Kentucky Provider Readiness Assessment Survey

Chapin Hall & Casey Family Programs

COLLABORATING AT THE INTERSECTION OF RESEARCH AND POLICY

PUBLIC CONSULTING GROUP

www.publicconsultinggroup.com

Purpose of the survey:

The purpose of this Readiness Assessment is to assess how ready or prepared organizations are to partner with the Kentucky Department of Community-Based Services (DCBS) on the implementation of the Family First Prevention Services Act and the Decoupling Initiative. The survey includes a number of domains relative to the implementation of evidenced-based practices, trauma-informed care, federal Qualified Residential Treatment Program criteria, continuous quality improvement, and decoupling of provider rates. Not all domains will be relevant to all respondents. Agency leaders are asked to respond only to questions that pertain to the range of services they provide.

Survey findings will inform DCBS' planning and decision-making related to the implementation of the Family First Prevention Services Act and Kentucky's larger child welfare transformation. DCBS is grateful for your responses and your partnership more broadly in our collective efforts to improve outcomes for Kentucky's most vulnerable children and families.

Participation

Your provider agency is encouraged to participate in this web-based online survey designed to assess Kentucky provider readiness related to the Family First Prevention Services Act and the decoupling of provider rates. This assessment process reflects a partnership between DCBS, Chapin Hall at the University of Chicago, and the Public Consulting Group. Only one Provider Readiness Assessment Survey should be submitted per provider agency.

Your participation in this survey is voluntary. You may refuse and exit the survey at any time without penalty.

Benefits

You will receive no direct benefits from participating in this survey. However, your responses will help us learn more about the readiness and capacity of private providers to partner with DCBS in the implementation of the Family First Prevention Services Act and the decoupling initiative.

Contact

If you have any questions about the survey, please contact representative by phone or email.

Access to the online Survey closes on designated date and time.

All fields are required. You must provide an answer to each question before moving to the next page in the survey and before submitting your survey.

1. Agency name:

2. Agency Main Location: *Address*

3. Agency Main Location: *Phone Number*

4. Contact Person for this Survey: *Name and Title*

5. Contact Person for this Survey: *Address*

6. Contact Person for this Survey: *Direct Phone Number*

7. Contact Person for this Survey: *Email Address*

8. Does your agency have a current contract with DCBS? ☐ Yes ☐ No

9. Do you operate a program for any of the following special populations

   a. Pregnant and Parenting Teens? ☐ Yes ☐ No *If Yes, In what county(ies) do you operate:*
   b. Sex Trafficking Victims? ☐ Yes ☐ No *If Yes, In what county(ies) do you operate:*
   c. Independent Youth Age 18 and older? ☐ Yes ☐ No *If Yes, In what county(ies) do you operate:*
   d. Family-Based Substance Abuse Treatment Facility? ☐ Yes ☐ No *If Yes, In what county(ies) do you operate:*

10. Does your agency operate a residential facility? ☐ Yes ☐ No
    If Yes, Please indicate the county(ies) in which the residential facility operates: drop-down list
    If Yes, respondent must complete Domain D – Qualified Residential Treatment Programs (QRTPs)

11. Does your agency have a Private Child Care (PCC) agreement and/or a Private Child Placing (PCP) agreement with the Kentucky Department of Community-Based Services (DCBS)?
    ☐ Yes ☐ No
    If Yes, respondent must complete Domain E – Decoupling Initiative

Provider Readiness Assessment Survey

The Provider Readiness Assessment Survey is designed to gauge the extent to which key indicators of capacity relevant to each domain exist or have the potential to be built over time. While survey findings will be used to inform DCBS' planning and decision-making related to Kentucky's child welfare transformation efforts, this survey also provides an opportunity for provider agencies to assess their own capacity related to each of the five domains and identify areas for enhancement and capacity building.

The survey is comprised of five (5) readiness domains as described in the chart below. Agencies should complete readiness domains as described below:

- **ALL** agencies must complete:
  - Domain A – Trauma Informed approach
  - Domain B – Evidence-based Programs (EBPs)
  - Domain C – Continuous Quality Improvement and Data Use
- Agencies that operate a Residential Facility must also complete:
  - Domain D - Qualified Residential Treatment Programs (QRTPs)
- Agencies that have a Private Child Care (PCC) agreement and/or a Private Child Placing (PCP) agreement with the Cabinet must also complete:
  - Domain E - Decoupling Initiative*

*Respondents will be prompted to “Submit” the Readiness Assessment portion of the survey before moving on to Domain E – Decoupling Initiative.

Administering the Survey

Agency leaders are encouraged to engage a diverse representation of staff at all levels of the organization in completing the readiness assessment. This may include executive leaders, clinicians, program managers, and direct service staff. This group activity can occur as part of a regularly scheduled meeting or representatives can be pulled together specifically for purposes of completing this survey. Completing the survey together and working to come to consensus around how the items are rated can promote meaningful discussion among key stakeholders about agency capacity across these key domains. Agency leaders may want to share a copy of the readiness assessment tool with participants in advance so they can familiarize themselves with the questions and come prepared to engage in the discussion and rating decision.

