Trillium HEALTH RESOURCES

Transforming Lives. Building Community Well-Being.

Alternative or "in Lieu of" Service Description
Family Centered Treatment®

SERVICE NAME AND DESCRIPTION:

Service Name

Family Centered Treatment®

Description

Family Centered Treatment® (FCT) is a researched, viable alternative to residential placements, hospitalization, correctional facility placement and other community-based services. A distinctive aspect of FCT is that it has been developed as a result of frontline Qualified Professionals' effective practice. FCT is one of a few home-based treatment models with extensive experience with youth with severe emotional and behavioral challenges, dependency needs, and mental health diagnosis as well as histories of delinquent behavior, otherwise known as crossover youth. In addition, FCT is extremely cost-effective and stabilizes youth at risk and their families.

Family Centered Treatment® is a comprehensive evidence-based model of intensive in-home treatment for at risk children and adolescents and their families. FCT is intended to promote permanency goals. FCT treats the youth and his/her family through individualized therapeutic interventions.

FCT is based on eco-structural therapy and emotionally focused therapy. It focuses on addressing the functions of behavior, including system functions that look deeper than behavioral compliance getting, thus creating sustainable change and decreasing the likelihood of recidivism. Based on the understanding that families requiring such services may have experienced trauma, all phases incorporate **trauma-focused treatment**. Other characteristics of the model that set FCT apart are highlighted below.

- An evidence-based model, FCT is an enhancement on many models of treatment used as part of community-based services because it is a systemic model that works intensively and collectively with family members, thereby positively impacting the family system and decreasing the likelihood of further involvement into the system by any family member.
- FCT was designed to be flexible to meet the needs of youth, family, and their community.

  The Qualified Professional-based model in large part had its formative years of development in North Carolina and has since been successfully established in several other states

- FCT is provided by FCT Certified or in-training credentialed staff, who must complete the rigorous FCT certification program.
- A distinct and meaningful difference of FCT is in determining whether a family is truly engaged in treatment or not. Many comparable models typically define engagement as two to three sessions. FCT, however, defines engagement in treatment as the completion of five sessions.
- Transitional indicators are utilized to assist the family in recognizing how they are moving through the treatment process. These indicators are determined by the family's progress and not by designated timeframes. This allows the family system to move through treatment at a pace specific to their needs. It also enables the family to feel empowered in the FCT process.
- Fifteen fidelity measures indicate progression through the phases of FCT treatment.
- A unique feature of FCT is the Giving Back Project. As part of the FCT phases, the family engages in a project that strengthens their ties to the community, builds their self-esteem, and provides an opportunity to bond further and to practice the skills they've learned.

It is intended that this service will serve as an alternative to Intensive In-Home and prevent entry into a Residential Level II, Residential Level III, and/or Psychiatric Residential Treatment Facility settings by providing intensive support for the family and youth while keeping the youth at home.

In cases when entry into Level II, III, or PRTF is medically necessary, FCT can become an appropriate step down shorten residential stays significantly.

FCT outcomes compare favorably with the best in the field, especially on such key dimensions such as

- Success in preventing out of home placement
- Reunification
- Engagement rates
- Customer satisfaction and
- Recidivism

Specific treatment techniques are integrated from empirically supported behavioral and family therapies including eco-structural and emotionally focused treatment. In addition to focusing on the youth, FCT also engages the family in treatment.

FCT Qualified Professionals strengthen the family's problem-solving skills and operant family functioning systems, including how they communicate, handle conflict, meet the needs for closeness, and manage the tasks of daily living that are known to be related to poor outcomes

for children/youth. The Qualified Professional, in conjunction with the youth, family, and other stakeholders, develops an individualized treatment plan. Using established psychotherapeutic techniques and intensive family therapy, the Qualified Professional works with the entire family, or a subset, to implement focused interventions and behavioral techniques designed to:

- Enhance problem-solving
- Improve limit-setting
- Develop risk management techniques and safety plans
- Enhance communication
- Build skills to strengthen the family
- Advance therapeutic goals
- Improve ineffective patterns of interaction
- Identify and utilize natural supports and community resources for the youth and parent/caregiver(s) in order to promote sustainability of treatment gains

FCT's personalized interventions are designed to strengthen the family's capacity to improve the youth's functioning in the home and community with a goal of preventing the need for a youth's admission to an inpatient hospital, psychiatric residential treatment facility, or other treatment setting. FCT utilizes a highly thorough and frequent session schedule to promote change for families with intensive needs.

