

SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
Comprehensive Home Based Services
Effective – 2/1/13

I. Services Description

Provision of comprehensive and intensive home based services for families involved with DCS/Juvenile Probation to address the short and long term behavioral health care needs. This service shall be for the entire family. The service shall include assessment of child/parent/family resulting in an appropriate service/treatment plan that is based on the assessed need and congruent with the DCS case plan. These in-home services must be evidence based models or promising practices, family centered, and culturally competent.

Examples of therapeutic interventions that are evidence-based models such as:

- Trauma-Focused Cognitive Behavioral Therapy,
- Cognitive Behavioral Therapy,
- Functional Family Therapy,
- Multi Systemic Therapy,
- Family Centered Treatment,
- Motivational Interviewing,
- Brief Strategic Family Therapy
- Child Parent Psychotherapy, OR
- Other DCS approved treatment models

Additional evidence-based programs are outlined at:

- The California Evidence- Based Clearinghouse at www.cebc4cw.org or
- the National Registry for Evidence Based Programs-SAMHSA (Substance Abuse and Mental Health Services Administration) at www.nrepp.samhsa.gov or
- the Office of Juvenile Justice and Delinquency Prevention at <http://ojjdp.ncjrs.gov>

The service shall be all inclusive (as defined below) and must aim at improving long term outcomes for children and their families by providing services that are effective in reducing maltreatment, improving caretaking and coping skills, enhancing family resilience, supporting healthy and nurturing relationships, and children's physical, mental, emotional and educational well-being. Additionally, the Home-Based Service must monitor and address any safety concerns for the child(ren). The intervention must be strength-based with the family participating in identifying the focus of services.

Additionally, the provider must provide intensive safety planning and crisis response services 24 hours a day/7 days per week/365 days a year.

II. Core Competency - Trauma Informed Care

Provider must develop a core competency in Trauma Informed Care as defined by the National Center for Trauma Informed Care—SAMHSA (<http://www.samhsa.gov/nctic/>):

Trauma-informed care is an approach to engaging people with histories of trauma that recognizes the presence of trauma symptoms and acknowledges the role that trauma has played in their lives. NCTIC facilitates the adoption of trauma-informed environments in the delivery of a broad range of services including mental health, substance use, housing, vocational or employment support, domestic violence and victim assistance, and peer support. In all of these environments, NCTIC seeks to change the paradigm from one that asks, "What's wrong with you?" to one that asks, "What has happened to you?"

When a human service program takes the step to become trauma-informed, every part of its organization, management, and service delivery system is assessed and potentially modified to include a basic understanding of how trauma affects the life of an individual seeking services. Trauma-informed organizations, programs, and services are based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate, so that these services and programs can be more supportive and avoid re-traumatization

Trauma Specific Interventions: (modified from the SAMHSA definition)

- The services will be delivered in such a way that the clients/families feel respected, informed, connected, and hopeful regarding their own future.
- The provider must demonstrate an understanding, through the services provided, of the interrelation between trauma and symptoms of trauma (e.g., substance abuse, eating disorders, depression, and anxiety)
- The provider will work in a collaborative way with child/family, extended family and friends, and other human services agencies in a manner that will empower child/family.

III. Inclusive Service Model

The service shall be all inclusive to meet the needs of the family. There should not be a need for DCS to contract/refer the child(ren) or family for additional services as the service provided shall be all inclusive to meet the needs of the family. The service includes but is not limited to assessment of service need, home based therapeutic and casework services, homemaker services, visitation supervision, parent engagement services, parent education, transportation assistance.

Examples of services that may be outside of the services provided under this Service Standard include: Diagnostic and Evaluation Services (Clinical Interview and Assessment, Psychological Testing, Neuropsychological Testing, Psychiatric Services), Residential Drug Treatment services, Detoxification Services and other medical services, Outpatient Drug Treatment. Given the dynamic range of evidence-based models and promising/research-informed practices that may fall under this service standard, there may be some variation in what is considered outside

the “all inclusive” services. [For example, certain models may specifically include substance use treatment *e.g.* the “family centered treatment” model.] To avoid confusion regarding services payable in addition to the Comprehensive Home Based Services per diem, Provider must actively communicate with the assigned DCS family case manager to determine which services are appropriate for the family and are consistent with model or practice in place. Provider must then confirm cancellation of extraneous services and confirm documentation of any DCS supervisor-approved additional services to be paid outside the per diem.

IV. Quality Service Reviews

In order to ensure providers are offering services in accordance with the DCS practice model, providers should be trained in the Quality Service Review process and participate in the regional Quality Service Reviews. At least one individual per region of service delivery will participate in the DCS provided QSR training. The provider will have one individual participate in each Quality Service Review occurring within the regions in which the provider is actively offering services.

V. Target Population

All clients served must be restricted to the following eligibility categories:

- 1) Children and families who have substantiated cases of abuse and/or neglect and will likely develop into an open case with IA or CHINS status.
- 2) Children and their families which have an Informal Adjustment (IA) or the children have the status of CHINS or JD/JS.
- 3) Children with the status of CHINS or JD/JS and their Foster/Kinship families with whom they are placed.

