within thirty (30) days from date of hire:

- Complete CPR/First Aid - 4 credit hours
- Recognizing and Reporting Child Abuse: Mandated Reporter (3 credit hours)

Within six (6) months from date of hire:

- NCI Initial Training - 6 credit hours
- Corporate Compliance - 3 credit hours
- County Autism Training

Additional county specific trainings-

Chester County- a total of 44 training credit hours during first six months, including:

- Completion of all trainings listed above **plus**:
- Chester County Autism Training - 12 credit hours (scheduled as a 2-day 14 hour training)

Delaware, Lancaster, Lebanon and Montgomery Counties- a total of 44 training credit hours during first six months, including:
Completion of all trainings listed above **plus 12 additional credit hours, including**:

- H&CS Autism Overview (6 credit hours on Moodle)

Then any three (3) of the following:

- Verbal Behavior I- 2 credit hours *(My Learning Plan)*
- Verbal Behavior II- 2 credit hours *(My Learning Plan)*
- Pivotal Response Training-2 credit hours *(Moodle)*
- ADHD- 2 credit hours *(Moodle)*
- Disruptive Behavior Disorders- 2 credit hours *(Moodle)*

Regular TSS/BHPCA/TSS-A/Respite worker: 20 training credit hours per year, including:

- Corporate Compliance (required annually) – 3 credit hours
- NCI Refresher (required annually) – 3 credit hours
- CPR/First Aid (required every two years) – 4 credit hours
- Elective trainings – 10 to 14 credit hours as needed to fulfill 20 hour annual requirement
- Child Abuse Mandated Reporter Training (required every 5 years)
- Adult Protective Services Mandated Reporter Training (required one time)

Position Description: Mobile Therapist

Position Title: **Mobile Therapist**
Reports To: Case Management team
Assignment: BHR Services
Department: Home and Community Services
Labor Relationship: CCRES Contractor
Position Definition: The person filling this position will provide insight into family dynamics, and provide support and assistance in the development of adaptive skills in order for the child or adolescent to take a more positive role in the family.
Relationship: The **Mobile Therapist** shall be directly responsible to the Case Management team.

QUALIFICATIONS:
Education/Experience:
Minimum qualifications for the Mobile Therapist include:

- Master's Degree in a mental health field with a clinical practicum.
- A minimum of 1-year direct experience providing clinically supervised treatment to children and adolescents with serious emotional disturbances.
- Specific training in individual and family therapy models as well as mental health issues.
- Training in the CASSP principles
- Experience with social skill development and strategies.
- Training to provide the appropriate intervention or treatment as outlined in the individual treatment plan.
- Must possess current/valid Act 33/34 and FBI clearances.

Skills/Knowledge:

- Must have strong communication and collaboration skills.
- Ability to evaluate, counsel, and work with clients, family members, designated

caregivers and staff.
- Ability to adhere to mandated timelines and provide services to clients and families.

Physical:
- Ability to physically manage children/adolescents.
- Due to itinerant nature of position, must have a valid driver's license.

Authority: The **MT** will have the authority to perform all functions listed above in accordance with established policies and procedures.

Functions/Duties/Responsibilities:
To perform this job successfully, an individual must be able to perform each essential function/duty/responsibility at acceptable standards. In accordance with both state and/or federal law, reasonable accommodations will be considered upon employee request.

Essential:
- Review and provide assessment of the child and ensure medical necessity for the child's involvement in the service.
- Provide insight into family dynamics.
- Provide support and assistance in the development of adaptive skills in order for the child to take a more positive role in the family.
- Provide child centered, family focused, individual, and family psychotherapy.
- Conduct sessions with the child or adolescent, family, school, and community members.
- Be the clinical leader and develop a treatment plan, as required.
- Attendance at, or Leading ISPT meetings (if required).
- Develop a 24-hour crisis plan.

Secondary:
- Collaborate with the BSC and/or TSS worker to monitor effectiveness of treatment plans (as required).
- When approved by funding agent, participate in interagency service and planning meetings to ensure consistency in all treatment settings.
- Complete and submit appropriate paperwork and documentation within required timelines.
- Perform other duties as assigned.

Service Description: Mobile Therapy

PURPOSE OF PROGRAM SERVICES:
Mobile therapy will provide intensive therapeutic services to a child or adolescent and the family in a setting other than a provider agency or office. Potential settings include, but are not limited to the child's home, school, church, community center, a neighbor's or extended family member's home and any other setting deemed to be appropriate and beneficial to the child. The core services include the following:
1. Assessment of strengths and treatment needs of the child and family.