*Only one Provider Readiness Assessment Survey should be submitted per agency. *

Domain A: TRAUMA INFORMED APPROACH

The items in this domain refer to the implementation of services or programs under an organizational structure and treatment framework that involves understanding, recognizing and responding to the effects of all types of trauma and in accordance with recognized principles of a trauma-informed approach and trauma specific interventions to address trauma's consequences and facilitate healing. *(Children's Bureau Information Transmittal: ACYF-CB-IM-18-02)*

A. TRAUMA INFORMED APPROACH		Completely true	Somewhat true	Not at all true
1.	The agency has adopted a formal policy or mission statement that refers to the importance of trauma and the need to account for youth and family experiences of trauma in all aspects of program operation.			
2.	Trauma competencies are identified in personnel policies and employee performance evaluations.			
3.	All direct service staff receive trauma training as part of the initial training process.			
4.	All non-direct service staff (i.e., maintenance, clerical, etc.) receive trauma training as part of the initial training process.			
5.	All direct service staff receive ongoing training on trauma related topics.			
6.	All non-direct service staff (i.e., maintenance, clerical, etc.) receive ongoing training on trauma related topics.			
7.	Training includes the effects of secondary traumatic stress and the importance of self-care for staff.			
8.	Staff members have received basic education in the maintenance of personal and professional boundaries (e.g., confidentiality, dual relationships, sexual harassment).			
9.	Policies regarding confidentiality and access to information are clear, provide adequate protection for the privacy of youth, and are communicated to families.			
10.	There is a clearly written, easily accessible statement of youth and family rights and grievance procedures.			
11.	There are policies, procedures and resources available to support staff to communicate effectively and convey information in a manner that is easily understood by diverse audiences (i.e., limited English proficiency, those who have low literacy skills, individuals with disabilities, and those who are deaf or hard of hearing).			
12.	There is a consistent screening process in place to identify individuals who have been exposed to trauma.			
13.	A trauma assessment is administered by a clinical service provider for the purpose of gathering specific information about events identified in the initial screening.			
14.	Trauma specific assessment tools are used to inform service planning.			
15.	Trauma informed safety plans are written for all children, youth and families (i.e., triggers, behaviors when over-stressed, strategies to lower stress, support people for child).			

16.	There are policies and procedures in place to support staff to engage with children and families in a way that is sensitive to their unique culture and identity.			
17.	Program activities and settings ensure the physical and emotional safety of youth, family and staff.			
18.	The agency has access to a clinician with expertise in trauma and trauma related interventions (on-staff or available for regular consultation)			
19.	The organization has regularly scheduled procedures/opportunities for youth and families to provide input into programming.			
20.	**Summary Rating Justification:** *Please write a brief summary/rationale for the responses selected in this domain. When the responses selected are "Completely True," the summary should include sufficient examples or additional detail to support that determination. When the responses "Somewhat True" or "Not At All True" are selected, the summary should speak specifically to what actions or resources would be needed to make the response "Completely True".*			

Many of the questions in this domain were adapted from the following sources:

- *Thrive Guide to Trauma-Informed Organizational Development*
- *Trauma Informed Organizational Survey (Trauma informed Care Project)*
- *Trauma Informed System Change Instrument (Children's Trauma Assessment Center)*
- *Creating Cultures of Trauma-Informed Care: Program Fidelity Scale*

Domain B: Evidence-Based Programs

The items in this domain refer to the implementation of evidence-based programs (EBPs). EBPs represent a range of multi-component interventions seeking to affect various outcomes, which have been experimentally evaluated and deemed effective in meeting specified goals. *(Child Trends Research-to- Results Brief, Publication #2007-14, What is Evidence-based Practice, Allison J.R. Metz, Ph.D., Rachele Espiritu, Ph.D. and Kristin A. Moore, Ph.D.) and (Children's Bureau Information Transmittal: ACYF-CB-IM-18-09, Attachment C - Clearinghouse Initial Criteria).*

*This domain includes branching logic which creates a custom path through the survey that varies based on a respondent's answers. Therefore, questions may appear or disappear depending on the answers provided.

B. EVIDENCE-BASED PROGRAMS		Completely true	Somewhat true	Not at all true
1.	Staff in this organization know about and understand Evidence-Based Programs (EBPs).			
2.	Staff in this organization hold positive attitudes towards the use of EBPs.			
3.	My agency is currently providing one or more EBPs (i.e., a program which has an evidence-rating by the California Evidence-Based Clearinghouse or similar entity).	☐ Yes ☐ No		

If Item 3 is answered Yes, answer Item 3.a. – 3.e. for the EBPS currently provided by the agency:

		3.a. Check off the EBPs below that are currently provided by the agency:	3.b. For each EBP identified, please indicate the county(ies) in which the EBP is currently provided.	3.c. For each EBP identified, please indicate if the agency uses child and family level data to monitor performance on intended outcomes. (Yes/No)	3.d. For each EBP identified, please indicate if the agency monitors fidelity to the EBP using reliable and valid tools and measures. (Yes/No)	3.e. What is the maximum number of clients (individuals or families based on the EBP model) you are able to serve annually at your current staffing level?
Mental Health:	Parent-Child Interaction Therapy					
	Trauma Focused-Cognitive Behavioral Therapy					
	Multisystemic Therapy					
	Functional Family Therapy					
Substance Abuse:	Motivational Interviewing					
	Multisystemic Therapy					
	Families Facing the Future					
	Methadone Maintenance Therapy					
In-Home Parent Skill Based:	Nurse-Family Partnership					
	Healthy Families America					
	Parents as Teachers					

If Item 3 is answered Yes, in the chart below, please identify any additional EBPs, not listed above, that are currently provided by the agency.

