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HealthChoices Quality Assurance Manager

COUNTY OF LEHIGH
Government Center
17 South Seventh Street
Allentown, PA 18101-2401

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Co-Occurring PTSD / AOD Veterans Treatment Services are financed in part by a grant from the Commonwealth of Pennsylvania, Department of Military and Veterans Affairs.

Costs for prescription medication and other medical costs are the responsibility of the individual when not covered by his/her insurance or VA benefits.

To refer a veteran into treatment please contact:

Halfway Home of the Lehigh Valley Admissions Tom Neel at:

610.439.2179

Treatment Trends, Inc. is a non-profit 501(c) 3

Admission Criteria

- Veteran of military service: defined as having served on active duty in the U.S. Armed Forces, in all branches of service including activation into active duty as a member of the National Guard or as a Reservist;
- Male or female Pennsylvania resident;
- May or may not be involved with the Criminal Justice System;
- Violence in history accepted if part of addiction, military service, related to military service or PTSD, including domestic violence;
- Individual must either be eligible for Medical Assistance or have active VA benefits

Exclusionary Criteria

- History of Arson;
- History of Sexual Assault Rape; Involuntary Deviant Sexual Intercourse, and/or Indecent Assault;
- Moderate or severe Traumatic Brain Injury;
- Schizophrenia (thought disorder); Unmanaged or unstable psychiatric or medical condition, including detoxification;
- Violence not part of addiction;
- Non-ambulatory

Eligibility criteria includes trauma symptomatology of Post Traumatic Stress co-occurring with addiction/alcoholism

- Assessed for placement in treatment utilizing PA Client Placement Criteria

- Assessed for trauma symptomatology utilizing trauma screening instruments

August, 2014

Treatment Trends, Inc.

Providing Treatment for Addiction Since 1969

Co-Occurring PTSD/AOD Veterans Treatment Services

Providing access to treatment for Pennsylvania veterans

For more information or to refer a veteran contact: Halfway Home of the LV Tom Neel, Admissions

610.439.2179

United Way of the Greater Lehigh Valley

Co-Occurring PTSD/AOD Veterans Treatment Services

Veterans may receive treatment in either of the following facilities based on screening and assessment processes:

- Keenan House
- Halfway Home of the Lehigh Valley

Veterans Treatment Services include a Veterans Pride Group offering veterans opportunities to build supportive networks with other veterans in treatment, tapping into the strength and resiliency of the shared military experience. When clinically indicated, trauma-specific therapy is provided.

Other elements of Veterans Treatment Services include:

- *Seeking Safety*, an evidence-based integrated therapy for PTSD and substance abuse. It focuses on empowerment and personal relationships
- *Healing Trauma Through the Expressive Arts*—an all-veteran group utilizing art and drama therapy
- Co-occurring groups
- Medication management
- Psycho-educational groups and individual counseling
- Mindful movement yoga

A physician and psychiatrist certified by the American Society of Addiction Medicine provide onsite medical and psychiatric care. Residents leaving treatment will have a comprehensive aftercare plan including referrals into outpatient treatment. Family education will be provided to support recovery from addiction and to elevate understanding of PTSD.

Keenan House

18-22 South 6th Street
Allentown, PA 18101
610.439.8479
www.treatmenttrends.org

Keenan House is a 95-bed community-based residential Therapeutic Community (TC). It is fully licensed as an inpatient, non-hospital facility and provides habilitative and rehabilitative treatment services for men with chronic addiction, drug-related criminal offenses, co-occurring disorders, and both voluntary and involuntary placements. Individualized treatment programs are tailored to fit the needs of clients. Keenan House provides variable length, clinically driven PCPC level 3B and level 3C care.

The TC model has the highest likelihood of success for individuals referred through the criminal justice system. In the environment of a TC, residents have the opportunity to learn the concept of "right living". Pro-social skills, work ethic, and healthy coping skills are a few of the benefits of the hierarchical model that encourages personal growth and social responsibility.

Halfway Home of the Lehigh Valley

119-121 North 8th Street
Allentown, PA 18101
610.439.0218
www.treatmenttrends.org

The Halfway Home of the Lehigh Valley is a 40-bed community-based residential drug and alcohol treatment facility. It is professionally staffed and managed and offers a supportive, chemical-free, housing after recovery environment. Men and women are housed in separate facilities.

The Halfway Home of the Lehigh Valley is fully licensed as an inpatient, non-hospital, residential program and maintains contracts with various entities throughout Pennsylvania to serve those in need. It is a voluntary program designed for men and women who meet the PCPC for 2B level of residential care with a length of stay of between 90 and 180 days.

