Treatment Family Care Workgroup Recommendations

Service Description and Definitions

32-005 Treatment Family Care Services: Treatment Family Care (TFC) services are available to clients age 20 or younger when the client has participated in a HEALTH CHECK (EPSDT) screen, the treatment is clinically necessary, and an Initial Diagnostic Interview and functional assessment document the need for continued care of this level. TFC occurs in home when caregiver(s) or specially trained foster parents are available at all times to provide consistent behavior management programs, therapeutic interventions, and render services under the direction of a supervising practitioner. TFC services must be community-based, family focused, culturally competent, and developmentally appropriate. Treatment is provided within a family environment with services that focus on improving the functionality of the client and the client/family's adjustment emotionally, behaviorally, socially, and educationally.

In addition to providing treatment for specific problems or conditions, TFC seeks to promote a stable family living arrangement for the children and youth it serves.

Providers must encourage family members to be involved in the assessment of the client, the development of the treatment plan, and all aspects of the client's treatment unless prohibited by the client, through legal action, or because of federal confidentiality laws.

Providers must be available to schedule meetings and sessions in a flexible manner to accommodate and work with a family's schedule. This includes the ability to schedule sessions at a variety of times including weekends or evenings.

The provider must document their attempts to involve the family in treatment plan development and treatment plan reviews. A variety of communication means should be considered. These may include, but should not be limited to, including the family via conference telephone calls, using registered letters to notify the family of meetings, and scheduling meetings in the evening and on weekends.

Youth in TFC are not automatically moved to a different non-kinship/relative placement after they have completed treatment. Placement following completion of the course of treatment will be based on the multi-disciplinary team's recommendations, and the youth's permanency goals and discharge plans. [Treatment Foster Care Workgroup Update to the Nebraska Children's Commission, November 15, 2016, page 3, item 5.b.i.]

32-005.01 Definitions: The following definitions and descriptions apply to TFC services:

Agency Staff: A TFC program must have an adequate number of staff to provide administration and direct services. Staff must be qualified, trained, and supported by the agency.

Family Role in Treatment: The role of the child's family may differ based on whether the parent retains legal custody of the child, the child's transition plan, and the needs of the child. The role of the legal parent(s), including involvement in treatment and services provided to the parent(s) will be guided by the court (if involved) and the multi-disciplinary treatment team. [Treatment Foster Care Workgroup Update to the Nebraska Children's Commission, November 15, 2016, page 2, item 4.d.i.] The treatment family should utilize a co-parenting approach with the youth's family, whether biological or adoptive family, or prospective adoptive placement. Nothing in this section may prevent a youth without legal parents from receiving TFC services. When possible, clients should be able to remain in their home of origin to receive TFC. When legal parents are TFC caregivers, provider will continue to make efforts to engage relatives, individuals with kinship relationships to the client, and other identified safe and supportive individuals.

Multi-disciplinary Team: Multi-disciplinary teams support the treatment, the child, and the family unit. Treatment professionals direct the team to make decisions for the child's needs. The agencies determine the multi-disciplinary team based on the individual needs of the child. [Treatment Foster Care Workgroup Update to the Nebraska Children's Commission, November 15, 2016, page 4, item 9.a-b.] The multi-disciplinary treatment team consists of the treatment parent, the TFC specialist, the supervising practitioner, and other persons as necessary (parents, Department case manager). Treatment teams will vary based on the needs of the child and the family.

Treatment Family Care Model: It is not necessary for an agency to implement a specific TFC model. TFC should be outcome focused, trauma, juvenile justice, and child welfare informed. State agencies should partner with provider agencies to determine service needs and desired outcomes, allowing variability in how these services and outcomes will be created by the provider agencies. [Treatment Foster Care Workgroup Update to the Nebraska Children's Commission, November 15, 2016, page 1, item 1.b.]

Treatment Family Care Specialist: A TFC specialist is a staff member who specializes in specifically serving TFC youth.

Intervention: Intervention is the coordinated and planned provision of services and use of procedures designed to improve the functionality of the client, improve the condition to the degree that it is no longer clinically indicated, and produce a planned outcome in a person's behavior, attitude, or general condition based on a thorough assessment of possible contributing factors

Treatment: The term treatment presumes stated, medically based, measurable goals based on professional assessment, a set of written procedures for achieving them, and a process for assessing these results. Treatment accountability requires that goals and objectives be time limited and outcomes systematically monitored.