If there are no additional EBPs provided, please indicate "none" in the space provided.

		Please Identify any additional EBP, not listed above, that is currently provided by the agency.	For the additional EBP identified, please indicate the county(ies) in which the EBP is provided.	For the additional EBP identified, please indicate if the agency uses child and family level data to monitor performance on intended outcomes. (Yes/No)	For the additional EBP identified, please indicate if the agency monitors fidelity to this EBP using reliable and valid tools and measures. (Yes/No)	What is the maximum number of clients (individuals or families based on the EBP model) you are able to serve annually at your current staffing level?
3.a.i.	First additional EBP					
3.b.i.	Second additional EBP					
3.c.i.	Third additional EBP					

4.	My agency is currently implementing a treatment model or program that does not have an evidence-rating by the California Evidence-Based Clearinghouse or similar entity.	☐ Yes ☐ No

If Item 4 is answered Yes, answer Items 4.a – 4.a.iii, for the model(s) or program(s) currently provided by the agency that does not have an evidence-rating:

		4.a. Name the treatment model or program currently provided by the agency that does not have an evidence-rating by the California Evidence-Based Clearinghouse or similar entity.	4.a.i. Select the county(ies) in which the Model or Program identified is provided:	4.a.ii. The agency uses child and family level data to monitor performance on intended outcomes for the Model or program identified? (Yes/No)	4.a.iii. The agency monitors fidelity to the model using reliable and valid tools and measures for the Model or Program identified in Question 4.a.? (Yes/No)	4.a.iv. What is the maximum number of clients (individuals or families based on the EBP model) you are able to serve annually at your current staffing level?
4.a.	First treatment model or program					
4.b.	Second treatment model or program					
4.c.	Third treatment model or program					

5.	My agency is currently implementing a Kinship Navigator Program *(i.e., a program that supports caregivers who have taken on the responsibility of caring for their relatives' children; these programs assist kinship caregivers in learning about, finding, and using programs and services to meet the needs of the children they are raising and their own needs.)* *If Item 5 is answered Yes, please answer Items 5.a – 5.a.iv.*	☐ Yes ☐ No

5.a. Name the Kinship Navigator Program currently provided by the agency.	5.a.i. Select the county(ies) in which the Program identified is provided:	5.a.ii. The agency uses client level data to monitor performance on intended outcomes for the program identified?	5.a.iii. The agency monitors fidelity to the program model using reliable and valid tools and measures for the Program identified in Question 5.a.?	5.a.iv. What is the maximum number of clients (individuals or families based on the model) you are able to serve annually at your current staffing level?

		Completely true	**Somewhat true**	**Not at all true**
6.	Financial resources are adequate and available to introduce new EBPs. (Costs may be related to policy, staffing, system, and software changes.)			

7.	Financial resources are adequate and available to sustain EBPs. (Consider the cost of ongoing training, sustainability/re-invention, and monitoring of fidelity.)			
8.	Implementation teams are formed with representative from multiple areas of the organization to guide the implementation of EBPs or other treatment models/programs.			
9.	Specific competencies and skills appropriate for assigned tasks or roles are identified and used to guide hiring and staffing decisions in the agency.			
10.	There is adequate time for training, reflection, practice, and assimilation of new skills.			
11.	Staff demonstrate evidence-based skills (e.g., client engagement, critical thinking, use of positive reinforcements, analytical thinking).			
12.	There is a staff training plan for EBPs or other treatment models/programs that involves theory and discussion.			
13.	There is a staff training plan for EBPs or other treatment models/programs that involves demonstration of new skills.			
14.	There is a staff training plan for EBPs or other treatment models/programs that involves Opportunities for practice and feedback.			
15.	A consultant/purveyor/coach is available for support to staff providing EBPs or other treatment model/program beyond the initial training phase.			
16.	There are adequate physical spaces to practice EBPs or other treatment models/programs. (e.g., space for group session).			
17.	**Summary Rating Justification:** *Please write a brief summary/rationale for the responses selected in this domain. When the responses selected are "Completely True," the summary should include sufficient examples or additional detail to support that determination. When the responses "Somewhat True" or "Not At All True" are selected, the summary should speak specifically to what actions or resources would be needed to make the response "Completely True".*			

Questions in this domain are adapted from the following source:

• Checklist to Assess Organizational Readiness (CARI) for Evidence-Informed Practice

Domain C: CONTINUOUS QUALITY IMPROVEMENT (CQI) AND DATA USE

The items in this domain refer to the use of data and evidence to identify, monitor and address areas needing improvement related to service delivery and client outcomes.

*This domain includes branching logic which creates a custom path through the survey that varies based on a respondent's answers. Therefore, questions may appear or disappear depending on the answers provided.