The Halfway Home of the Lehigh Valley offers individualized treatment services tailored to fit client needs as they develop the skills and resources to transition into self-regulated recovery.

This includes involvement in the 12-Step community for support; obtaining employment to sustain financial needs; and establishing a safe recovery-oriented environment for themselves and their families following completion of residential care.

Early Intervention BHRS Positive Outcomes For Children & Their Families

- Making gains in communicating and expressing needs to families and peers.
- Developing age-appropriate social and emotional skills.
- Having better overall awareness of the environment and what is expected.
- Learning early coping skills and strategies.
- Following directions and learning how to make choices more independently.
- Learning and using reasoning and basic problem-solving skills in the natural teaching environment.
- Giving guardians and parents a support system and a voice to be heard.
- Helping families be proactive and learn strategies to help their children have stronger outcomes in life.

KidsPeace

Mission
To give hope, help and healing to children, families and communities

Vision
To help people in need overcome challenges and transform their lives by providing emotional and physical healthcare and educational services in an atmosphere of teamwork, compassion and creativity

What we value...
Integrity, Human Well Being, Quality, Community, Respect and Excellence

On the Web
www.kidspeace.org
www.fostercare.com
www.TeenCentral.Net
www.ParentCentral.Net
www.facebook.com/kidspeace.org
www.twitter.com/KidsPeace

Contact Information
KidsPeace CDTRC, EI BHRS
1620 Broadway Street
Bethlehem, PA 18015
610-799-8222

021-0016

KidsPeace

Early Intervention Behavioral Health Rehabilitation Services

BHRS

Bethlehem, PA

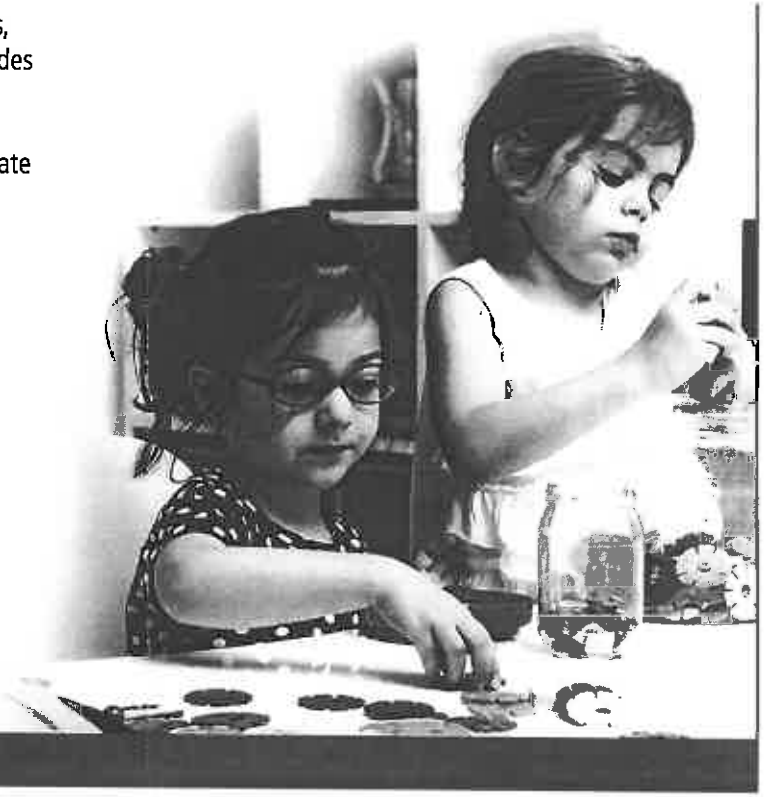
KidsPeace® Early Intervention BHRS Services

KidsPeace is happy to announce the start of the New Early Intervention BHRS Program at the KidsPeace Broadway Campus in Bethlehem, PA. This program is a medical assistance funded specialized program that provides young children with autism spectrum disorder a more intense, individualized level of therapy, while using key elements of Applied Behavior Analysis to help children meet their developmental goals.