FCT is best delivered with a minimum of two multiple-hour sessions per week but flexibility is allowed as indicated by the youth and family's evolving needs as documented in the PCP. Frequent, intensive therapy in the context of the family/home setting facilitates sustainable change via immediate and on-site enactments or coaching to parents, offering support where and when suggestions are most needed. Phone contact and consultation are provided as part of the intervention. In addition, unlike other in-home models, the first and last month of FCT treatment—joining and discharge respectively—reflect the titration up and down of service provision.

With FCT, a Qualified Professional is available (telephonically and/or in person) 24 hours a day, seven days a week during each phase of FCT to provide additional support and crisis services as indicated.

When/where applicable, best practice standards of in home therapy are paramount. All FCT Qualified Professionals are expected to understand and abide by best practice standards for in home therapy including but not limited to safety of client/family/others & self, coordination of services including medical, on-call and crisis service, quick and timely responses to intake of services, and interventions that are timely, accessible, and not experimental in nature.

Information About Population to be Served:

Population	Age Ranges	Characteristics
Children with behavioral and/or emotional needs.	03-21	▲ there is a mental health or substance use disorder diagnosis (as defined by the DSM-5, or any subsequent editions of this reference material), other than a sole diagnosis of intellectual and developmental disability; **and** ▲ there are significant family functioning issues that have been assessed and indicated that the beneficiary would benefit from family systems work (to include access to service issues and social determinants such as food and housing insecurity. The child exhibits **difficulties in one or more of the following areas:** ▲ Problem Solving defined as difficulty achieving a variety of basic, developmental and crisis tasks such as problem or task identification, communicating the problem, exploration of alternative solutions, implementation of selected approaches and evaluation of efforts. ▲ Communication, defined as difficulty achieving mutual understanding, and using methods such as indirect, masked and direct and masked and indirect communication making the message ambiguous or clouded. ▲ Role Performance, defined the ability to fulfill their role as parent, assign roles to family members and carry out behavior of the role. ▲ Affective Responsiveness, defined as the ability to express welfare and emergency emotions, affection, warmth, support, fear anger and disappointment. ▲ Affective Involvement, defined as being secure and autonomous and able to meet the emotional/security needs of each other. ▲ Behavioral Control, as defined by the family's management style in physically dangerous situations, meeting psychological needs and socialization behaviors.

Population	Age Ranges	Characteristics
		Examples that illustrate or evidence the above may be: • a step down from a higher level of care • there has been DSS involvement in the last year • there has been a behavioral health Emergency Room visit and/or hospitalization in the last 6 months • there have been crisis intervention in the last 6 months to include (but not exclusive of) law enforcement involvement, crisis line calls, mobile crisis service, emergency crisis bed stay • physical abuse • verbal abuse • sexual abuse • physical neglect • emotional neglect • parent or caretaker that abuses substances • parent or caretaker that is the victim of domestic violence • parent or caretaker that has a mental health diagnosis • the loss of a parent or caretaker to divorce, abandonment or death • a parent of caretaker that is incarcerated • a significant other traumatic event to include (but not exclusive of) watching a sibling being abused, homelessness, surviving and recovering from a severe accident.

Treatment Program Philosophy, Goals and Objectives:

Family Centered Treatment Philosophy

The evidence-based model Family Centered Treatment® (FCT©) is founded in the belief that families seemingly stuck in a downward spiral can make positive, lasting changes. Resilience theory holds that children and families have the capacity to function well in the face of significant life challenges. Because of this belief, all aspects of treatment value the youth and family's voice in the process and employ strength-based approaches that focus on hope rather than on deficits, challenges, and barriers. The intention is to promote permanency goals while preserving the dignity of youth and families within their culture and community.

FCT's origins derive from Qualified Professionals' efforts to find practical, commonsense solutions for families faced with forced removal of their children from the home or dissolution of the family, due to both external and internal stressors and circumstances. FCT is an alternative model grounded in the use of sound and research-based treatment. Personalized techniques are integrated from empirically supported behavioral and family therapies and services are provided frequently, with FCT Qualified Professionals available 24/7 (telephonically and/or in person as clinically indicated) to support the youth and family when needed. Addressing needs while observing strengths and patterns of interaction as they are happening allows skilled Qualified Professionals to help families create change in the core components of family functioning.