2. Inclusion of the child as a participant in his/her own treatment.
3. Inclusion of the parents and other caretakers in treatment.
4. Provide insight into family dynamics.
5. Provide support and assistance in the development of adaptive skills in order for the child to take a more positive role in the family.
6. Develop a treatment plan for therapeutic services.
7. Provide child-centered, family-focused, individual and family psychotherapy.
8. Conduct sessions with the child or adolescent, family, school, and community.
9. Develop a 24-hour crisis plan.

IDENTIFICATION OF CLINICAL NEED:

The counties have a wide diversity of mental/behavioral health needs. Many children are put on a waiting list to receive the services of Mobile Therapy. There are few options open to children who do not require the intensity of services that are offered in residential setting, but because of the lack of other interventions, find themselves in residential settings. With the assistance of Mobile Therapy, these children can be served in a natural setting. This service enhances the quality of the full continuum of treatment with a focus on less restrictive, less costly interventions that continue to offer a high level of intensity. The Mobile Therapy service will adhere to the following principles:

1. Families are seen as powerful social institutions, which should be supported in their efforts to care for their children and adolescents at home.
2. Emphasize family strengths and the power of family attachments. Keep a family systems perspective that views the family as the focus of treatment.
3. A commitment to families to provide individualized treatment services.
4. An holistic approach that emphasizes the interdependence of the child or adolescent with all the systems in which they operate.

LINK TO CASE MANAGEMENT:

The H&CS will utilize the CASSP principles. An effort will be made to integrate services into an effective, coordinated system of care that will benefit the child and the family.

SPECIFIC DESIGN OF SERVICES:

Mobile Therapy services offered by H&CS will provide care to the highest standards based upon CASSP principles, Federal, and/or State regulatory acts. Mobile Therapy will specifically provide individual and family therapy models for mental health issues. They will provide insight into family dynamics, and provide support and assistance in the development of adaptive skills in order for the child or adolescent to take a more positive role in the family.

- The MT will report to the Case Management team. The MT will be available for consultation in interagency services planning meetings to ensure that in-home treatment efforts are coordinated with the child or adolescent and the family. MT services will be guided by the psychological evaluation and specified in the MT treatment plan.

STAFF SUPERVISION AND QUALIFICATION:

A Mental Health Specialist who will have a minimum of a Master's degree in a human service field and at least 2 years experience in a CASSP system will supervise the MT.

- The MT must attend 1 hour of supervision monthly**.**

TRAINING REQUIREMENTS:

- All MTs are required to attend a minimum of 10 hours a year of training.
- Training courses and criteria will be updated yearly.

Position Description: Behavioral Specialist Consultant

Position Title: *Behavioral Specialist Consultant*
Reports To: Case Management team
Assignment: BHR Services
Department: Home and Community Services
Labor Relationship: CCRES Contractor
Position Definition: The person filling this position will design behavioral interventions in collaboration with the treatment team.
Relationship: The **Behavioral Specialist Consultant** shall be directly responsible to the Case Management team.

QUALIFICATIONS**:**
Education/Experience:
Minimum qualifications for the Behavioral Specialist Consultant include:

- Licensed psychologist, Master's or Doctoral level.
  OR
- Master's level clinician with demonstrated training in behavioral intervention techniques.
- PA licensure as Behavior Specialist if working with client diagnosed with Autism Spectrum Disorder.
- Minimum 1-year, post-graduate, full time experience providing clinically supervised treatment to children and adolescents.
- Documentation of a minimum of 12 graduate credit hours in course work related to behavioral management theory, interventions, protocols or techniques; and at

least one-year experience practicing those behavior interventions, protocols and techniques.
AND

- Training in the CASSP principles
- Must possess Act 33/34 and FBI clearances.

Skills/Knowledge:

- Must have strong communication and collaboration skills.
- Ability to evaluate, counsel, and work with clients, family members, designated caregivers and staff.
- Ability to adhere to mandated timelines and providing services to clients and families.
- Ability to write positive, goal directed strength-based behavior intervention plans.
- Due to itinerant nature of position, must have a valid driver's license.
- Ability to be a clinical leader.

Physical:

- Ability to drive.
- Ability to physically manage children/adolescents.