KidsPeace Early Intervention BHRS Services is a Medical Assistance Program that Offers:

- 10 hours per week of quality Therapeutic Support Staff (TSS) Services in the home or daycare setting, working to improve behaviors, collaborate with siblings and guardians and addressing goals on the child's treatment plan.
- 5 additional hours per week of TSS services provided on-site at the KidsPeace Broadway Campus.
- 5 hours per week of Behavior Specialist Consultant (BSC) onsite and/or in the home and daycare setting. The BSC creates and monitors the child's Functional Behavior Assessments and behavioral treatment plan, assists in the development of adaptive skills, trains TSS on appropriate interventions and provides consultation to the family and/or daycare.
- A play skills room with developmentally appropriate toys and activities.
- A work skills room for children who need a more quiet and focused area
- A sensory room, a large indoor gross motor room and an outdoor playground.
- Parent and guardian support groups
- Parent and guardian trainings
- Professional case managers that are available to assist you in getting the best services your child needs.

Early Diagnosis + Parent Involvement + Strong Approach = Great Outcomes



610-799-8222

Compliance: CHA minutes 11/16/2016

CFST data-

Lehigh County Summary:

53 adults, 29 parents/guardians = 82 total surveyed.

19 of 22 questions scored > 94%

5 questions scored 100%:

4. A. Adults: Have you ever been referred for Community Treatment Team services? If so, were you comfortable with the process?
B. P/G: If your child was referred for residential treatment, were you made aware of the Child and Adolescent Service System Program (CASSP) process?

6. When I attend meetings regarding my treatment, the appropriate decision makers representing the programs that I might attend are present.

9. The service providers use everyday language that I can understand.
11. The service providers help me locate services that I need from alternative sources such as "consumer-run" or "advocacy agencies".

16. If I have used the complaint or grievance process, the process was easy to navigate?

No questions scored below the 85% threshold.

Northampton County Summary:

37 adults, 19 parents/guardians, & 0 children/adolescents = 56 total surveyed.

20 of 22 questions scored ≥ 94%

9 questions scored 100%:

1. I am pleased with the quality of services provided to me.
2. The services I receive help me deal more effectively with my illness.
4. Adults: Have you ever been referred for Community Treatment Team services? If so, were you comfortable with the process?
5. In the planning of my treatment, I am viewed as an equal partner and my views and opinions are documented in my treatment plan.
8. My caregivers respect my culture, beliefs, customs, and the ways that I do things.

11. The service providers help me locate services that I need from alternative sources such as "consumer-run" or "advocacy agencies".
16. If I have used the complaint or grievance process, the process was easy to navigate?
19 b. I feel free to speak-up regarding issues I may have with the services I receive from Magellan Behavioral Health, without fear of negative consequences?
22. Overall, I am satisfied with Magellan Behavioral Health services?

No questions scored below the 85% threshold.

Notifications:

DEPARTMENT OF HUMAN SERVICES-Notices

Bulletin Number(s)	Program(s)	Subject/Title	Issue Date
OMHSAS-10-02		Educational Portions of "Non-Educational" Residential Placement This letter is to inform you of upcoming revisions to the inspection procedures for determining compliance with 55 Pa. Code § 3800.229, relating to Education consistent with renewed efforts by the Department of Human Services (DHS) to ensure access to public education for children placed in residential facilities. As section 3800.229 recognizes, children do not lose their legal entitlement and opportunity to attend public school programs when they reside in residential facilities. Department of Human Services bulletin number OMHSAS-10-01, titled: *Educational Portions of "Non Educational" Residential Placement* sets forth the common policy of the Department and the Department of Education (PDE) regarding educational services for students who receive non-educational placements.	

9/16/2016- Compliance Forum

Email Blasts:

October 2016-Outpatient Group Therapy and structured breaks

Recent audits have revealed a trend of outpatient providers billing for time not spent providing direct services. Specifically, providers are conducting group therapy and the curriculum includes one or multiple 10-15-minute breaks during the session; however they are bundling this break time into the total time billed. For example, a provider conducts a scheduled group between 9:00- 11:00 a.m. At 10:00 a.m. the clinician excuses all participants for a 15-minute break. The group reconvenes at 10:15 a.m. and then wraps up at 11:00 a.m. The provider is contracted for group therapy by 15-minute units and bills the continuous time frame between 9:00- 11:00 a.m. or 8 total units. However, only 7 full units of direct service were provided. Thus, the provider billed for services not rendered. In this case, the provider should have billed for 7 units instead of 8.

