Family Preservation Provider call 5-29-2020

QUESTIONS:

1. For the cases we have currently that are IA's or in-Home CHINS that have multiple providers, how will it be determined which provider will provide services under Family Preservation?

   Referrals will begin Monday, June 1st 2020. This will be a case by case decision based on decision from the Child and Family Team deciding what's best for that particular family. The Team may decide not to change family to Family Preservation at all if what they are doing is working. Newer cases more likely may transfer to Family Preservation.

2. Regarding our training needs for the various EBP's, our assumption is that we follow the curriculum and recommendation of the program/model itself with regards to training requirements, is that correct?

   Yes, that's correct. Per the Family Preservation Service Standard, models must be followed to their fidelity by individuals who meet qualifications, who are trained, and competent in the delivery of the model.

3. There has been some talk of school based services being one of the additional treatment modalities that would NOT be considered as part of the per diem, can you verify? I ask because our team is conflicted based on information discussed on the calls.

   If your school based services are outside of your foundational model they can continue to be billed to Medicaid even after receiving a referral for Family Preservation.

4. What is the best way to get billing logistics questions answered? I know that the premise of this model is that billing will be "easier" but as someone who oversees our billing department and EHR, the small details make huge differences in setting up our workflows.

   Since it is a per diem, they will check for the first face-to-face to ensure it matches the first date of service and monthly report included to ensure services are being provided, payment should process. Due to COVID-19 concerns, a virtual contact will be allowed for initial contact for now. This may change later.

5. How do the emergency calls work when we get a call about a family not on our caseload?

   If it's not a family you have a referral for, DCS shouldn't be calling you to provide the emergency service for that family. If you do have a referral, we would expect you to follow the crisis response expectations in the service standard.

6. First, in regards to counseling services, would all families that are referred to Family Preservation services be on Medicaid or is it possible that they would not qualify for Medicaid?

   Some families may not be on Medicaid, but may be eligible. We encourage providers to assist families navigate through application processes to gain Medicaid if they qualify. With your assistance can get more eligible families to gain Medicaid assistance.

7. Regarding evidence based models vs. practice: Are we required to follow the model (adhere to Fidelity Measures) or the Service Standard? Ex. Homebuilders: Initial Assessment and Service Plan are due to DCS within 10 days of intake. The intake is completed within 24 hours of receipt of referral. The Protective Factors Survey, In Home Safety Assessment, and ongoing reports are not a part of the model (although weekly emails re: progress and safety concerns are). Some of the items listed in the Service Standard are in conflict with the evidence based models selected.

   We recognize Family Preservation requirements may not line up perfectly with any particular model. We need you to follow both Family Preservation and the model's requirements to fidelity. If anything in direct conflict please reach out to us so we can see what we can do. This may mean you do more than one assessment, which can be done.

8. I think my concern about the CAT Training is that there is an indication that providers must pay for concrete services. If there would be a way to highlight that the work of providers will be first and foremost to connect families to community resources this would be most helpful because our worry is the take away for FCM's is that the bottom line is providers must pay. Providers understand that this will come of the per diem but the wording indicates that although it's a Team decision the provider doesn't then have the flexibility to "override" the decision if we feel the family needs to exhaust community resources first. Our practice will be to staff these internally before payments are made so that we can closely monitor how concrete services are utilized.

   Concrete assistance must be paid by the provider when necessary to keep families together. For instance, we don't want to disrupt attachment and inflict trauma on children because of a family's temporary inability to heat their home in winter due to a job loss. We would expect the provider to pay the gas bill. We want providers to help connect families to community resources and learn how to budget and plan for emergencies. (slide 16)

   Providers will be asked to use their per diem reimbursement to assist families with concrete supports if needed. This should only be done if failing to do so would result in DCS needing to remove the child, and if the Child and Family Team agrees. (slide 24)

Examples of appropriate concrete supports would be paying rent to avoid an eviction or providing safe bedding to a child, not buying Play Stations or fancy sneakers! We want providers to help families learn how to use their own resources in their communities. Encourage providers to help families apply for public assistance when indicated. The use of the per diem for concrete supports should be a TEAM decision. (slide 25)

This needs to be a team decision and we want you to have a process to talk through these concrete funds being used. If failure to pay a concrete service would result in the removal of a child, this should be seriously considered by the team as a concrete need that should be paid. If other resources are available, work with the family to understand what resources are available in their community to resolve payment issues.