Another guiding principle of FCT is that it is family centered. While the referred client is integral to the treatment process, FCT is a family system model of home-based treatment, and treatment can and does occur with other members when their behaviors or roles are critical to the progress of the referred family member (client). All phases of FCT involve the family intensively in treatment. During the assessment phase, the family defines their "family constellation," and those members are invited to participate in the structural family assessment and subsequent treatment activities as directed. Other individuals who may have key roles in the youth's wellbeing (e.g., caregivers, stakeholders, psychiatrists, etc.) are also viewed as critical to the success of FCT and are, at minimum, informed of treatment progress. They can be more integrally involved based on the family's need.

In addition, FCT places emphasis on the value of support systems—both during and after treatment. FCT develops a system of community resources and natural supports based on the youth and family's needs and preferences to enhance the individualized treatment plan by providing opportunities for further skill development. Building a network of support will also promote sustainable outcomes by providing the youth and family with resources to utilize after discharge.

Objectives and Goals:

The overarching objective of providing FCT to families is to keep children safe and thriving in their home environment. Specifically, the objective of FCT is to provide an alternative to out-of-home placements, minimize the length of stay in out-of-home placements, and reduce the risk of additional out-of-home placements by improving child/youth and family functioning. To achieve this, targeted goals for FCT include:

- Decrease in crisis episodes and inpatient stays
- Decrease in the length of stay in inpatient and crisis facilities
- Decrease in emergency room visits
- Successfully engage families in treatment (target = 85% of families)

- Maintain low recidivism rate (target = less than 10% of clients will require future FCT services minimally six months post discharge because of an increase in sustainability and stability due to focus on family functioning)
- Reduce or eliminate symptoms, including antisocial, aggressive, violent behaviors or those symptoms related to trauma or abuse/neglect
- Achieve permanency goals (target = 80% of clients will either remain in their home, reunite with their family, live independently or have a planned placement upon discharge)
- Improve and sustain developmentally appropriate functioning in specified life domains
- Enable family stability via preservation of or development of a family placement
- Enable the necessary changes in the critical areas of family functioning that are the underlying causes for the risk of family dissolution
- Reduce hurtful and harmful behaviors affecting family functioning
- Develop an emotional and functioning balance in the family so that the family system can cope effectively with any individual member's intrinsic or unresolvable challenges
- Enable changes in referred client behavior to include family system involvement so that changes are not dependent upon the Qualified Professional
- Enable discovery and effective use of the intrinsic strengths necessary for sustaining the changes made and enabling stability

Expected Outcomes:

- Decrease in trauma symptomology
- Improved family functioning
- Improved functioning in the home, school and community settings
- Increased utilization of learned coping skills and social skills
- Increased utilization of natural supports in the community
- Increased capacity to monitor and manage the individual's behavior

Identified by the Trillium Health Resources

- Decrease in crisis episodes and inpatient stays
- Decrease in the length of stay in inpatient and crisis facilities
- Decrease in Emergency Room Visits
- 85% of families will successfully engage in treatment

- Less than 10% of clients will need future FCT services minimally 6 months post discharge because of an increase in sustainability and stability due to focus on family functioning
- 80% of clients will either remain in their home, reunite with their family, live independently or have a planned placement upon discharge

Staffing Qualifications, Credentialing Process, and Levels of Supervision Administrative and Clinical) Required:

Provider Requirements

FCT providers must meet the provider qualification policies, procedures and standards established by the NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS), the requirements of 10A N.C.A.C 27G and NC G.S. 122C, and any competencies specified by the NC Division of Medical Assistance (DMA). Provider must ensure clinicians and staff that provide FCT meet the requirements to deliver FCT. Clinicians performing FCT must be enrolled in the FCT online training system and must complete the first 4 units of training before they can begin seeing families. The clinicians are expected to achieve full FCT certification within their first year of hire/enrollment into the training system.

Provider must be accredited through a national accrediting body or achieve national accreditation within 1 year of contract with the MCO or request a waiver to extend the timeframe to get this completed. This version supersedes previous versions.

In addition, the provider agency must maintain FCT licensure through the FCT Foundation, and all staff must maintain the required certification, which includes all recertification requirements and field observations. The FCT Foundation, monitors and tracks staff training and certification development. Upon successful passing grade completion of the three training components including the Wheels of Change on line audio/visual training course, field based practice of the required FCT core skills and field based performance evaluation to assess competency, FCT Foundation will issue certification as an FCT clinician to the staff member.