Similarly, some participants may arrive late to a group session or leave early; however the scheduled group session time is being recorded on the member's progress note instead of the actual face-to-face time. For example, a group session is scheduled from 2:00- 4:00 p.m., however member A arrives at 2:10 p.m. and a member B leaves at 3:50 p.m. In the overpayments that have been identified during audits, a provider will indicate that all group participants attended the group from 2:00- 4:00 p.m. and bill accordingly. However, the documentation for member A should show attendance from 2:10- 4:00 p.m. and 1 less unit should be billed. Member B's documentation should show attendance from 2:00- 3:50 p.m. and again, 1 less unit should be billed.

Providers must implement a sound tracking mechanism for group participation including arrival and departure time as well as structured breaks. This is individualized by each participant's actual attendance and must correlate to the billable units. Only face-to-face time is billable for all outpatient services (excluding psychological and neuropsychological testing).

September 2016-Compliance Resources

Although providers are ultimately responsible for knowing and complying with all applicable regulations, Magellan proactively engages providers on an ongoing basis to make sure they are aware of compliance related requirements and expectations. Medicaid Program Integrity is truly a collaborative effort between our providers, county customers, Magellan, BPI and other oversight agencies. The monthly e-mail blast topics are typically generated from audit results and trends; however, are also sent in response to recent Magellan policy updates; newly released or relevant MA Bulletins and Policy Clarifications; or Regulation changes. The intention is to afford our providers with as many resources as possible to combat FWA and reduce overpayments.

To further support this shared responsibility; Magellan hosted a five-county informational presentation on September 16, 2016 regarding efforts to prevent and combat Medicaid Fraud, Waste and Abuse. The forum was a collaborative effort between Magellan and the Office of Attorney General's Medicaid Fraud Control Section (MFCS). The packed agenda included the following topics: an overview of Medicaid Compliance oversight including presentations by Magellan's Special Investigations Unit (SIU) and MFCS; Auditing Electronic Health Records (EHR); Audit Trends; and Provider Self-Monitoring protocols. The forum was well attended with 72 total participants including 34 providers, our county customers and OMHSAS. The power point presentations from the training have been included here for your ongoing reference.

We encourage providers to take full advantage of all the resources that are available; and to also offer us feedback on other ways we can support you. Please remember to regularly visit the Compliance page on our website (http://www.magellanofpa.com/for-providers-pa/fraud,-waste-abusecompliance.aspx).

As a reminder, **all providers** are held to minimum documentation standards in addition to level of care specific regulatory requirements. Retractions may be pursued, if documentation does not meet Magellan or the state's minimum expectations. Our requirements are included in the Provider Handbook and also listed below. As providers convert to Electronic Health Records (EHR), please ensure that the specifications continue to meet these requirements.

Magellan has established minimum record keeping requirements that align with Pennsylvania Medical Assistance regulations. Specifically:

- The record must be legible throughout.
- The record must identify the patient on each page.
- Entries must be signed and dated by the responsible licensed provider. Care rendered by ancillary personnel must be counter-signed by the responsible licensed provider.
- Alterations of the record must be signed and dated.

The record must contain a preliminary working diagnosis, as well as a final diagnosis, and the elements of a history and physical examination upon which the diagnosis is based.

- Treatments, as well as the treatment plan, must be entered in the record. Drugs prescribed as part of the treatment, including the quantities and dosages, must be entered in the record. If a prescription is telephoned to a pharmacist, the prescriber's records require a notation to this effect.

- The record must indicate the progress at each visit, change in diagnosis, change in treatment and response to treatment.
- The record must contain the results, including interpretations, of diagnostic tests and reports of consultations.
- The disposition of the case must be entered in the record.
- The record must contain documentation of the medical necessity of a rendered, ordered or prescribed service.

The documentation of treatment or progress notes for all services, at a minimum, must include:

- The specific services rendered;
- The date that the service was provided;
- The name(s) of the individuals(s) who rendered the services;
- The place where the services were rendered;
- The relationship of the services to the treatment plan—specifically, any goals, objectives and interventions;
- Progress at each visit, any change in diagnosis, changes in treatment and response to treatment; and
- **The actual time in clock hours that services were rendered**. For example: the recipient received one hour of psychotherapy. The medical record should reflect that psychotherapy was provided from 10:00 a.m. to 11:00 a.m.