9. How is DCS scoring the PFS? Is there an algorithm or some way you want this scored via in comparison to pre and posttest? I know there is direction or a manual that we can download from the site but wanted to double check to see if you guys were thinking something specific outside of that instruction?

   We want the survey to be administered and scored at the frequency spelled out in service standard. This means it will need to be completed within 30 days of the referral receipt and every 3 months after. You can use supplementary surveys with families if there are some inconsistencies with initial FPS.

10. In the standard it says a home safety check must be completed each week and documented in the monthly report. That is all the standard says. In our last family preservation phone call it was stated that it has to be uploaded in KidTraks each week. Can you please clarify if a weekly home safety check needs to be uploaded in KidTraks each week or not?

    The safety check is required to be done every week and uploaded in monthly report. If you are unable to complete the safety check or if there is a safety concern call us. The service standard does not say you have to upload the safety check every week but it is a good idea to do so.

11. In the DCS FPS training, they go over the Risk Assessment Tool and the Safety Assessment Tool. Is this something providers should plan on doing or is it what DCS staff routinely do and will continue to do?

    As we discussed in previous calls we wanted to share the exact same training with providers that DCS received. You will note there was a part that could be clicked on for FCMs. This was the same process they had prior to Family Preservation. It's important for providers to follow service standard as is written. The training gives you an idea what FCM's are doing as well. If you note safety concerns make sure to call and speak to

someone, not just email or leave a message. Any concerns of abuse or neglect need to be reported to hotline.

12. Section K Providers, in order to ensure safety of the child(ren), must visit the child(ren) and identified caregivers in the home at a minimum of one time per week or more frequently if requested by DCS. 1**. The entire home must be assessed for safety during these visits.** 2. Documentation of this must occur and be reflected in the required monthly reports. 3. Any safety concerns found must be immediately reported to DCS in accordance with subsection I.I above.

    Is the weekly assessment about the home only?

No, the weekly assessment is about seeing every child and every caregiver in the home at least one time per week and ensuring that the home itself is safe. We do not want providers just seeing the children in the school or on the porch and missing safety concerns within the home.

13. We are supposed to send the results of the Protective Factors Survey to the FCM within 30 days of the first face-to-face contact and then every 3 months thereafter. Should this information be in the monthly report?

    Yes, per the service standards you will need to complete the PFS within 30 days of when a referral is received, not first contact.

14. For monthly reports...they will follow the uniform format with 1 report per family. Is it expected that all services provided are listed with dates and times even if not provided through family preservation. So if dad has IOP billed to Medicaid, mom has counseling billed to Medicaid, and 1 child has school case management billed to Medicaid would all those services be listed in the report or just summarized in the report content?

    In the scenario described: yes just one monthly report for the family but you need to include this information in the report. It should also be in the report how well these services are working and what goals are being worked on. Is participant attending as recommended? What symptoms are being targeted? How is participant responding? There should be more detain in regards to the foundational Model you are using. When contacted? What are you trying to achieve? Any concrete support that is given needs to be in monthly report as well.

15. If a brand new IA referral is sent to us under our community-based contract on 5-20-2020 for a case, will that referral have to change to the Family Preservation contract after June 1, 2020?

This is a case by case decision. A consideration that is taken into account is how long those services have been in place. A newer case will be more likely to shift to FP. This decision will be made by the Child and Family Team. We will also look at capacity when considering shifting to FP.

16. It's our understanding that the billing comes from a per diem, so we get paid 7 days a week. If we see a client on Monday and Wednesday but not the other 5 days of the week, what are the expectations for billing for the days without client contact? We want to make sure that we are documenting services correctly and we cannot bill without a service in place.