Authority: The **BSC** will have the authority to perform all functions listed above in accordance with established policies and procedures.

Functions/Duties/Responsibilities:

To perform this job successfully, an individual must be able to perform each essential function/duty/responsibility at acceptable standards. In accordance with both state and/or federal law, reasonable accommodations will be considered upon employee request.

Essential:

- Provide assessment, program design, and monitoring of clients in the area of behavioral management.
- As the clinical leader, develop a treatment plan for the client.
- Facilitate the interagency team meetings, planning meetings, and in-school guidelines meeting to ensure consistency in all treatment settings.
- Coordinate resources to enhance the well being of the child and overall family functioning.
- Assist in problem solving when conflicts arise over behavioral paradigms in other involved systems.
- Troubleshoot with the team when behavioral interventions are seen as ineffective for the child or family.
- Develop a 24-hour crisis plan.
- Travel to and from client's home/school/community to perform duties.
- Responsible to both review and train members of the treatment team on the implementation of the behavioral treatment plan.
- Responsible to consult with and oversee TSS at least twice per month.
- Responsible to observe the client over several different settings. This includes observing each and every staff (TSS) working with the client.
- Experienced in performing/developing Functional Behavioral Assessments

Secondary:

- Collaborate with the MT and/or TSS worker to monitor effectiveness of treatment plans.
- May participate in collaborative consultations including IEP meetings, psychological evaluations and meetings with MH/IDD and medical, educational and therapeutic personnel.
- Complete and submit appropriate paperwork and documentation within required timelines.
- Perform other duties as assigned.

Service Description: Behavioral Specialist Consultant

PURPOSE OF PROGRAM SERVICES:

BSC services primarily provide assessment, program design and monitoring. This person will serve as a consultant to the treatment team, rather than provide direct therapy. This person will work in collaboration with other members of the treatment team in order to design behavioral interventions and behavior modification interventions through a written plan, which is individualized to the child or adolescent and to the family's needs. The services would include, but not be limited to:

1. Coordinating resources to enhance the well being of the child, adolescent, and overall family functioning.
2. Assist in the collaboration of problem solving when conflicts arise over behavioral paradigms in other systems such as the school.
3. Identification of behavioral goals and intervention techniques that are both measurable and observable.
4. The design and implementation of a behavioral intervention plan.
5. Troubleshooting when the team needs specific behavioral interventions, or when behavioral interventions already in place do not seem to be effective for the child, adolescent, or family.
6. The BSC must consult with each TSS on a weekly basis.
7. The BSC must provide an updated treatment plan to all team members.

IDENTIFICATION OF CLINICAL NEED:

The counties have a wide diversity of mental/behavioral health needs. Many children are put on a waiting list to receive the services of BSC. There are few options open to children who do not require the intensity of services that are offered in residential setting, but because of the lack of other interventions, find themselves in residential settings. With the assistance of BSC, these children can be served in a natural setting. The BSC services provide consultation to members of the treatment team, which are responsible to implement the individualized treatment plan for the child in a less restrictive setting. This service enhances the quality of the full continuum of treatment with a focus on less restrictive, less costly interventions

that continue to offer a high level of intensity.

The BSC service will adhere to the following principles:

1. Families are seen as powerful social institutions, which should be supported in their efforts to care for their children and adolescents at home.
2. Emphasize family strengths and the power of family attachments. Keep a family systems perspective that views the family as the focus of treatment.
3. A commitment to families to provide individualized treatment services.
4. A commitment to have skills transferred to the parent and caregiver.
5. Immediate, brief, and very intensive services.
6. An holistic approach that emphasizes the interdependence of the child or adolescent with all the systems in which they operate.

SPECIFIC DESIGN OF SERVICES:

BSC services offered by the H&CS will provide care to the highest standards based upon CASSP principles, Federal, and/or state regulatory acts. BSC will provide specific expertise in the area of behavioral interventions/management techniques in order to serve as a consultant to the treatment team. This person will provide behavioral assessment, program design and monitoring of all behavioral techniques used for the child or adolescent and his/her family. This person will facilitate all interagency service and planning meetings to ensure that all behavioral interventions within the home, school, and community are consistent within all treatment settings. The BSC may participate in all special child-centered, family-focused meetings. BSC services will be guided by the psychological evaluation and specified in the BSC treatment plan.

STAFF SUPERVISION AND QUALIFICATIONS:

A Mental Health specialist who will have a minimum of a Master's degree in a human service field and at least two (2) years experience in a CASSP system will supervise the BSC.