Provider organizations are required to maintain all other FCT Foundation licensure standards as outlined in a licensure agreement.

Provider organizations must:

- Demonstrate the ability to submit FCT fidelity and adherence documentation for all families in receipt of FCT
- Ensure that a minimum threshold, as set by FCTF Board given stage of implementation, of all active and discharged FCT families have fidelity documentation completed and submitted for *last phase of treatment completed.*

- Ensure that a minimum threshold, as set by FCTF Board given stage of implementation, of all active and discharged FCT families have adherence/dosage documentation completed and submitted for the *last phase of treatment completed.*

Staffing Requirements

- Staff must be credentialed as a Qualified Professional.
- All staff must be fully certified in FCT within twelve months of their initial hire via the official FCT certification program, Wheels of Change©. Certification is granted through the Family Centered Treatment Foundation (FCT Foundation) when staff pass and show competence in required components.
- All staff must demonstrate field-based competency in 16 core skills related to the FCT model to complete the full FCT certification process. These field based competencies are completed during direct observations of the Qualified Professional's sessions with clients by a certified FCT Trainer.
- All staff must complete a minimum of 10 hours per year of Continuing Education. This is monitored by the Clinical Director.
- All staff must be recertified in FCT every 2 years.

Supervision:

FCT understands that for effective services to implement and perform to scale, effective supervision is essential. Through rigorous training and oversight, FCT supervisors provide critical key clinical oversight to their teams and with guidance through the FCT Foundation. Both peer and individual supervision is provided as part of the FCT model. FCT Supervisors must be Associate of Fully Licensed Behavioral Health Clinicians practicing within the scope of their licensure.

FCT Supervisors provide supervision of Qualified Professionals and regional office staff. FCT Supervisors are selected based upon credential qualifications, experience, leadership skills, family systems orientation, and team leadership skills.

FCT Qualified Professionals receive multiple hours of supervision per week. This is a combination of peer supervision, individual supervision, as well as field and on call supervision support. FCT expectations dictate that Qualified Professionals should receive no less than two (2) hrs. of supervision per week Peer supervision occurs in FCT teams which meet no less than weekly for clinical case supervision and oversight. The FCT Supervisor, designated licensed staff members, or other FCT Directors/Trainers provide individual supervision or consult. The FCT Supervisor is available for on-call to each employee and may refer the employee to other FCT Directors/Trainers for consultation. Each supervision session, whether provided in the field, office, or on the phone (on-call), is recorded by the FCT Qualified Professional on a supervision form indicating direction given. The form is signed by the Qualified Professional

and person providing the supervision and is then entered into the Qualified Professional's personnel file.

Use of the national recognized best practices family system's case review process (family mapping, intervention, goals and strategies; aka John Edward's MIGS) is utilized and strategies determined are reviewed during the next team meeting. Weekly team meetings are comprised of FCT Supervisor, and staff who are FCT certified or are in the process of certification, and the FCT Trainer, where applicable. The mixture of expertise, licensure, certification, and experience at each team meeting provides continuity of care, alternative perspectives on treatment, allows for specialty expertise to be brought in at critical junctures AND focuses highly on effective Qualified Professional *use of self* (process that examines what the Qualified Professional are bringing into the treatment process themselves). Supervision notes, team meeting minutes and case reviews are tracked and monitored for adherence to the model via the FCT Clinical Practice Team.

It is required that FCT Supervisors have completed the FCT Supervision Certification, or are enrolled in the FCT Supervisors course and have a minimum of two years of service delivery of FCT or Licensed/Associated Licensed and a Certified Supervisor in FCT, or enrolled in the FCT Supervisors course.

FCT Management and Supervisory Training:

FCT's management and supervisory components are integral to the model fidelity and client outcomes that are achieved. Therefore, all direct supervisors of frontline staff are required to complete the FCT Supervisory Certification Course which includes an experiential practice-based component. The requirements for the FCT Management and Supervisory Course also include the successful completion of the online training curriculum as well as the assignments associated with each unit. There are eight units in the online curriculum and FCT Supervisor Certification is overseen by the FCT Foundation.