Treatment Family: The treatment family is viewed as the primary treatment setting, with TFC parents trained and supported to act as the primary interventionist [Treatment Foster Care Workgroup Update to the Nebraska Children's Commission, November 15, 2016, page 2, item 4.c.i.], implement the in-home portion of the treatment plan and promote the goals of permanency planning for children in their care. The TFC parents provide the main behavioral intervention and are available at all times. (At least one TFC parent per home must be considered a professional TFC parent whose time is dedicated to the TFC program.) While their role is essential to the model, TFC parents do not carry primary or exclusive responsibility for the design of treatment plans. This is a team function carried out under the clinical direction of qualified program staff. TFC parents are a part of the multi-disciplinary team, which is directed by treatment professionals making decisions for the child's needs. [Treatment Foster Care Workgroup Update to the Nebraska Children's Commission, November 15, 2016, page 2, item 4.c.i.].

Standards for Providers

32-005.02 Standards of Participation for Service Providers: The Nebraska Medical Assistance Program does not pay for care that is chronic or custodial. An agency that provides treatment family care services shall meet the following standards for participation to ensure that payment is made only for active treatment:

1. The agency shall meet all applicable licensing standards;
2. The TFC homes shall meet the minimum regulations for foster homes caring for children and be licensed through the Department or approved by the placing agency

3. The agency providing TFC must be licensed as a Child Placing Agency;
4. The agency's records must be sufficient to permit the Department to determine the degree and intensity of treatment services furnished to the client/family;
5. The program is designed to meet the developmental needs of persons age 20 and younger;
6. The place of service must be the treatment family home.

An outline of the information required in a program plan is available from the Division of Medicaid and Long-Term Care.

Agencies providing TFC must be appropriately licensed by the Department of Health and Human Services, Division of Public Health.

Provider Qualifications: Agencies shall be licensed by the State of Nebraska as a Child Placing Agency and accredited by a national accrediting body. Each agency will employ or contract with licensed program/clinical directors to supervise unlicensed direct care staff consistent with State licensure. {Nebraska State Plan Under Title XIX of the Social Security Act, Attachment 3.1-A Item 4b, Page 19]

32-005.02B Annual Renewal/Update: The program will submit information with the provider agreement (see 471 NAC 32-005.02A) and update the information annually and whenever requested by the Division of Medicaid and Long-Term Care.

Guidelines for Program Use

32-005.03 Guidelines for Use of the Treatment Family Care Services for Children: A youth must have a diagnostic condition listed in the current diagnostic and statistics manual of the American Psychiatric Association for this level of care. NMAP applies the following general guidelines to determine when TFC services for children are clinically necessary for a client:

1. Utilization of TFC is appropriate for individualized treatment and is expected to improve the client's condition to facilitate least restrictive interventions;
2. The child/youth's problem behaviors can be managed with this level of structure and cannot be managed at a lower level of structure. The child/youth is not required to exhaust higher or lower level structured services to receive TFC services;
3. The child/youth's daily functioning is moderately impaired in such areas as family relationships, education, daily living skills, community, health, etc.;
4. The child/youth has identified behaviors are persistent but can be improved with this level of intervention/intensity; or
5. The child/youth has special needs severe enough that in the absence of such programs, they would be at risk for more restrictive care settings such as hospitals, psychiatric centers, correctional facilities, or residential treatment programs; or for removal from their family home.

Staffing Pattern and Standards

32-005.04 Staffing Pattern: Staffing pattern must allow for the intensity of service required in TFC. All staff, regardless of role must operate within the scope of practice guidelines established by the Nebraska Department of Health and Human Services, Division of Public Health.