C. CONTINUOUS QUALITY IMPROVEMENT & DATA USE		Completely true	Somewhat true	Not at all true
1.	There is a current Continuous Quality Improvement (CQI) plan in place that outlines the organization's approach to identifying and analyzing program strengths and challenges and implementing and revising solutions. *(If Not at all true, skip to Item 7)*			
1.a.	The CQI plan includes client outcomes for each program and service.			
1.b.	The CQI plan includes practice expectations and requirements (e.g. timeliness of assessments, visits with children and parents)			
1.c.	The CQI plan addresses compliance with regulatory requirements.			
1.d.	The CQI plan describes procedures for data collection (including case record review procedures), data aggregation, review, analysis and reporting.			
1.e.	The CQI plan describes the performance improvement process utilized by the organization to solve problems.			
2.	There are designated staff charged with implementing and overseeing CQI processes.			
3.	Designated staff participate in training to build CQI skills and competency.			
4.	Staff at all levels are encouraged to participate in CQI activities and discussions.			
5.	Training is available for all staff to understand the agency's CQI process, why it is relevant to their work, and ways in which they can be active participants in program monitoring and improvement.			
6.	The agency maintains an automated information management system. *(If Not at all true, skip to Item 12)*			
6.a	The automated information management system collects demographic data on the children, youth and families served.			
6.b	The automated information management system collects data on the services provided to children, youth and families.			
6.c	The automated information management system collects data on the progress made by children, youth and families.			
6.d	The automated information management system is able to generate reports.			
6.e	The agency uses reports generated from the automated information management system to monitor progress toward specific child and family outcomes.			
6.f	The agency uses reports generated from the automated information management system to identify opportunities for improvement.			
7.	There is a case record review process in place that monitors child welfare practice. *(If Not at all true, skip to Item 13)*			
7.a	Case record reviews are conducted on a prescribed frequency.			
7.b	Data collected from case record reviews are used to monitor progress toward specific child and family outcomes.			

7.c	Data collected from case record reviews are used to identify opportunities for practice improvement.			
8.	There are other types of internal reviews and tracking activities (e.g., supervisory reviews, risk management reviews) that take place.			
9.	External monitoring reports (e.g., data reports from funders or other entities) are used to monitor progress toward specific child and family outcomes and to identify opportunities for improvement.			
10.	Data are routinely analyzed for patterns and trends in child and family outcomes relevant to the agency's strategic plan.			
11.	Data reports are produced that are used by Executive leadership to understand overall system/agency performance and effectiveness of programs and services.			
12.	There is a TEAM level CQI team/committee (or equivalent structure) that meets regularly to discuss data and performance quality.			
13.	There is a PROGRAM level CQI team/committee (or equivalent structure) that meets regularly to discuss data and performance quality.			
14.	There is an EXECUTIVE level CQI team/committee (or equivalent structure) that meets regularly to discuss data and performance quality.			
15.	There is a process in place to identify and prioritize areas of performance found to need improvement.			
16.	Action plans/interventions/solutions are developed and implemented to address areas needing improvement.			
17.	Action plans and interventions are monitored, and adjustments made as needed based on what is learned through the monitoring process.			
18.	Results of action plans and interventions are shared and evaluated to inform ongoing planning and performance measurement.			
19.	**Summary Rating Justification:** *Please write a brief summary/rationale for the responses selected in this domain. When the responses selected are "Completely True," the summary should include sufficient examples or additional detail to support that determination. When the responses "Somewhat True" or "Not At All True" are selected, the summary should speak specifically to what actions or resources would be needed to make the response "Completely True".*			

Domain D: QUALIFIED RESIDENTIAL TREATMENT PROGRAM (QRTP) REQUIREMENTS

The items in this domain assess the extent to which a residential facility meets the criteria for being considered a Qualified Residential Treatment Program as outlined in the Family First Prevention Services Act. *(Children's Bureau Information Transmittal: ACYF-CB-IM-18-02, Attachment C)*

D. QUALIFIED RESIDENTIAL TREATMENT PROGRAM (QRTP) REQUIREMENTS		Completely true	Somewhat true	Not at all true
1.	My agency currently has a trauma-informed treatment model that is designed to address the needs, including clinical needs as appropriate, of children with serious emotional or behavioral disorders or disturbances.			
2.	My agency currently is able to implement the treatment identified for the child by the required 30-day assessment of the appropriateness of placement.			
3.	My agency currently, to the extent appropriate and in accordance with the child's best interests, facilitates participation of family members in the child's treatment program.			
4.	My agency currently facilitates outreach to the family members of the child, including siblings.			
5.	My agency currently documents how the outreach to the family members is made (including contact information).			
6.	My agency currently maintains contact information for any known biological family and fictive kin of the child.			
7.	My agency currently documents how family members are integrated into the treatment process for the child, including post-discharge.			
8.	My agency currently documents how sibling connections are maintained.			
9.	My agency currently provides discharge planning and family-based aftercare support for at least 6 months post-discharge.			
10.	My agency currently is licensed and accredited by at least one of the following independent, not-for-profit organizations: The Commission on Accreditation of Rehabilitation Facilities (CARF), the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Council on Accreditation (COA), or any other independent, not-for-profit accrediting organization approved by HHS.			
11.	My agency currently has registered or licensed nursing staff and other licensed clinical staff who provide care within the scope of their practice as defined by state/tribal law. They are on-site according to the treatment model and are available 24 hours a day and 7 days a week. (A rule of construction in section 472(k)(6) of the Family First Act indicates that this requirement shall not be construed as requiring a QRTP to acquire nursing and behavioral health staff solely through means of a direct employer to employee relationship.)			
12.	**Summary Rating Justification:** *Please write a brief summary/rationale for the responses selected in this domain. When the responses selected are "Completely True," the summary should include sufficient examples or additional detail to support that determination. When the responses "Somewhat True" or "Not At All True" are selected, the summary should speak specifically to what actions or resources would be needed to make the response "Completely True".*			

Domain E: Decoupling Initiative

This section of the survey is for Agencies that have a Private Child Care (PCC) agreement with the DCBS.