- The BSC must attend 1 hour of supervision monthly.

TRAINING REQUIREMENTS:

- All BSCs are required to attend a minimum of 10 hours per year of training.
- Training courses and criteria will be updated yearly.

Date: March 2016

Position Description: Case Manager

Position Title: **Case Manager**
Reports To: Coordinator of Home and Community Services
Assignment: BHR Services
Department: Home and Community Services
Labor Relationship: IU Employee
Position Definition: The person filling this position will provide support and guidance to, consulting psychologists or psychiatrists, BSCs, MTs, and TSS/Behavioral Health Personal Care Assistant workers. The person filling this position will also review records, manage cases, review treatment plans, hold weekly supervision groups and assign staff appropriately as dictated by the treatment team.
Relationship: The **Case Manager** for BHR Services shall be directly responsible to the Coordinator of Home and Community Services.
QUALIFICATIONS:
Education/Experience:
- Minimum of a Bachelor's degree in human services or education.
- Supervisory Case Manager needs a minimum of a Master's degree in Mental Health field with any licensing and certification required.
- One (1) years experience in a CASSP recognized field
- Training in the CASSP principles
- Must possess current/valid Act 33/34 and FBI clearances.

Skills/Knowledge:
- Must have strong communication, organization, collaboration, and leadership skills.
- Ability to evaluate, counsel, and work with clients, parents, provider staff, outside agency staff, and school personnel.
- Ability to adhere to mandated timelines in providing services to clients and families and meet regulatory requirements.
- Ability to prioritize assigned tasks.
- Ability to use time management effectively.
- Must have knowledge of human services programs, regulations and operations, including those from each county agency: OCY, JPO, and MH/IDD.

Physical:
- Due to itinerant nature of the position, a valid driver's license is required.

Authority:
- The **Case Manager** will have the authority to perform all functions listed above in accordance with established policies and procedures of the Chester County Intermediate Unit.

Functions/Duties/Responsibilities:

- To perform this job successfully, an individual must be able to perform each essential function/duty/responsibility at acceptable standards. In accordance with both state and/or federal law, reasonable accommodations will be considered upon employee request.

Essential:

- Review and obtain assessment of the child and ensure medical necessity for the child's involvement in the service.
- Coordinate resources and schedule staff to ensure services are rendered without gaps in treatment.
- Facilitate problem solving and conflict resolution when problems arise over differences with staff and other involved systems.
- Troubleshoot with the team when behavioral interventions are seen as ineffective for the child or family.
- Track all H&CS clients by reviewing and correcting appropriate documentation and submitting it to the appropriate agencies as required by the Pennsylvania Department of Human Services, the Office of Mental Health, the Office of Medical Assistance, Behavioral Health Managed Care Organization, and County MH/IDD offices.
- Arrange services for clients beginning with intakes.
- Guide and assist eligible individuals in gaining access to necessary medical, educational rehabilitative and social services, monitor service delivery and evaluate outcome and continued need for services.
- Participate in the intake process, selection, orientation and training of clinical staff, including TSS, BSCs, MTs and other Case Manager's.
- Provide weekly supervision to TSS workers.

Secondary:

- Collaborate with the MTs, BSCs, and TSS workers and Behavioral Health Personal care Assistants to monitor effectiveness of treatment plans.
- Provide clinical guidance and support when required.
- May participate in interagency service and planning meetings to ensure consistency in all treatment settings.
- Complete appropriate paper work and documentation accurately and promptly as required.
- Perform other duties as assigned.

Service Description: Case Manager
Purpose of Program Services:

The purpose of Case Management is to coordinate the delivery of BHR services and facilitate access to available resources necessary for the implementation of BHRS treatment. Specific functions of the Case Manager include, but may not be limited to:

1. Help create the service coordination plan, which includes a comprehensive

approach to meeting the child's individual needs, with a particular emphasis on all available resources within the community, particularly based upon the recommendations of the Interagency Team and the prescriber of service.
2. Maintain ongoing communication with all persons providing services to the child or adolescent in order to maintain a current perspective on progress.
3. Monitoring the effectiveness and integrity of services.
4. Serve as a liaison between all agencies/personnel involved in service delivery and the Interagency Team.
5. Ensuring that all documentation is in the child's chart, completed and in order.
6. Scheduling psychological evaluations
7. Continual reassessment of service needs.
8. Crisis management.