PRFC service staff shall receive ongoing and regular clinical supervision through a Child Placing Agency by a person meeting the qualifications of a psychiatrist or psychologist with experience regarding this specialized mental health service, and such supervision shall be available at all times to provide back up, support, and/or consultation. Practitioners providing substance abuse or mental health services must meet the training requirements outlined by Medicaid and/or its designee, in addition to any required scope of

practice license required for the facility or agency to practice in the State of Nebraska. [Nebraska State Plan Under Title XIX of the Social Security Act, Attachment 3.1-A Item 4b, Page 19]

32-005.04 Staffing Standards for Participation

32-005.04A Staff Members: The following staff positions are requirements of TFC. All staff that are required to be licensed must operate within their scope of practice and the guidelines established by the Nebraska Department of Health and Human Services, Division of Public Health.

32-005.04A1 Supervisor: The role of the Supervisor is to provide support and consultation to the treatment team and TFC Specialist.

1. Supervisor responsibilities are –
    a. Team supervision: The Supervisor will provide regular support and guidance to the team members. The supervisor to TFC specialist ratio must not exceed 1 to 6.
    b. Treatment planning: The supervisor is a member of the treatment team and shares the responsibilities of developing the plan. S/he also evaluates progress reports and updates.
    c. Crisis on-call: The supervisor provides coordination and backup to ensure that 24-hour on-call crisis intervention services are available and delivered.
    d. Other: May include but is not limited to any of the following:
        (1) Treatment assessment with the supervising practitioner;
        (2) Determining Treatment needs;
        (3) Parent support and consultation;
        (4) Clinical and administrative supervision of staff;
        (5) Treatment parent recruitment;
        (6) Orientation;
        (7) Training and selection for the unique needs of the population;
        (8) Youth intake and placement;
        (9) Record keeping;
        (10)Program evaluation;
        (11) Ongoing consultation and supervision
2. Supervisor activities must be performed by a clinical staff member who is acting within his/her scope of practice per DHHS, Division of Public Health requirements.

32-005.04A2 TFC Specialist: The TFC specialist is a member of the treatment team and works in development of the treatment plan, supports and consults with the treatment families, client families, and other members of the treatment team. The TFC specialist also advocates for, coordinates, and links treatment families and client families to other services available in the community.

1. TFC Specialist responsibilities:
    a. Treatment team:
        (1) Under the direction of the supervising practitioner and the supervisor, the TFC specialist takes primary day-to-day responsibility for the treatment team. The TFC specialist organizes and manages all team meetings and team decision making. The TFC specialist takes an active role in identifying goals and coordinating treatment services provided to the youth.
        (2) The TFC specialist provides information and training to treatment team members who may not be familiar with the TFC model. The TFC specialist prepares these individuals to work with TFC parents and client families in a

manner which is supportive of their roles. The TFC specialist also prepares them to work with the team in a manner consistent with the TFC practice and values.

b. Support/consultation to TFC parents:
    (1) The TFC specialist will provide regular support and technical assistance to the TFC parents in their implementation of the treatment plan and with regard to other responsibilities they undertake. The fundamental components of technical assistance will be the design or revision of in-home treatment strategies including proactive goal setting and planning, the provision of ongoing child-specific skills training, and problem solving during home visits.
    (2) Other types of support/supervision include emotional support and relationship building, the sharing of information and general training to enhance professional development, assessment of the client's progress, observation/assessment of family interactions and stress, and assessment of safety issues. The TFC specialist will provide at least weekly contact by phone or in person with the treatment parent of each client family on his/her caseload. The TFC specialist will visit the treatment home to meet with at least one TFC parent no less than twice per month, or more often as is necessary.
c. Caseload: The number of client/families assigned to a TFC specialist is determined based on: the size/density of the geographic area, the array of job responsibilities assigned, clinical needs of the client, and the complexity of the population served.
d. Contact with client/family: The TFC specialist or other program staff shall provide one-on-one face-to-face contact with the client and the TFC parent at least twice monthly, or more often based on the current needs of the client/family and the TFC parents.
e. Family Engagement: The specialist will seek support and enhance the client's relationships with his/her family during his/her time in TFC. The specialist will arrange and encourage regular contact and visitation as specified in the treatment plan. The specialist will seek to include the client/family in treatment team meetings, treatment planning, and decision making, family team meetings, and will keep them informed of the client's progress.
f. Community connections and pro-social activities: The TFC specialist will work with the treatment team to determine which community resources will help meet the needs of the client/families to meet the objectives of the treatment plan. The TFC specialist will advocate for and coordinate these services while providing technical assistance to the community agency.
g. Crisis on-call: Support shall be provided to allow for 24 hour coverage.