COMMONWEALTH OF PENNSYLVANIA

DEPARTMENT OF PUBLIC WELFARE

DATE OF ISSUE	EFFECTIVE DATE	NUMBER
January 4, 2010	January 4, 2010	OMHSAS-10-02

SUBJECT

Educational Portions of "Non-Educational" Residential Placement

BY:

Richard J. Gold, Deputy Secretary for Children, Youth and Families

Joan L. Erney, J.D., Deputy Secretary for Mental Health and Substance Abuse Services

Kevin Casey, Deputy Secretary for Developmental Programs

SCOPE:

County Mental Health and Mental Retardation Administrators
County Children and Youth Administrators
Base Service Units
Community Residential Rehabilitation Directors
Children and Adolescent Service System Program Coordinators
Child Residential and Day Treatment Providers
Non-State Intermediate Care Facilities for People with Mental Retardation (ICF/MR)
Community Homes for Individuals with Mental Retardation
Supports Coordination Organization Directors
Juvenile Court Judges
Chief Juvenile Probation Officers

PURPOSE:

The purpose of this bulletin is to set forth the common policy of the Department of Public Welfare and the Department of Education regarding educational services for students who receive non-educational placements.

BACKGROUND:

School age children are sometimes placed in residential programs for reasons not primarily related to their educational needs. This may occur, for example, under the auspices of a County Mental Health and Mental Retardation program, Children and Youth agency, Juvenile Probation Offices, or through a local court. To distinguish these placements from those that are made by school districts primarily for educational reasons, we call these placements "non-educational" placements.

Because many of the individuals receiving these non-educational placements are of school age, they also need educational services. Some of the private providers are licensed both as non-education (for example, mental health) providers and as private schools (for example, approved private schools, schools within private residential rehabilitative institutions, and other licensed private schools). This creates the possibility of a single institution providing both the educational and non-educational services a child needs. In some cases, this is desirable.

However, this arrangement will not always be appropriate. When a non-educational placement is made, there should be no assumption by either the referring public agency or the private provider that the child will be included in the private provider's educational program. Rather, the decision regarding the educational portion of the child's day is to be made on an individualized basis, with input from all knowledgeable sources – parents and local public education officials. This type of individualized decision making is consistent with Department policy supporting individualized services for the child through family support, and further enhanced by County Mental Health and Mental Retardation Program services that can assist in supporting a child in a regular school setting.

The policy articulated in this bulletin is the product of a concern of the Pennsylvania Department of Education and the Pennsylvania Department of Public Welfare that the educational portions of agencies' arrangements for these children are often in more restrictive, less integrated settings than is necessary. This policy is also the product of a joint concern that a unilateral inclination to "bundle", or forcibly tie various services together, in some cases delays the onset of services to the child, as arrangements for one type of service are delayed while agencies debate the merits of another part of the bundle. This violates children's rights under education laws.

DISCUSSION:

The procedures that are followed and the systems involved in placements of school age Pennsylvanians are so diverse that we do not attempt in this bulletin to articulate the legal requirements that would apply to each situation. However, a number of state agencies have considered the issue, and our collective policy is clear. That policy, in brief, is that, when a school age child is placed by a public agency in a residential setting for non-educational reasons, the child is to be educated in a regular public school unless there is a legitimate reason making such educational placement unwise for the child or otherwise improper.

This means that, when a "non-educational" placement is made, such placement is presumed to determine where the child lives, and where the child receives non-educational services, but his residential placement is not presumed to determine where the child will be educated. Rather, unless there is a court order that specifically dictates another result, the presumption is that the child will receive his or her education in a regular public school unless appropriate public officials together with parents have made a different determination (consistent with the provisions of the Pennsylvania Department of Education Basic Education Circular (BEC) entitled *Educational Portions of "Non-Educational" Placements*, Attached). In the case of children with a disability, this determination is made through the special education system's individualized education program (IEP) process or a 504/Chapter 15 Service Agreement process. In order to ensure access to appropriate educational services, a residential facility cannot schedule its therapeutic program in a manner that precludes youth's attendance at a regular public school.

There are, of course, legitimate reasons that would overcome the presumption of education in a regular school. Many placements made through the juvenile justice system, for example, require separate schooling for community protection reasons that are an inherent part of a court order. Security and safety of the child are also important parts of some placements made by other systems. This is not to say, however, that all court-ordered or other non-educational placements are incompatible with education in regular school buildings. Therefore, this determination should be made not by presumption, but on an individualized basis. Also, the treatment needs of some children placed by Children and Youth agencies, Juvenile Probation Offices, County Mental Health and Mental Retardation agencies may be incompatible with educating the child at any site other than at the therapeutic treatment site.

Again, such incompatibility with education in a regular school should never be assumed; education in a regular school, with appropriate support services, must be presumed, with the presumption overcome only by the individualized determination of a court, or a public education agency (for example, through the IEP process or 504 Service

Agreement), in consultation with the parents.