This section of the survey was developed by Public Consulting Group (PCG) and all data collected will be utilized by PCG in assessing strengths and challenges surrounding Decoupling implementation.

*All fields are required. You must provide an answer to each question before moving to the next page in the survey and before submitting your survey. *

PART 1: CREDENTIALING		
1.	Is your organization currently enrolled as a Kentucky Yes Medicaid Provider?	☐ Yes ☐ No
	If Question 1 is answered Yes, answer questions 1.a – 1.c 1.a. Enter the Medicaid Provider number.	
	1.b. How does your agency manage your Medicaid billing?	○ Use of in-house billing ○ Use a clearing house ○ Contract out billing ○ Other, please specify
	1.c. What is the amount of Medicaid billing your organization processes yearly? (enter amount in dollars)	
2.	How many staff are currently employed by your organization? Please include all full-time, part-time and contracted staff.	
2.a.	How many of your organization's staff are administrative staff (e.g., administrators, program administrators, managerial office, and clerical employees)?	
2.b.	How many of your organization's staff provide direct service to children under a Private Child Caring (PCC)/Private Child Placing (PCP) agreement?	
2.b.i.	How many of your organization's direct staff are independently licensed?	
2.b.ii.	How many of your organization's direct staff are licensed under supervision?	
2.b.iii.	How many of your organization's direct service staff are currently actively enrolled Medicaid providers?	

3.

	3. Does your organization currently employ or contract with any of the following staff levels?	3.a. Provide the number of staff and the estimated average number of hours worked per week for each of the staff levels indicated:		3.b. For each staff level indicated, do they have a current valid Department of Environmental Affairs (DEA) certificate?
Medical Doctor		Staff:	Hours:	
Doctor of Osteopathy		Staff:	Hours:	
Doctor of Podiatric Medicine		Staff:	Hours:	
Doctor of Dental Science		Staff:	Hours:	
Doctor of Dental Medicine		Staff:	Hours:	

	Registered or Licensed Nurse | | Staff: | Hours: |	
4.	What is your organization's current liability insurance MINIMUM, as indicated on an insurance certificate (e.g., enter 1,000,000 for the minimum if indicated on the insurance certificate as $1,000,000/$3,000,000)?	
4.a.	What is your organization's current liability insurance LIMIT, as indicated on an insurance certificate (e.g., enter 3,000,000 for the limit if indicated on the insurance certificate as $1,000,000/$3,000,000)?	
5.	Is your organization currently accredited?	☐ Yes ☐ No
5.a	*If Question 5 is answered Yes,* Please indicate the accrediting body (select all that apply):	○ Joint Commission On Accreditation of Healthcare ○ Organizations (JCAHO) ○ Commission on Accreditation of Rehabilitation Facilities (CARF) ○ Counsel on Accreditation (COA) ○ Other, please specify
6.	Is your organization currently under any sanctions or corrective action plan with the Office of the Inspector General (OIG)?	☐ Yes ☐ No

PART 2: FINANCIAL SUSTAINABILITY		
7.	Per your agreement with DCBS as a licensed PCP or PCC, your organization currently receives revenue from DCBS for DCBS children placed with your organization. Does your organization's annual revenue include additional funding sources outside of DCBS funds (e.g. fund raising, contracts, private pay, Medicaid, or other federal funds)?	☐ Yes ☐ No
7.a.	What percentage of your organization's annual revenue is comprised of funds from DCBS? For example: your organization's DCBS funded revenue in FY2018 was $200,000 and your organization's total annual revenue in FY2018 was $300,000; therefore, your DCBS funded annual revenue is approximately 67%.	
7.b.	Please provide any comments about the value entered for the DCBS funded annual revenue:	