32-005.04A4 Supervising Practitioner: The role of the supervising practitioner is to support and supervise the treatment team in providing active treatment to the client/family.

1. The supervising practitioner must be a licensed practitioner of the healing arts who is able to diagnose and treat major mental illness within his/her scope of practice and must maintain this licensure in the state in which the program operates (see 471 NAC 32-001.04, Staffing Standards);
2. Supervising practitioner responsibilities:
    a. Treatment team participation: The supervising practitioner will provide regular support and guidance to the treatment team;
    b. Treatment planning: The supervising practitioner helps in the development of a comprehensive treatment plan based on an assessment for each client/family admitted to the program and input provided by the entire multidisciplinary team;
    c. Crisis on-call: Support shall be provided to allow for 24 hour coverage; and

d. Client contact: The supervising practitioner will meet with the client/family as described in the treatment plan to assess the client's needs and monitor progress toward treatment goals.

32-005.04B Staff Training and Support: All professional staff require preservice and ongoing professional development relevant to TFC and to their individual job responsibilities.

32-005.04B1 Crisis On-Call: The program shall provide on-call crisis intervention support to allow for 24-hour coverage.

32-005.04B2 Liability Insurance: Professional staff must be covered by liability insurance.

32-005.04B3 Legal Advocacy and Representation: The agency shall assist staff in obtaining legal advocacy and representation should the need arise in connection with the proper performance of their professional duties.

Treatment Family Care Parent Responsibilities

32-005.04C TFC Parents: TFC parents are primary interventionists and [Treatment Foster Care Workgroup Update to the Nebraska Children's Commission, November 15, 2016, page 2, item 4.c.i.] members of the multi-disciplinary [Treatment Foster Care Workgroup Update to the Nebraska Children's Commission, November 15, 2016, page2, item 4.c.i.] treatment team whose primary responsibility is to implement the specific strategies of the treatment plan in the home [Treatment Foster Care Workgroup Update to the Nebraska Children's Commission, November 15, 2016, page2, item 4.c.i.]. Their responsibilities also include providing parenting duties as outlined in state and agency regulations concerning foster parents. A treatment parent must be available 24 hours a day to respond to crisis or emergency situations. With the exception of kinship and relative placements, TFC parents may not provide day care for children in their home.

32-005.04C1 Treatment Parent Responsibilities:

1. Role: The following are the responsibilities of TFC parents as outlined in the Nebraska Caregiver Responsibility (NCR) tool-
    a. Nutrition;
    b. Clothing;
    c. Shelter and physical care;
    d. Nurturance and acceptance;
    e. Supervision; and
    f. Transportation;
2. *A treatment family* is also required to *perform the following functions* in addition to the responsibilities noted above*:*
    a. *Promotes improvement in the EPSDT eligible client's social skills and family and peer relationship skills through training and education of the EPSDT eligible and the legal parents/primary caregiver*
    b. *Teaches and instructs the caregiver in crisis and de-escalation techniques*
    c. *Teaches and models appropriate behavioral treatment interventions and techniques for the EPSDT eligible and the legal parents/primary caregiver*
    d. *Teaches and models appropriate coping skills to manage dysfunctional behavior for the legal parents/primary caregiver*
    e. *Teaches and models proper and effective parenting practice to legal parents/primary caregiver*

f. Provides information about medication compliance and relapse prevention and reports to her/his supervising licensed mental health practitioner

g. Provides training and rehabilitation of basic personal care and activities of daily living through training the EPSDT eligible and the usual legal parents/primary caregiver

h. Assists the EPSDT eligible to develop positive peer relationships

i. Works with the legal parents/primary caregiver to explore community resources in the EPSDT eligible client's natural setting [Nebraska State Plan Under Title XIX of the Social Security Act, Attachment 3.1-A Item 4b, Page 18]