A significant element of this policy is that the educational system must be prepared to work with families and County Mental Health and Mental Retardation, Children and Youth agencies, and Juvenile Probation Offices, as well as the private providers in order to arrive promptly at a sound educational decision. The ability of the education system to do this was enhanced in 1993 when legislation known as Act 16 clarified the respective duties of the home school district and the districts in which the private provider is located.

This legislation amended Section 1306 of the Public School Code, and is the subject of BECs (Attached). Conversely, when public non-education agencies are contemplating a placement, they must be prepared to identify and notify the responsible school district before the placement is made, or in the case of an emergency non-education placement, promptly after the placement is made.[1]

When school districts and those involved in non-educational placements work together to understand the range of needs of the child without a preconception that all services must be provided by the same provider, an appropriate decision as to services, providers, and sites emerges. The intent is to foster and support this kind of local multi-system decision-making without trying to dictate the result at the state level.

Although the main responsibility for carrying out this policy is with public agencies, there is one important implication for private agencies as well. Private agencies should not insist on "bundling" educational and non-educational services together so as to create a presumption that the provider of therapeutic or residential services will also be the provider of education services. Our policy precludes that. We will avoid the use of private providers that insist on "bundling" educational and non-educational services. The Pennsylvania Department of Education and the Department of Public Welfare will exclude a private provider from the approved provider pool of a specific program, including the Medical Assistance Program, if that private provider has a general policy or practice of insisting that each child placed under that program must also receive services of the private provider that fall outside of the program, unless a court order

[1] As described in these BECs, the statute makes the district in which the residential treatment facility is located responsible for designing and delivering an appropriate education program, unless other arrangements are made. Thus, school districts in which residential facilities are located may be called on to anticipate the arrival of students as mental health and other agencies develop residential plans for children. Districts directly involved in these situations should familiarize themselves with the BECs and, ultimately, the Public School Code as well.

explicitly prescribes how educational services are to be provided. Similarly, the Pennsylvania Department of Education and the Department of Public Welfare will not participate financially in placements that are contrary to this policy. The Department of Public Welfare will implement this policy with regard to its programs the Pennsylvania Department of Education will implement the policy with regards to their programs.

RESPONSIBILITY OF RESIDENTIAL FACILITY

The first step in the process is to ensure that the school district in which a facility is located (known as the "host" school district) knows when a child is admitted to the facility and enrolls the student in the district. The residential facility should do so by sending the attached enrollment form to the host school district as soon as a school-aged child or youth is admitted to the facility. The form will provide school districts with necessary information regarding the placement.

If the child does not already have an IEP or a Chapter 15 Service Agreement, the facility should notify the parent or educational decision-maker of the right to request an evaluation from the host school district. One indication that a child should be evaluated would be that the host or resident school district, a parent or a professional is of the opinion that the child's educational needs cannot be met in a regular public school setting.

It is also urgently important that, when students are discharged from a residential facility, the transition to the new school setting is smooth and that there is no gap in the child's education or special education program. Therefore, the residential facility should notify the host and the resident school district at least two (2) weeks prior to the anticipated discharge date for the child. The residential facility also needs to communicate and cooperate on an on-going basis with the host and resident school districts to facilitate the education of the students, the provision of a free appropriate public education for students eligible or thought-to-be eligible under IDEA or 504, and discharge planning. Such cooperation includes providing staff from a host or resident school district or another education entity access to the facility to view the child's program and to participate in the planning process.

RESPONSIBILIY OF PLACING AGENCIES

Any public agency, such as the County Mental Health and Mental Retardation program, Children and Youth agency, or Juvenile Probation Office, that plays a role in placing a child or adolescent in a residential facility has the responsibility to notify both the resident school district (where the child's parent/guardian lives) and the host school district (where the facility is located) of the child's change in placement. This notification should occur before the date of placement if at all possible, but in no event later than

one business day after the child is admitted.

This policy is an important part of our adherence to applicable law and – no less important – to serving children and families effectively in as natural a setting as is consistent with the individual child's needs.

OBSOLETE BULLETIN: Mental Health Bulletin OMH-95-07 issued April 3, 1995; Children, Youth and Families Bulletin 00-95-02 issued January 3, 1995.

Questions specific to this bulletin may be directed to:

Bureau of Children's Behavioral Health Services, Office of Mental Health and Substance Abuse Services, (717) 705-8289; Office of Developmental Programs, (717) 783-5771; Office of Children, Youth and Families, (717) 787-3984.