IDENTIFICATION OF CLINICAL NEED:

The counties have a wide diversity of mental/behavioral health needs. Many children are put on waiting lists to receive the BHR Services. There are few options open to children who do not require the intensity of services that are offered in a residential setting, but because of the lack of other interventions, find themselves in a residential setting. With the assistance of BHR Services, these children can be served in a natural setting. The Case Manager monitors the implementation of the BHR Services that are available to the client and family. This service enhances the quality of the full continuum of treatment with a focus on less restrictive setting, less costly interventions that continue to offer a high level of intensity.

LINK TO EDUCATIONAL SYSTEM:

In order to prevent a more restrictive placement, Case Management services will serve as a liaison between BHR Services and the child/adolescent's school setting in order to maintain the child/adolescent in the most appropriate environment.

SPECIFIC DESIGN OF SERVICES:

The Case Management services offered by H&CS will provide care to the highest standards based upon CASSP principles, Federal and/or State regulatory acts. The Case Manager will coordinate services provided to the identified child/adolescent in cooperation with any currently existing Case Management services. This person may participate in interagency service and planning meetings to ensure that all interventions within the home, school, and community are consistent within all settings. The specific design of services will be delivered in accordance with the current needs of the child/adolescent as outlined by the Interagency Team.

STAFF SUPERVISION AND QUALIFICATION:

A Mental Health Specialist who will have a minimum of a Master’s degree in a

human service field and at least two years experience in a CASSP system will supervise the Case Manager. Additional supervision will include a Master's level Coordinator.

- The Case Manager must attend 1 hour of supervision monthly**.**

TRAINING REQUIREMENTS:

- All Case Managers are required to attend a minimum of 10 hours a year of training.
- Training courses and criteria will be updated yearly.

Position Description: Case Specialist

Position Title: **Case Specialist**
Reports To: Coordinator of Home and Community Services
Assignment: BHR Services
Department: Home and Community Services
Labor Relationship: IU Employee

Position Definition: The Case Specialist will be responsible for all clerical duties related to the position, ensuring the timely development and submission of client-centered plans; promoting positive relations with referral, regulatory and funding agencies; and promoting the integration of children with disabilities in the community. The Case Specialist will participate in the client intake process and the orientation of clinical staff, including TSS, BSCs, MTs and Supervisory Case Managers and Case Specialists.

Relationship: The **Case Specialist** for BHR Services shall be directly responsible to the Coordinator of Home and Community Services.

QUALIFICATIONS:

Education/Experience:

- Minimum of a High School diploma.
- One (1) year experience in a CASSP recognized field
- Training in the CASSP principles
- Must possess current/valid Act 33/34 and FBI clearances.

Skills/Knowledge:

- Must have strong communication, organization, collaboration, and leadership skills.
- Ability to apply knowledge of current research and theory in specific field.
- Ability to establish and maintain effective working relationships with staff, administration, agencies, and the community.
- Ability to communicate clearly and concisely.
- Ability to adhere to mandated timelines in providing services to clients and families and meet regulatory requirements.
- Ability to prioritize assigned tasks.
- Ability to use time management effectively.

- Must have knowledge of human services programs, regulations and operations, including those from each county agency: OCY, JPO, and MH/IDD.

Physical:

- Due to itinerant nature of the position, a valid driver's license is required.

Authority:

- The **Case Specialist** will have the authority to perform all functions listed above in accordance with established policies and procedures of the Chester County Intermediate Unit.

Functions/Duties/Responsibilities:

- To perform this job successfully, an individual must be able to perform each essential function/duty/responsibility at acceptable standards. In accordance with both state and/or federal law, reasonable accommodations will be considered upon employee request.

Essential:

- All clerical responsibilities related to the promptness of packet submission and the receipt of service authorization from all identified funders/insurances, etc.
- Work with the staffing agency recruiter to ensure appropriate staffing of caseloads.
- Facilitate problem solving and conflict resolution when problems arise over differences with staff and other involved systems.
- Coordinate and oversee delivery of services delineated in plan of care summary whereby individualized plans can be carried out.
- Monitor the billing system to ensure reimbursement from Medicaid and private insurers for services provided to clients.
- Track all H&CS clients by reviewing and correcting appropriate documentation and submitting it to the appropriate agencies as required by the Pennsylvania Department of Human Services, the Office of Mental Health, the Office of Medical Assistance, Behavioral Health Managed Care Organization, and County MH/IDD offices.