3. Treatment planning: The TFC parents shall assist the team in development of treatment plans for the client/family in their care. TFC parents contribute vital input based upon their observations of the client/family in the natural environment of the treatment home;
4. Treatment implementation: The TFC parents have the primary responsibility for implementing the interventions identified in the treatment plan in the TFC home [Treatment Foster Care Workgroup Update to the Nebraska Children's Commission, November 15, 2016, page2, item 4.a.i.].
5. Treatment team meetings: The TFC parents shall work cooperatively with other team members and will attend team meetings, training sessions, and other meetings to support the child's treatment needs and as outlined in treatment plans;
6. Record keeping: The treatment parent shall document activities as required by the agency and the standards under which it operates. The treatment parent shall keep a record of the client/family's behavior and progress in targeted areas on a daily basis (or more often as medically necessary);
7. Contact with child's family: The treatment parent shall assist the client in maintaining contact with his/her family and work actively to enhance and support these relationships [Treatment Foster Care Workgroup Update to the Nebraska Children's Commission, November 15, 2016, page 2, 4.d.i.];
8. Permanency planning assistance: The treatment parent shall assist with efforts specified by the treatment team to meet the child's permanency planning goals. These must include, but are not limited to –
    a. Emotional support;
    b. Advice;
    c. Demonstration of effective child behavior management and other therapeutic interventions to the child's family; and
    d. Support to the child and family during the initial period of post treatment placement.
9. Community relations: The treatment parent shall develop and maintain positive working relationships with service providers in the community such as schools, departments of recreation, social service agencies, and mental health programs and professionals;
10. Advocacy: The treatment parent shall work with other members of the treatment team to advocate on behalf of the child/family to achieve the goals identified in the treatment plan. This includes obtaining educational, vocational, medical, and other services needed to implement the treatment plan and to assure full access to and provision of public services to which the child is legally entitled; and
11. Notice of request for child move: Unless a move is required to protect the health and safety of the child or other treatment family members, the treatment parent shall provide at least 14 days' notice to program staff if requesting a child's removal from the home so as to allow for a planful and minimally disruptive transition.

<u>32-005.04C3 Treatment Parent Training:</u> Treatment parent training must be a systematic, planned, and documented process which includes content relative to placement type, such as kinship, licensed

kinship, relative, licensed relative, licensed foster, and legal family placements. TFC parents are provided additional, enhanced training that is competency based, trauma informed, and adequate to give foster parents the needed skills to serve the population of youth served by TFC. [Treatment Foster Care Workgroup Update to the Nebraska Children's Commission, November 15, 2016, page 2, 8.a] Training must be consistent and with the program's treatment philosophy and methods. It should prepare TFC parents to carry out their responsibilities as agents to the treatment process. The training must include the following components:

1. Preservice training: Licensed foster homes shall be required a number of hours commensurate with state and accrediting body (if applicable) requirements and sufficient to ensure that all material is covered adequately.
2. In-service training: The number of hours required should be commensurate with state and accrediting body requirements and sufficient to ensure that all material is covered adequately.
3. Ongoing training: Training should be specific to the needs of the child. Training may be through active teaching of daily interventions.

Parent Support

32-005.04C4 Treatment Parent Support: TFC programs are obligated to provide intensive support, technical assistance, and supervision to all TFC parents. This must include specific management and supervision services in addition to those listed below:

1. Information disclosure: All information the TFC program receives concerning a client/family to be placed with a treatment family must be shared with and explained to the prospective TFC family prior to placement. TFC parents have access to full disclosure of information concerning the child as well as the responsibility to maintain agency standards of confidentiality regarding such information. The information must include, but is not limited to –
    a. The child's strengths and assets;
    b. Potential problems and needs; and
    c. Initial intervention strategies for addressing these areas.
2. Other support (the cost of these supports must be included in the cost report):
    a. Counseling: During their tenure as Treatment Families, treatment families must have access to counseling and therapeutic services arranged by the TFC program for personal issues or problems caused or exacerbated by their work as treatment families. These issues may include marital stress or abuse of their own children by a client/family in their care.
    b. Peer support: The TFC program shall facilitate the creation of support networks for treatment families (these may include formal groups, informal meetings, of "buddy" systems).
    c. Damages and liability: The TFC program shall have a written agency procedure concerning compensation for damages done to a treatment family's property by client/families placed in their care.