    You get paid every day after first f to f as long as the referral is valid. You must document days served in monthly

17. Currently CWS is billed at the end of the month for the previous month's services and that system works very well. Could we also use this model for billing for Family Preservation?

    Yes – this is ideal. Bill at the conclusion of the month after uploading the monthly report (by 10th of the following month)

18. If children are removed for a short period of time do we continue billing the family while the child is not in the home? How long are children typically out when they're removed "short term"

    This is a case by case decision made with the child and family team – determine if removal should result in ending referral. If removal is formal and indefinite, that will end the referral and billing; if the child is removed short term (detox, for example) – continue working with the family and when mom/child return home you can return regular service. In this instance, you can continue to bill while mom is in detox. CFT should convene if a child is removed at all to determine how the family will be served through the critical case juncture.

19. The service standard will be Family Preservation, but would you like the name of the actual services written out…like Home Based Therapy, Home Based Casework, Home Maker/Parent Aide? Just clarifying if you need the services listed.

    Yes we do want you to list both the recommended services based on clinical impressions of therapy. We would like to see something like; the family will participate in family therapy 2 times/week using EBP to work on … We want to know what model is being delivered to families so we are confident we will get to a good outcome. Tell us all that you are recommending.

20. FP are providers required to attend all court hearings?

Yes should be present at court hearings. A representative should be there to report out and answer any questions about progress. Whomever we request to be there should hopefully be able to come to court. Same as with CFTM's. Please be there, we want your voice to be part of this.

21. In practice model relaunch training it mention 10/2020 we would begin to implement Title IV-E.

    The official date of Family First implementation is 'late' 2020 and this could change. We have until October of 2021. We may get to a point with Family First that some requirements of these contracts are changed but we don't know yet. Focus on delivery of EBP model.

22. Please discuss Homebuilders preservation cases and how that will work if do not count for contract quotas. These are different kind of contracts where you have staff funded through Department that are in place to respond to these referrals. Homebuilders is a model on California clearing house and can be part of FP. It will not count on quota through other Homebuilders contract.

23. Will there ever be supervised visits under FP? Such as; one out of home parent but case is in-home CHINS but visits needed for parent out of home.

    This could be provided in FP but depending on circumstances also could be a separate referral.

24. Case notes and monthly reports: Will they be submitted the same way they are now?

    We want one report for these services. There may be a lot of detail in this report depending on how much work is being done.

25. If we have two staff both running a different evidence based model, (ex a therapist doing TFCBT and a parent worker doing STEP), I assume you want a monthly report from each worker to report on their own model/progress, etc? I keep seeing only one monthly report, is that just if an agency only uses one worker?
    1. Both workers should contribute to the same monthly report. The report is based on the referral, so they should both indicate their work with the family on that referral in a given month.

26. If an interpreter is needed how is that supposed to be billed?

    Interpreter service is paid as cost reimbursement, just like the community based referrals.

27. In the startup our staff will work under home based service standards for some cases and begin FP cases. Supervision is different. For home based services it is two hours twice a month and in FP it is reduced to one hour because it is one on one. If staff have some of each caseload which supervision standard should we use?
    If the evidence-based model that you're utilizing for family preservation does not have a specific qualification standard for supervision, then, providers must follow the qualification standards that are written in the service standards, including the possession of an Indiana license. We really want to make sure that there's competent supervision with these cases, which is why, in the absence of some other criteria set by the evidence-based model, we want individuals to be licensed.

    In addition, you should follow the service standard per each referral. So staff the HBCW cases with the worker according to that standard, and the Family Pres according to that standard.

28. Can these questions with answers be emailed to providers?

We have been sending them to the invite list once we have them completed after the call.

29. I'm sorry if I missed this question, but can the initial face to face contact be virtual? Some are anxious because of Covid 19?
    Initial contacts, ***at this time***, may be done virtually and used to help assess and inform the Child and Family Team of any presenting COVID-19 risks. After the initial contact and services are initiated, Child and Family Teams should work together to decide how services should be delivered to the family to balance presenting COVID-19 and child-safety risks.