PART 3: SERVICES		
8.	Does your organization provide the following service(s) to youth? Check all that apply.	
Screening	Screening shall be the determination of the likelihood that a person has a mental health, substance use, or co-occurring mental health and substance use disorder. The purpose is not to establish the presence or specific type of such a disorder but to establish the need for an in-depth assessment.	
Assessment	Assessment shall include gathering information and engaging in a process with the client that enables the provider to establish the presence or absence of a mental health and/or substance use disorder, determine the client's readiness for change, identify client strengths or problem areas that may effect the process of treatment and recovery, and engage the client in the development of an appropriate treatment relationship. The purpose of an assessment is to establish (or rule out) the existence of a clinical disorder or service need and to work with the client to develop a treatment and service plan, if a clinical disorder or service need is assessed. This does not include psychological or psychiatric evaluations or assessments.	
Psychological Testing	Psychological testing for individuals with mental health, substance use, or co-occurring mental health and substance use disorders may include psychodiagnostic assessment of personality, psychopathology, emotionality, and/or intellectual abilities. The service also includes interpretation and written report of testing results.	
Crisis Intervention	Crisis intervention shall be a therapeutic intervention provided for the purpose of immediately reducing or eliminating risk of physical or emotional harm to the client, or others. The service shall be provided as an immediate relief to the presenting problem or threat. It must be followed by non-crisis service referral as appropriate. It must be provided in a face-to-face, one-on-one encounter between the provider and the client. Crisis intervention may include further service prevention planning such as lethal means reduction for suicide risk and substance use relapse prevention.	
Mobile Crisis	Mobile crisis is a multi-disciplinary team based intervention that ensures access to acute mental health and substance use services and supports. The service aims to effect symptom or harm reduction, or to safely transition an individual in acute crisis to the appropriate least restrictive level of care. Mobile crisis services are provided face-to-face and available in locations outside of the provider's facility (e.g., home or community) 24 hours per day, 7 days per week and 365 days per year. This service is provided in duration of less than 24 hours and is not an overnight service. Mobile crisis involves all supports and services necessary to provide integrated crisis prevention, assessment and disposition, intervention, continuity of care recommendations, and follow-up services.	
Residential Crisis Stabilization	"Residential Crisis Stabilization services are provided in Crisis Stabilization Units. Crisis Stabilization Units are community-based, residential programs that offer an array of services including screening, assessment, treatment planning, individual, group, and family therapy, and peer support in order to stabilize a crisis and divert the individual from a higher level of care. It is not part of a hospital. They are used when individuals in a behavioral health emergency cannot be safely accommodated within the community, are not in need of hospitalization but need overnight care. The purpose is to stabilize the individual, provide treatment for acute withdrawal, when appropriate, and re-integrate him back into the community, or other appropriate treatment setting, in a timely fashion. These units provide a non-hospital residential setting and services 24-hours per day, seven (7) days per week, 365 days a year. The estimated length of stay for children is three (3) to five (5) days. The estimated length of stay for adults is seven (7) to 10 days. The component services of crisis stabilization units are screening, assessment, service planning, psychiatric services, individual therapy, family therapy, group therapy, and peer support. "	
Day Treatment	"Day Treatment is a non-residential, intensive treatment program designed for children/youth under the age of 21 who have a mental health, substance use, or co-occurring mental health and substance use disorder, and who are at high risk of out-of-home placement due to behavioral health issues. Intensive coordination/linkage with schools and or other child serving agencies is included. Intensive coordination is needed in order to successfully transition youth recipients to a lower level of care. See below for basic components of the required linkage agreement between the provider and the local education authority that specifies the responsibility of the authority and the provider for: Appropriately licensed	

	teachers and provisions for their professional development; Educational supports including classroom aides and textbooks; Educational facilities; Physical education and recreational therapies; Transportation; and Transition planning. Day treatment services do not include services covered in a child's Individualized Education Plan (IEP). Day treatment may focus on resolving multiple mental health and/or substance use issues and is typically provided as an alternative to a school or other traditional day time setting for children. "	
Peer Support	Peer Support is emotional support that is provided by persons having a mental health, substance use, or co-occurring mental health and substance use disorder to others sharing a similar mental health, substance use, or co-occurring mental health and substance use disorder in order to bring about a desired social or personal change. It is an evidence-based practice. Peer Support Services are structured and scheduled non-clinical but therapeutic activities with individual clients or groups provided by a self-identified consumer of mental health, substance use, or co-occurring mental health and substance use disorder services who has been trained and certified in accordance with state regulations. Services should promote socialization, recovery, self-advocacy, preservation and enhancement of community living skills for the client.	
Parent/Family Peer Support	Parent/Family Peer Support is emotional support that is provided by parents or family members of children having a mental health, substance use, or co-occurring mental health and substance use disorder to parents or family members with a child sharing a similar mental health, substance use or co-occurring mental health and substance use disorder in order to bring about a desired social or personal change. It is an evidence-based practice. Peer Support Services are structured and scheduled non-clinical but therapeutic activities with individuals or groups provided by a self-identified parent/family member of a child/youth consumer of mental health, substance use, or co-occurring mental health and substance use disorder services who has been trained and certified in accordance with state regulations. Services should promote socialization, recovery, self-advocacy, preservation and enhancement of community living skills for the client.	
Intensive Outpatient Program	Intensive Outpatient Program (IOP) is an alternative to or transition from inpatient hospitalization or partial hospitalization for mental health and/or substance use disorders. An IOP must offer a multi-modal, multi-disciplinary structured outpatient treatment program that is significantly more intensive than individual, group, and family therapies. IOP services must be provided at least three (3) hours per day and at least three (3) days per week. Programming must include individual therapy, group therapy, and family therapy unless contraindicated, crisis intervention as it would occur in the setting where IOP is being provided, and psychoeducation (Psychoeducation is one component of outpatient therapy for mental health conditions. During psychoeducation, the client and/or his family is provided with knowledge about his diagnosis, the causes of that condition, and the reasons why a particular treatment might be effective for reducing his symptoms. Clients and their families gain empowerment to understand and accept the diagnosis and learn to cope with it in a successful manner).	
Individual Outpatient Therapy	Individual Outpatient Therapy shall consist of a face-to-face therapeutic intervention provided in accordance with a recipient's identified treatment plan and is aimed at the deduction of adverse symptoms and improved functioning. Individual therapy must be provided as a one-on-one encounter between the provider and the client. Individual therapy services shall be limited to a maximum of three (3) hours per day, per client, but can be exceeded based on medical necessity.	
Group Outpatient Therapy	Group therapy shall be therapeutic intervention provided to a group of unrelated persons, with the exception of multi-family group therapy. A group consists of no more than twelve persons. It is usually for a limited time period (generally 1 to 1 1/2 hours in duration). In group therapy, clients are involved with one another at a cognitive and emotional level. Group therapy focuses on psychological needs of the clients as evidenced in each client's plan of treatment. Group therapy centers on goals such as building and maintaining healthy relationships, personal goal setting, and the exercise of personal judgment. The group shall have a deliberate focus and must have a defined course of treatment. Individual notes must be written for each recipient within the group and be kept in that individual's medical record. Services shall be limited to a maximum of three (3) hours of group therapy per day, per client, but can be exceeded based on medical necessity.	
Family Outpatient Therapy	Family Therapy shall consist of a face-to-face therapeutic intervention provided through scheduled therapeutic visits between the therapist and the recipient and one or more members of a recipient's family to address issues interfering with the relational functioning of the family and improve interpersonal relationships within the home environment.	
Collateral Outpatient Therapy	Collateral services shall be limited to recipients under the age of twenty-one, who are clients of the rendering provider. A collateral service shall be a face-to-face encounter with a parent/caregiver, legal representative/guardian, school personnel or other person in a position of custodial control or supervision of the client, for	