32-005.05 Covered Services for Treatment Family Care: Payment for TFC services under the Nebraska Medical Assistance Program is limited to payment for necessary treatment services for diagnosable conditions. Medicaid shall pay for treatment provided to ameliorate or correct the diagnosed condition. Medicaid does not make payment for care that is primarily chronic or custodial in nature.

32-005.05A Coverage Criteria: The Department covers TFC services when the following criteria are met. The services must be –

1. Active Treatment, which must be –
    a. Treatment provided under a treatment plan developed by the multidisciplinary treatment team based on a thorough evaluation of the client's restorative needs and potentialities, including the developmental needs of clients age 20 or younger. The multidisciplinary treatment team includes the supervising practitioner, the TFC specialist, the parent, and other staff as necessary. The treatment plan must be retained in the client's record.
2. The treatment plan must be completed within 14 days of the client's admission to TFC. The goals and objectives documented on the treatment plan must reflect the recommendations from the Initial Diagnostic Interview, the supervising practitioner and the therapist. The treatment interventions provided must reflect these recommendations, goals, and objectives. Evaluation of the treatment plan by the therapist and the supervising practitioner should reflect the client's response to the treatment interventions based on the recommendations, goals and objectives.
    a. Reasonably expected to improve the client's medical condition or to determine a diagnosis. The treatment must, at a minimum, be designed to correct or ameliorate the client's symptoms to facilitate the movement of the client to a less restrictive environment within a reasonable period of time.
    b. Consistent with the requirements listed in 471 NAC 32-001.06.
3. Necessary Treatment Services, which must be an appropriate level of care based on documented evaluations, including a comprehensive diagnostic work up and team-ordered treatment.
4. Generally limited to one treatment child per home, or one sibling strip of up to two children. Programs may place more than one child or sibling strip of more than two only after specific review by the treatment team and prior authorization through the Division of Medicaid and Long-Term Care.
5. Therapeutic passes for client involved in TFC. Therapeutic passes are an essential part of the treatment for client/families involved in TFC. Documentation of the client's continued need for TFC must follow overnight therapeutic passes. Therapeutic passes must be indicated in the treatment plan as they become appropriate. NMAP reimburses for only 60 therapeutic pass days per client, per year. This includes all treatment services in which the client is involved during the year.

Therapeutic leave days are counted by the entity reimbursing for the care. Because the NMAP fee-for-service program reimburses for therapeutic leave days on a post-service basis and because providers have one year to bill for services, the Department cannot guarantee that an accurate account of the therapeutic leave days that have been used.

In the event that a client does require hospitalization while in TFC, NMAP will reimburse the treatment program for up to 15 days per hospitalization. This reimbursement is only available if the treatment placement is not used by another client.

Special Treatment Procedures

32-005.05B Special Treatment Procedures in Treatment Family Care: Parents or legal guardian or the Department case manager must approve use of this procedure through written informed consent and must be informed within 24 hours each time they are used. If a child/adolescent needs behavior management and containment beyond time outs or redirection, special treatment procedures may be utilized. Special treatment procedures in TFC is limited to physical restraint. Mechanical restraints and pressure point tactics are not allowed

TFC Programs must meet the following standards regarding special treatment procedures:

1. De-escalation techniques must be taught to staff and TFC parents and used appropriately before the initiation of special treatment procedures;
2. Special treatment procedures may be used only when a child/adolescent's behavior presents a danger to self or others, or to prevent serious disruption to the therapeutic environment; and
3. The child/adolescent's treatment plan must address the use of special treatment procedures and have a clear plan to decrease the behavior requiring physical restraints.

These standards must be reflected in all aspects of the treatment program. Attempts to de-escalate, the special treatment procedure and subsequent processing must be documented in the clinical record and reviewed by the supervising practitioner.

Intake/Authorization/Limitations/Documentation

32-005.06 Intake Process: TFC services are available to clients age 20 or younger when the treatment is clinically necessary, the need for this level of care has been identified in the Initial Diagnostic Interview and the client has a serious emotional disturbance as indicated by the following:

1. The youth must have a diagnosable condition under the current Diagnostics and Statistics Manual of the American Psychiatric Association, and that condition is seen as primarily responsible for the client's problems;
2. The child/youth's daily functioning is moderately impaired in such areas as family relationships, education, daily living skills, community, health, etc.