The FCT Supervision curriculum consists of learning key concepts on how to guide staff in delivering each phase of treatment effectively. There are supervisory documents that help guide the process to ensure that supervisors are adhering to and producing high fidelity to the model.

When applicable, FCT Trainers work weekly with FCT Qualified Professionals to ensure adherence to the fidelity of the model and assure quality services with field observation. In addition the trainers model the skill and provides practice experiences to teach and coach Qualified Professionals. They also observe Qualified Professionals in the field or via videotape to assess competency in the core required FCT skills. FCT Trainers are expected to undergo a specific process, overseen by the FCT Foundation, to verify Trainer status.

Family Centered Treatment® Training:

The FCT certification program, including Wheels of Change©, ensures that each FCT Qualified Professional is trained in the principles of youth-guided, family-driven empowerment and can

identify and assess child abuse/neglect, domestic violence, and substance abuse issues, as well as how to assist families affected by past trauma in times of crisis. Wheels of Change© (WOC) is a component of a structured certification process that utilizes the five aspects of training modalities: teaching, observing, performing the required task or skill, being observed with checklists to assess competence, and evaluation. Successful completion results in certification in FCT by the FCT Foundation.

FCT Qualified Professionals undertake and successfully complete an intensive competency-based, standardized training/certification process. This knowledge based portion of the certification process includes testing of knowledge, audio visual learning, discussion boards, and videos of core skills in practice. FCT staff are trained in direct mental health services, long- and short-term mental health interventions designed to maintain family stability, individual and family assessments, Community-Based Partnerships, Cultural Competency, individual, family, and group counseling, individualized service planning, 24-hour crisis intervention and stabilization, skills training, service coordination and monitoring, referrals to community resources, follow-up tracking, and coordination with local stakeholders.

Trauma Focused Training:

Because all families are assessed for trauma at the onset of services, all FCT Qualified Professionals must maintain a level of competency in this area. In order to demonstrate the skills necessary to assess trauma, staff must undergo comprehensive trauma-based training. These skills include recognizing the presence of trauma through interactions and assessment tools and developing personalized interventions to address trauma as identified. The subjects covered in the guided online Trauma

Based Training component of the WOC program units include:

i. Essential Elements of Trauma Treatment (Why do we utilize Trauma Treatment?)
ii. Trauma Assessments, FCT Trauma Treatment and Creating a New Narrative
iii. Practical Tools and Implementation

Field-based practice of the required core skills and supervision occurs simultaneously as trainees take the online course.

Additionally, it is best practice to cite and address trauma and trauma impact in safety plans, when/where applicable.

Unit of Service:

Services
FCT Service (length of treatment based on family progress) - 1 unit/30 days
Outcome Payment 3 months Post Discharge
Outcome Payment 6 months Post Discharge

Anticipated Units of Service per Person and Team Caseload:

FCT's anticipated length of stay is six months. Outcome payments at three and six months are eligible for FCT recipients who are discharged from episode two to six months.

Eligibility for Outcome Payments dependent upon the following criteria:

- Enrolled in Family Centered Treatment for at least 60 days
- No inpatient admissions
- No residential Level II or higher from discharge (planned or unplanned),
- No return to Family Centered Treatment, admission to Intensive In-Home or Multisystemic Treatment.

Targeted Length of Service:

National target standards are 6 months, with the national average at 6.4 months (n=>2,000 families).

Utilization Management

Entrance Criteria

There is a mental health or substance use disorder diagnosis (as defined by the DSM-5, or any subsequent editions of this reference material), other than a sole diagnosis of intellectual and developmental disability; **and**

There are significant family functioning issues that have been assessed and indicated that the beneficiary would benefit from family systems work (to include access to service issues and social determinants such as food and housing insecurity.

Child functioning multi-stress situations **as evidenced by difficulties in one or more of the following areas:**

- **Problem Solving** defined as difficulty achieving a variety of basic, developmental and crisis tasks such as problem or task identification, communicating the problem, exploration of alternative solutions, implementation of selected approaches and evaluation of efforts.
- **Communication,** defined as difficulty achieving mutual understanding, and using methods such as indirect, masked and direct and masked and indirect communication making the message ambiguous or clouded.
- **Role Performance,** defined as the ability to fulfill their role as parent, assign roles to family members and carry out behavior of the role.
- **Affective Responsiveness,** defined as the ability to express welfare and emergency emotions, affection, warmth, support, fear anger and disappointment.