30. Would you then need the dates and times for these Medicaid services?

    You would not need to document those on our reports as you currently do for fee for service, but we certainly would want to know how often, goals, progress etc.

31. Did I hear clearly that we are to provide an overview of a client's participation, engagement, goals etc. in therapy? Does that apply if the therapy isn't being done by us?
    Yes, ideally you should have an ROI with any other treatment professionals that the family may be seeing, such as a therapist through their insurance, etc. and include any relevant information as far as progress as it relates to your treatment plan. If you're unable to get a ROI, you can note that in your report, and provide the family's information on that service, but, note that that an ROI was unable to be obtained.

32. When will we get guidance on how to name/save documents that we upload into KidTraks?

There will be an updated document attachment guide. This naming guidance will be in the updated vendor guide. The case name on the end would be ideal.

33. Can Medicaid eligibility be discussed more? I am confused and would like to provide an example. If mother has depression and that led to a truancy case. If we use a therapist to use an EBM to treat mom's depression, and she has Medicaid, and there are no other needs in the home so we complete the weekly safety check, are we not billing DCS for family preservation and only billing Medicaid for mom's therapy?

    In this situation, the provider with the Family Preservation referral may invoice the per diem, and additionally invoice Medicaid for eligible services.

34. Does the FCM enter in the amount of children on the referral?

    The number of children will be included in the referral as well as the household members and parents.

35. Can you discuss expectations of providers if the client has a communicable disease/lice, etc? Would we provide telehealth until they are cleared from a doctor? Specifically when it comes to the weekly safety check.

    Lice wouldn't be considered a communicable disease. Lice should obviously be addressed but you can take precautions with these cases. Covid-19 concerns need to be addressed within the team to ensure all members safety.

36. Do we use the current CSV or XML format when submitting FP invoices?

    Yes, the same KidTraks e-Invoicing mechanisms will remain available for the new service standard - CSV, XML and manual input.

37. Does the initial assessment need to be a full psychosocial? Or can we do an intake assessment to identify immediate needs and use a 30 day time line to complete a full psychosocial? Would this satisfy the service standard?

    There may be some caveats from courts. We want your initial impressions documented within 7 days, probably won't be as complete as a full psychosocial. We would like some recommendations from initial impression. Over time will have more info and would like updates to assessment/treatment plans. Treatment plans should be updated every month. Family should know what the treatment plan is.

38. If we are using an evidence based model for therapy, but some casework services are needed are those considered support staff now?

To clarify: We have decided to use TFCBT as our foundation EBP and a Therapist will do that however the family has some employment and housing issues so we can bring in an

additional worker to address those needs and may not have TFCBT being used in those FTF session with the support worker. Correct?

Absolutely

39. How should providers proceed when DCS does not request them to attend the court hearings or CFTM's, but the client requests the provider to attend?

    I would go as a support and knowledge for the family even if DCS doesn't request.

40. I was told that they were going to send a CW referral.

    Family Preservation has its own referral.

41. For family preservation will ALL children living in the home be included in family size (i.e., in current referrals small children or babies are usually not included due to not receiving services)?

    Only children who are included in the IA or in-home CHINS will be referable

42. Regarding the Homebuilders quota question. I think the question is regarding Homebuilders Specialists whose workloads are split between Family Preservation and Reunification cases, not regarding billing. If a Specialist does 8 Family Preservation cases and 10 Reunification cases, that would be considered a full 18 cases for the Fidelity model and for the DCS Homebuilders contract, correct?

    You have to follow the model to fidelity. So, if Homebuilders says you can have two cases, you can only have those two cases. With FP we could have team members or therapists with the ability to provide multiple models to provide the right services for our families.

43. Will the referral be a family or specific member? Those will need to match the monthly report?

    The referral when it gets to you should have children/parents/caregivers on it. It will show everyone on it.