Secondary:

- Monitor service delivery and evaluate outcome and continued need for services.
- Participate in the intake process, selection, orientation and training of clinical staff, including TSS, BSCs, MTs and other Case Managers.
- Complete appropriate paper work and documentation accurately and promptly as required.
- Perform other duties as assigned.

Service Description: Case Specialist

PURPOSE OF PROGRAM SERVICES:

The purpose of Case Specialist services is to coordinate the delivery of services and access all necessary and available resources to best meet the needs of the child or adolescent. Specific functions of the Case Specialist include, but may not be limited to:

1. Help create the service coordination plan, which includes a comprehensive

approach to meeting the child's individual needs, with a particular emphasis on all available resources within the community, particularly based upon the recommendations of the Interagency Team and the prescriber of service.
2. Facilitating access to BHR services.
3. Maintain ongoing communication with all persons providing services to the child or adolescent in order to maintain a current perspective on progress.
4. Monitoring the effectiveness and integrity of services.
5. Serve as a liaison between all agencies/personnel involved in service delivery and the Interagency Team.
6. Advocating for the child and family.
7. Ensuring that all documentation is in the child's chart, completed and in order.
8. Scheduling psychiatric/psychological evaluations
9. Continual reassessment of service needs.

IDENTIFICATION OF CLINICAL NEED:

The counties have a wide diversity of mental/behavioral health needs. Many children are put on waiting lists to receive BHR Services. There are few options open to children who do not require the intensity of services that are offered in a residential setting, but because of the lack of other interventions, find themselves in a residential setting. With the assistance of BHR Services, these children can be served in a natural setting. The Case Specialist monitors the implementation of the BHR Services that are available to the client and family. This service enhances the quality of the full continuum of treatment with a focus on less restrictive setting, less costly interventions that continue to offer a high level of intensity.

LINK TO EDUCATIONAL SYSTEM:

In order to prevent a more restrictive placement, Case Specialist services will serve as a liaison between BHR Services and the child/adolescent's school setting in order to maintain the child/adolescent in the most appropriate environment.

SPECIFIC DESIGN OF SERVICES:

The Case Specialist services offered by H&CS will provide care to the highest standards based upon CASSP principles, Federal and/or State regulatory acts. The Case Specialist will coordinate services provided to the identified child/adolescent in cooperation with any currently existing Case Management services. This person will participate in all interagency service and planning meetings to ensure that all interventions within the home, school, and community, are consistent within all settings. The specific design of services will be delivered in accordance with the current needs of the child/adolescent as outlined by the Interagency Team.

STAFF SUPERVISION AND QUALIFICATION:

A Mental Health Specialist who will have a minimum of a Master's degree in a human service field and at least two years experience in a CASSP system will supervise the Case Specialist. Additional supervision will include a Master's level Coordinator.

- The Case Specialist must attend 1 hour of supervision monthly**.**

TRAINING REQUIREMENTS:

- All Case Specialists are required to attend a minimum of 10 hours a year of training.
- Training courses and criteria will be updated yearly.

Position Description: Coordinator

Position Title: **Coordinator**
Reports To: Supervisor of Home and Community Services
Assignment: BHR Services
Department: Home and Community Services
Labor Relationship: IU Employee
Position Definition: The person filling this position will provide clinical support and guidance to Case Managers, Case Specialists, Behavior Specialists, MTs, TSS/Aide workers, and BHPCAs. The person filling this position will also have fiscal and managerial oversight of the department to include (but not limited to) staffing and billing concerns. They will additionally review records, design strategies, approve treatment plans, and interview and assign staff as needed. Coordinators will be assigned to a specific county/counties.
Relationship: The **Coordinator** for BHR Services shall be directly responsible to the Supervisor of Home and Community Services.
QUALIFICATIONS:
Education/Experience:

- Master's degree in mental health field with any associated licensure and/or certification.
- Five years experience in a CASSP recognized field.
- Minimum one 1-year postgraduate experience providing clinically supervised treatment to children and adolescents.
- Highly preferred to have documentation of a minimum of 12 graduate credit hours in course work related to behavioral management theory, interventions, protocols, or techniques; and at least 1-year experience practicing those behavioral interventions, protocols, or techniques.
- Training in the CASSP principles

- Must possess current/valid Act 33/34 and FBI clearances.