32-005.06A Intake Criteria: The following criteria must be met for a client's admission to a TFC program:

1. The need for TFC must be identified on an Initial Diagnostic Interview based on the following criteria:
    a. The client must have sufficient need for active treatment at the time of intake to justify the expenditure of the client/family's and program's time, energy, and resources;
    b. Of all reasonable options for active treatment available to the client, active treatment in this program must prevent placement in a more restrictive setting and be reasonably expected to improve the client's condition;
2. The proposed or revised treatment plan must be the most efficient and appropriate use of the program to meet the client/family's particular needs;
3. The plan must address active and ongoing involvement of the family in care provision; and
4. The program is designed to meet the needs of clients age 20 and younger.

32-005.07 Preadmission Authorization and Continued Stay Review

32-005.07A Preadmission Authorization: For TFC services to be covered by Medicaid, the need for admission to this level of care must be precertified by a licensed practitioner of the healing arts who is able to diagnose and treat major mental illness within his/her scope of practice through an Initial Diagnostic Interview.

32-005.07B Prior Authorization: TFC Services must be prior authorized by the Division of Medicaid and Long-Term Care or its designee.

32-005.07C Continued Stay Review/Utilization Review: Each program is responsible for establishing a utilization review plan and procedure. A site visit by Medicaid and/or Health and Human Services staff for purpose of utilization review may be required for further clarification and review for payment (see 471 NAC 32-001.11).

32-005.08 Documentation

32-005.08A Treatment Plan: The treatment plan must be developed within the first 14 days after the client's admission to the program. The plan must be reviewed by the multidisciplinary team at least every 30 days thereafter.

The multi-disciplinary treatment team consists of the treatment parent, the TFC specialist, the supervising practitioner, and other persons as necessary (parents, Department case manager). Treatment teams will vary based on the needs of the child and the family.

Copies of the treatment plan must be retained in the client's record.

The treatment plan retained in the client's record must include –

1. The client's name;
2. The client's Medicaid number;
3. An indication if the client is a Department ward;
4. Date of the HEALTH CHECK during which the condition was disclosed;
5. The name of the referring professional;
6. The client's gender;
7. The client's age;
8. An indication if this is an initial or updated document;
9. The date of the initial diagnostic interview;
10. The date of the last report;
11. The date of this report;
12. Current active symptoms and/or functional impairments;
13. Date of onset of current acute condition;
14. An indication of whether psychological testing and/or a substance abuse evaluation has been completed (a copy of the results must be included);
15. Associated medical, legal, social, educational, occupational, or other problems;
16. Consultations;
17. Diagnoses;
18. Progress or complications since last report, including the client/family's participation in treatment;
19. Short term goals;
20. Long term goals;
21. Therapeutic interventions prescribed by the multi-disciplinary treatment team (frequency and by whom);
22. Medication prescribed, physician monitoring medication, frequency, and dose;
23. The estimated length of stay at this level of care;
24. Placement and discharge plan;
25. Prognosis and brief explanation;
26. The provider's name; and
27. The provider's Medicaid number. The treatment plan must be signed by the supervising practitioner.

32-005.08B Documentation in the Client's Clinical Record: Each client/family's clinical record must contain the following information:

1. The treatment plan;

2. The team progress notes, recorded chronologically. The frequency is determined by the client's condition. The progress notes must contain a concise assessment of the client/family's progress and recommendations for revising the treatment plan, as indicated by the client/family's condition, and discharge planning;
3. The program's utilization review committee's abstract or summary;
4. The discharge summary; and
5. Other documentation as required in 471 NAC 32-001.05.

32-005.11 Services Not Covered: Payment is not available for TFC for clients –

1. Receiving services in an out-of-state facility, except as outlined in 471 NAC 1- 004.04, Services Provided Outside Nebraska;
2. Whose needs are social or educational only;
3. Whose primary diagnosis and functional impairment is not stable enough to allow them to participate in and benefit from the program; or
4. Whose behavior may be very disruptive and/or harmful to themselves, or is unable to be safely maintained in TFC.

32-005.12 Inspections of Care: The Department's inspection of care team may conduct inspection of care reviews for TFC Services. Please refer to 471 NAC 32- 001.08 and 32-001.09.