	the purpose of providing counseling or consultation on behalf of a client in accordance with an established plan of treatment. The parent or legal representative in a role of supervision of the client shall give written approval for this service. This service is only reimbursable for a recipient under age 21.	
Partial Hospitalization	"Partial Hospitalization is a short-term (average of four (4) to six (6) weeks), less than 24-hour, intensive treatment program for individuals experiencing significant impairment to daily functioning due to substance use disorders, mental health disorders, or co-occurring mental health and substance use disorders. Partial Hospitalization may be provided to adults or children. This service is designed for individuals who cannot effectively be served in community-based therapies or IOP. The program consists of individual, group, family therapies and medication management. Educational, vocational, or job training services that may be provided as part of Partial Hospitalization are not reimbursed by Medicaid. The program has an agreement with the local educational authority to come into the program to provide all educational components and instruction with are not Medicaid billable or reimbursable. Services in a Medicaid-eligible child's Individual Education Plan (IEP) are coverable under Medicaid. Partial Hospitalization is typically provided for at least four (4) hours per day. Partial Hospitalization is typically focused on one primary presenting problem (i.e., Substance use, sexual reactivity, etc.)."	
Service Planning	Service planning involves assisting the recipient in creating an individualized plan for services needed for maximum reduction of a mental health disorder and restoration of a recipient to his best possible functional level. A person-centered planning process is required. The plan is directed by the recipient and must include practitioners of the recipient's choosing. The providers include more than licensed professionals-it may include the recipient (and his guardian if applicable), care coordinator, other service providers, family members or other individuals that the recipient chooses.	
Residential Services for Substance Use Disorder	"Residential services for substance use disorders is residential treatment (24 hour/day) that may be short-term or long-term for the purposes of providing intensive treatment and skills building, in a structured and supportive environment, to assist individuals (children and adults) to obtain abstinence and enter into alcohol/drug addiction recovery. This service is provided in a 24-hour live-in facility that offers a planned and structured regimen of care that aims to treat persons with addictions or substance use disorders and assists them in making the necessary changes in their lives that will enable them to live drug or alcohol free lives. Individuals must have been assessed and meet criteria for approval of residential services, utilizing a nationally recognized assessment tool. "	
Screening, Brief Intervention, and Referral to Treatment	SBIRT is an evidence-based early intervention approach that targets individuals with non-dependent substance use to provide effective strategies for intervention prior to the need for more extensive or specialized treatment. SBIRT consists of three major components: Screening- Assessing an individual for risky substance use behaviors using standardized screening tools; Brief Intervention- Engaging a patient showing risky substance use behaviors in a short conversation, providing feedback and advice; and Referral Treatment- Provides a referral to additional mental health, substance use, or co-occurring mental health and substance use disorder services to patients who screen in need of additional services to address substance use. The Referral to Treatment is part of the Brief Intervention and thus referral to a behavioral health service.	
Assertive Community Treatment	"Assertive community treatment (ACT) is an evidence-based psychiatric rehabilitation practice which provides a comprehensive approach to service delivery for consumers with serious mental illnesses. ACT uses a multidisciplinary team of professionals including psychiatrists, nurses, case managers, therapists and peer support specialists. Component services include assessment, treatment planning, case management, medication management including administration, individual and group therapy, peer support, mobile crisis intervention, mental health consultation, family support and basic living skills. Mental health consultation involves brief, collateral interactions with other treating professionals who may have information for the purposes of treatment planning and service delivery. Family support involves the ACT team working with the recipient's natural support systems to improve family relations in order to reduce conflict and increase recipient autonomy and independent functioning. Basic living skills are rehabilitative services focused on restoring activities of daily living to reduce disability and improve function (i.e., taking medications, housekeeping, meal preparation, hygiene, interacting with neighbors) necessary to maintain independent functioning and community living. "	
Comprehensive Community Support Services	Comprehensive Community Support Services covers activities necessary to allow individuals with mental illness to live with maximum independence in the community. Activities are intended to assure successful community living through utilization of skills training as identified in the individual service plan. Skills training is designed to reduce a mental health disorder and restore the recipient to his best possible functional level. Comprehensive community support services	