Skills/Knowledge:

- Must have strong communication, collaboration, and leadership skills.
- Ability to evaluate, counsel, and work with clients, parents, adult caregivers, provider staff, outside agency staff, and school personnel.
- Ability to adhere to mandated timelines in providing services to clients and families and meet regulatory requirements.
- Ability to prioritize assigned tasks.
- Ability to use time management efficiently.
- Must have understanding of the mental health and Medicaid systems.
- Must have knowledge of human services programs, regulations and operations, including those from each county agency: OCY, JPO, and MH/IDD.
- Ability to interview, hire and maintain appropriate staffing.

Physical:

- Due to itinerant nature of the position, a valid driver's license is required.

Authority:

- The **Coordinator** will have the authority to perform all functions listed above in accordance with established policies and procedures of the Chester County Intermediate Unit.

Functions/Duties/Responsibilities:

- To perform this job successfully, an individual must be able to perform each essential function/duty/responsibility at acceptable standards. In accordance with both state and/or federal law, reasonable accommodations will be considered upon employee request.

Essential:

- Review, access, and provide assessment of the child and ensure medical necessity for the child's involvement in the service.
- Coordinate resources and schedule staff to ensure services are rendered without gaps in treatment.
- Facilitate problem solving and conflict resolution when problems arise over differences with staff and other involved systems.
- Troubleshoot with the team when behavioral interventions are seen as ineffective for the child or family.
- Track all H&CS clients by reviewing and correcting appropriate documentation and submitting it to the appropriate agencies as required by the Pennsylvania Department of Human Services, the Office of Mental Health, the Office of Medical Assistance, Behavioral Health Management Care Organization, and County MH/IDD offices.
- Oversee entire Home and Community Staff in their designated region and supervise workers according to DHS regulations and CCIU policies and procedures.
- Oversee the intake process, selection, orientation and training of clinical staff, including TSS/Aides, BHPCAs, BSCs, MTs, Case Specialists and Case Managers.
- Oversee and coordinate training programs for therapeutic staff.

Secondary:

- Collaborate with the Case Manager, Case Specialist, MTs, BSCs, BHPCAs and TSS workers to monitor effectiveness of treatment plans.
- Provide clinical guidance and support when required.
- Participate in interagency service and planning meetings to ensure consistency in all treatment settings.
- Complete appropriate paper work and documentation as required.
- Perform other duties as assigned.

Service Description: Coordinator

PURPOSE OF PROGRAM SERVICES:

The purpose of the Coordinator is to coordinate the delivery of services and access all necessary and available resources to best meet the needs of the child or adolescent. Specific functions of the Coordinator include, but may not be limited to:

1. Creating the service coordination plan, which includes a comprehensive approach to meeting the child's individual needs, with a particular emphasis on all available resources within the community, particularly based upon the recommendations of the Interagency Team and the prescriber of service.
2. Facilitating access to services.
3. Oversee and maintain ongoing communication with all persons providing services to the child or adolescent in order to maintain a current perspective on progress.
4. Monitoring the effectiveness and integrity of program services within their county.
5. Serve as a liaison between all agencies/personnel involved in service delivery and the Interagency Team.
6. Ensuring that all documentation is in the child's chart, completed and in order.
7. Oversee the scheduling of psychological evaluations, and any other testing as deemed necessary by the treatment team.
8. Continual reassessment of service needs.
9. Crisis management.
10. Facilitate specified trainings.

IDENTIFICATION OF CLINICAL NEED:

The counties have a wide diversity of mental health needs. In this county, many children are put on waiting lists to receive the BHR Services. There are few options open to children who do not require the intensity of services that are offered in a residential settings, but because of the lack of other interventions, find themselves in a residential setting. With the assistance of BHR Services, these children would be able to be served in a natural setting. The Coordinator is responsible for the monitoring and implementation of the BHR Services that are available to the child in their assigned region. The Coordinator is also responsible for the recruiting, training and/orientation of staff according to DHS and CASSP Principles. This service enhances the quality of the full continuum of treatment with a focus on less

restrictive setting, less costly interventions that continue to offer a high level of intensity.

SPECIFIC DESIGN OF SERVICES:

The Coordinator services offered by the H&CS will provide care to the highest standards based upon CASSP principles, federal and/or state regulatory acts. The Coordinator will coordinate services provided to the identified child/adolescent in cooperation with any currently existing services. This person will participate in interagency service and planning meetings to ensure that all interventions within the home, school, and community are consistent within all settings. The specific design of services will be delivered in accordance with the current needs of the child/adolescent as outlined by the Interagency Team.