- **Affective Involvement,** defined as being secure and autonomous and able to meet the emotional/security needs of each other.
- **Behavioral Control,** as defined by the family's management style in physically dangerous situations, meeting psychological needs and socialization behaviors.

Examples that illustrate or evidence the above may be:

- a step down from a higher level of care
- there has been DSS involvement in the last year
- there has been Juvenile Justice involvement in the last 6 months
- there has been a behavioral health Emergency Room visit and/or hospitalization in the last 6 months
- there have been multiple school suspensions
- there have been crisis intervention in the last 6 months to include (but not exclusive of) law enforcement involvement, crisis line calls, mobile crisis service, emergency crisis bed stay
- physical abuse
- verbal abuse
- sexual abuse
- physical neglect
- emotional neglect
- parent or caretaker that abuses substances
- parent or caretaker that is the victim of domestic violence
- parent or caretaker that has a mental health diagnosis
- the loss of a parent or caretaker to divorce, abandonment or death
- a parent of caretaker that is incarcerated.
- a significant other traumatic event to include (but not exclusive of) watching a sibling being abused, homelessness, surviving and recovering from a severe accident.

Entrance Process

The process for a beneficiary to enter this service includes:

- A Comprehensive Clinical Assessment (CCA) that demonstrates medical necessity shall be completed prior to provision of this service. If a substantially equivalent assessment is available, reflects the current level of functioning**,** and contains all the required elements as outlined in community practice standards as well as in all applicable federal

and state requirements, it may be used as part of the current comprehensive clinical assessment.

- Relevant diagnostic information shall be obtained and included in the PCP.
- For Medicaid FCT services, a signed service order shall be completed by a physician, licensed psychologist, physician assistant, or nurse Qualified Professional according to his or her scope of practice. Each service order shall be signed and dated by the authorizing professional and shall indicate the *date* on which the service was ordered. A service order shall be in place *prior to* or on the day that the service is initially provided in order to bill Medicaid for the service. The service order shall be based on a comprehensive clinical assessment of the beneficiary's needs.
- Prior authorization by the Medicaid approved vendor is required for Medicaid funded FCT services on or before the first day of service. To request the initial authorization, submit the required clinical information to the Medicaid approved vendor for review.

Continued Stay Criteria

The beneficiary is eligible to continue this service if the desired outcome or level of functioning has not been restored, improved, or sustained over the time frame outlined in the beneficiary's PCP; or the beneficiary continues to be at risk for out-of-home placement, based on current clinical assessment, history, and the tenuous nature of the functional gains.

AND

One of the following applies:

a. The beneficiary/family is making satisfactory progress toward meeting goals and there is documentation that supports that continuation of this service will be effective in addressing the goals outlined in the PCP;

b. The beneficiary/family is making some progress, but the specific interventions in the PCP need to be modified so that greater gains, which are consistent with the beneficiary's premorbid level of functioning, are possible; or

c. The beneficiary/family fails to make progress, or demonstrates regression, in meeting goals through the interventions outlined in the PCP. The beneficiary's diagnosis should be reassessed to identify any unrecognized co-occurring disorders, and interventions or treatment recommendations shall be revised based on the findings. This includes consideration of alternative or additional services.

Discharge Criteria

The beneficiary meets the criteria for discharge if any one of the following applies:

a. The beneficiary has achieved goals and is no longer in need of FCT services;

b. The beneficiary's level of functioning has improved with respect to the goals outlined in the PCP, inclusive of a transition plan to step down to a lower level of care;

c. The beneficiary is not making progress or is regressing, and all reasonable strategies and interventions have been exhausted, indicating a need for more intensive services;

d. The beneficiary or legally responsible person no longer wishes to receive FCT services; or

e. The beneficiary, based on presentation and failure to show improvement despite modifications in the PCP, requires a more appropriate best practice treatment modality based on North Carolina community practice standards (for example, National Institute of Drug Abuse, American Psychiatric Association).

Service Exclusions

Family Centered Treatment cannot be provided during the same authorization period as Intensive In-Home, MST, Intercept, and or Outpatient Therapy Services.

Description of Monitoring Activities:

FCT Foundation oversees and consistently performs program evaluation through data analysis (data is given to FCT Foundation on a quarterly basis for evaluation). Trillium intends to receive copies of the external fidelity reviews regularly. Trillium will conduct post payment review to ensure eligibility for outcome payments.