	consists of using a variety of psychiatric rehabilitation techniques to improve daily living skills, self-monitoring of symptoms and side effects, emotional regulation skills, crisis coping skills and developing and enhancing interpersonal skills.	
Therapeutic Rehabilitation Program – Mental Health only	A Therapeutic Rehabilitation Program is a rehabilitative service for adults with serious mental illness and children with serious emotional disabilities designed to maximize reduction of a mental health disorder and restoration of the recipient's best possible functional level. Services shall be designed for the reduction in disabilities related to social, personal, and daily living skills, as well as the restoration of these skills. The recipient establishes his own rehabilitation goals within the person centered service plan. Component services are delivered using a variety of psychiatric rehabilitation techniques and focus on improving daily living skills (hygiene, meal preparation, and medication adherence), self-monitoring of symptoms and side effects, emotional regulation skills, crisis coping skills and interpersonal skills. Services may be delivered individually or in a group.	
9.	In the online survey, you will be asked to indicate the level of direct staff providing each of the services selected in Question 8.	○ Licensed Psychologist (LP) ○ Licensed Psychological Associate (LPA) ○ Licensed Psychological Practitioner (LPP) ○ Licensed Clinical Social Worker (LCSW) ○ Clinical Social Worker, Masters Level (CSW) ○ Licensed Professional Clinical Counselor (LPCC) ○ Licensed Professional Clinical Counselor Associate (LPCA) ○ Licensed Professional Art Therapist (LPAT) ○ Licensed Professional Art Therapist Associate (LPATA) ○ Licensed Marriage and Family Therapist (LMFT) ○ Marriage and Family Therapist Associate (MFTA) ○ Psychiatrist ○ Advanced Practice Registered Nurse (APRN) ○ Physician Assistant (PA) ○ Certified Alcohol and Drug Counselor (CADC) ○ Licensed Behavior Analyst (LBA) ○ Licensed Behavior Analyst Associate (LABA) ○ Bachelors level ○ Other non-Bachelors level

PART 4: SPECIAL POPULATIONS		
10.	Does your organization serve any special populations including, but not limited to, Developmentally Disabled, Intellectually Disabled, Autism?	☐ Yes ☐ No
10.a.	Please specify the special population. Provide a description of the direct service provided to this special population of youth.	
10.b.	Please specify any additional special population. Provide a description of the direct service provided to this special population of youth.	
10.c.	Please specify any additional special population. Provide a description of the direct service provided to this special population of youth.	
10.d.	Please specify any additional special population. Provide a description of the direct service provided to this special population of youth.	
10.e.	Please specify any additional special population. Provide a description of the direct service provided to this special population of youth.	

PART 5: INFORMATION TECHNOLOGY SYSTEMS		
11.	Does your organization utilize an Information Technology System?	☐ Yes ☐ No
11.a.	What is the name of the system your organization utilizes?	
11.b.	Is your Information Technology system capable to handle the following functions (check all that apply)?	○ Centralized scheduling ○ Clinical data with a Meaningful Use Certified Electronic Health Record (treatment plans, medication prescribing & management, program notes, etc.) ○ Comprehensive bio psycho social assessment ○ Submissions of claims electronically (using both 837i and 837p billing formats) ○ Financial accounting and revenue cycle management tools ○ Reporting ○ Quality Assurance

PART 6: MCO – Level of Care/Utilization Management				
12.	Is your organization currently contracted with a Managed Care Organization (MCO) operating in Kentucky?	☐ Yes ☐ No		
	If Question 12 is answered Yes, answer questions 13 – 22.			
13.	Enter the MCO Name.			
		Completely true	**Somewhat true**	**Not at all true**
14.	My organization meets the MCO service authorization requirements, including timeframes.			
15.	My organization's clinical supervisors understand the MCO Utilization Management (UM) requirements and supervise staff to practice accordingly.			
16.	My organization's staff members understand and effectively meet MCO Level of Care (LOC) and utilization management expectations.			
17.	My organization's staff members can articulate the clinical need for services, including the ability to translate psycho-social issues, such as homelessness, into a clinical need as documented in the client record.			
18.	My organization provides regular training to assure current understanding of LOC and UM expectations.			
19.	My organization is capable of assessing whether staff are able to effectively work within the LOC/UM expectations established by the MCO.			
20.	My organization has a mechanism for providing feedback to/having discussions with MCOs concerning LOC, UM, denials and appeals expectations.			
21.	My organization can monitor ongoing authorizations and prompt staff to seek initial and re-authorizations when appropriate.			
22.	My organization has an individual responsible for knowing MCO requirements and procedures for obtaining authorizations for covered services.			
23.	My organization has an individual responsible for knowing MCO requirements and procedures for transition of care.			