STAFF SUPERVISION AND QUALIFICATION:

A Mental Health Specialist who has the following qualifications will supervise the Coordinator:

- Master's degree in mental health field with any licensing and certification required.
- Five years experience in a CASSP recognized field.
- Minimum one 1-year postgraduate experience providing clinically supervised treatment to children and adolescents.
- Documentation of a minimum 12 graduate credit hours in course related work related to behavioral management theory, interventions, protocols, or techniques.
- At least 1-year experience practicing those behavioral interventions, protocols, or techniques. This year could be concurrent with postgraduate experience.
- Training in the CASSP principles.
- The Coordinator must attend 1 hour of supervision monthly with the Supervisor of Home and Community Services.

TRAINING REQUIREMENTS:

- The Coordinator is required to attend a minimum of 10 hours a year of training.
- Training courses and criteria will be updated yearly.

Position Description: Supervisor

Position Title: Supervisor
Reports To: Director of Student Services
Assignment: Behavioral Rehabilitation Services
Department: Home and Community Services
Labor Relationship: IU Employee

Date: March 2016

Position Definition: The Supervisor of Home and Community Services is responsible for providing administrative and clinical leadership for all aspects of a regional behavioral health rehabilitative services program. Incumbent ensures program delivery to eligible children up to 21 years of age in Chester, Delaware, Lancaster, Lebanon, and Montgomery counties. Responsibilities include program development, program oversight, financial management, quality assurance, risk management, human resource management, and external relations. The Supervisor is responsible for all programs within Home and Community Services.
Relationship: The **Supervisor** for BHR Services shall be directly responsible to the Director of Student Services.

QUALIFICATIONS:

Education/Experience:

- The incumbent will have a Master's degree, with a minimum of five (5) years of program-based experience as a supervisor of Behavioral Health Rehabilitative Services or similar program, such as Health Services, Public Policy/Health Administration or an MBA in Health Administration.
- Five years experience in a CASSP recognized field.
- Minimum one 1-year postgraduate experience providing clinically supervised treatment to children and adolescents.
- Documentation of a minimum 12 graduate credit hours in course related work related to behavioral management theory, interventions, protocols, or techniques; and at least 1-year experience practicing those behavioral interventions, protocols, or techniques.
- Training in the CASSP principles.
- Must possess Act 33/34 and FBI clearances.

Skills/Knowledge:

- Must have knowledge of publicly funded human services programs, regulations and operations.
- Must have a working knowledge of legal and procedural protections relating to the rights of children and their families.
- Must have knowledge of Special Education programs, regulations and operations.
- Must be aware of the state and federal initiatives regarding provision of integrated (educational and social) services to children and the role of education in coordinating or facilitating those services.
- Must have training and intervention knowledge and skills to address the needs of districts and agencies in developing new systems of pre-referral and student services interventions.
- Must remain current on the latest legal and effective practice developments in areas of responsibility and must interact with appropriate local and state agencies around issues related to special programs and services.
- Must be an expert in the field of Public Policy and/or Health Administration with regard to Medical Assistance.
- Ability to apply knowledge of current research and theory in specific field.

- Must have the ability to establish and maintain effective working relationships with staff, administration, agencies, and the community.
- Ability to transport between central office and various locations throughout the county and state as required by the position.
- Ability to communicate clearly and concisely.
- Ability to meet demands from several people, and to multi-task.

Physical:

- Due to itinerant nature of the position, a valid driver's license is required.

Authority:

- The **Supervisor** will have the authority to perform all functions listed above in accordance with established policies and procedures of the Chester County Intermediate Unit.

Functions/Duties/Responsibilities:

- To perform this job successfully, an individual must be able to perform each essential function/duty/responsibility at acceptable standards. In accordance with both state and/or federal law, reasonable accommodations will be considered upon employee request.

Essential:

- Supervise entire Home and Community Staff and supervise workers according to DHS, State, and Federal regulations.
- Supervise and coordinate training programs for therapeutic staff.
- Develop, review and execute department budget and policies.
- Collaborate with the Coordinators, Case Manager, Case Specialist, MTs, BSCs, BHPCAs, and TSS workers to monitor effectiveness of H&C services.
- Provide clinical guidance and support when required.