Note: The specific service model chosen to be used under this Service Standard may require a more focused population. However, all clients served under this Service Standard must fit within the above eligibility categories.

VI. Goals and Outcomes

Goal #1 Maintain timely intervention with the family and regular timely communication with referring worker.

Objectives:

- 1) Staff is available for consultation to the family 24-7 by phone or in person.

Fidelity Measures:

- 1) 95% of all families that are referred will have face-to-face contact with the client within 48 hours of receipt of the referral or inform the current Family Case Manager/Probation Officer if the client does not respond to requests to meet.

- 2) 95% of families will have a written treatment plan prepared and sent to the current Family Case Manager/Probation Officer following receipt of the referral within 30 days of contact with the client.
- 3) 95% of all families will have monthly written summary reports prepared and sent to the current Family Case Manager/Probation Officer by the 10th of the month following the services.

Goal #2 Clients will achieve improved family functioning.

Objectives:

1) Goal setting, and service planning are mutually established with the client and Direct Worker within 30 days of the initial face-to-face intake and a written report signed by the Direct Worker and the client is submitted to the current FCM/Probation Officer.

Client Outcome Measures:

- 1) __% of the families that have a child in substitute care prior to the initiation of service will be reunited by closure of the service provision period.
- 2) __% of the individuals/families will not be the subjects of a new investigation resulting in the assignment of a status of “substantiated” abuse or neglect throughout the service provision period. (To be measured/evaluated by DCS/Probation staff)
- 3) __% of the individuals/families that were intact prior to the initiation of service will remain intact throughout the service provision period.
- 4) __% of the children/youth involved with an open JD/JS case will have no occurrences of reoffending throughout the service provision period.
- 5) __% of those individuals/families with a successful case closure will not have a further incident of abuse or neglect at 12 months post discharge.
- 6) __% of those children/youth with a successful case closure will not have any occurrences of reoffending at 12 months post discharge.

Goal #3 DCS/Probation and clients will report satisfaction with services.

Outcome Measures:

- 1) DCS/ Probation satisfaction will be rated 4 and above on the Service Satisfaction Report.
- 2) 90% of clients will rate the services “satisfactory” or above on a satisfaction survey developed by the service provider, unless one is distributed by DCS/Probation to providers for their use with clients.

VII. Minimum Qualifications

Direct Worker:

Bachelor’s Degree in social work, psychology, sociology, or a directly related field.

Supervisor:

Master’s Degree in social work, psychology, or other directly related human services field OR Bachelor’s degree with minimum of 5 years/preferred 7years of experience in social services, case management, education in a community setting, or other relevant experience.

Note: When treatment/service models chosen and/or Indiana licensure/certification bodies require a higher level of staffing qualifications than above, those qualification requirements shall be followed.

It is the responsibility of the provider to maintain staff with the skills necessary to effect change in the families that will be referred. This responsibility includes the supervision and training of the staff.

Providers are to respond to the on-going individual needs of staff by providing them with the appropriate combination of training and supervision. The frequency and intensity of training and supervision are to be consistent with “best practices” and comply with the requirements of each provider’s accreditation body and the Evidence Based Practice Model or Promising Practice Model that is being provided. Supervision may include individual, group, and direct observation modalities and can utilize teleconference technologies.

Staff must possess a valid driver’s license and must comply with the state policy concerning minimum car insurance coverage.

VIII. Reporting

Providers will be required to prepare, maintain, and provide any statistical reports, program reports, other reports, or other information as requested by DCS relating to the services provided. These monthly reports are due by the 10th of the month following service.

DCS will require an electronic reporting system which will include documenting time and services provided to families. DCS may also adopt a standardized tool for evaluating family functioning. Services will include administration of this tool at the initiation of services as well as periodically during service provision.

IX. Billable Unit

Initial Assessment: The initial assessment will assess the service needs of the child/family and decide if the child/family should be accepted into the program. There will be no charge to DCS for this service.

Per Diem rate: The per diem will start the day of the first face to face contact after the assessment is complete and recommendation for acceptance into this program is approved by DCS.

The per diem rate will be all inclusive of the services outlined in Section III above.

Per Diem rate for MRO eligible clients: The per diem will start the day of the first face to face contact after the assessment is complete and recommendation for acceptance into this program is approved by DCS. This rate will include only those services that are not billable to MRO.

If available, Provider shall bill Medicaid or private insurance for services prior to billing DCS. If provider has separate per diem rates- one which includes Medicaid-eligible services and one for only non-medically necessary services, it may bill DCS for the non-medically necessary per diem as otherwise allowed by State fiscal policy. In no event shall provider bill both DCS and insurance (Medicaid or otherwise) for the same service time.

X. Case Record Documentation

Case record documentation for service eligibility must include:

- 1) A completed, signed, and dated DCS/ Probation referral form authorizing services
- 2) Documentation of regular contact with the referred families/children
- 3) Written reports no less than monthly or more frequently as prescribed by DCS/Probation. Monthly reports are due by the 10th of each month following the month of service, case documentation shall show when report is sent.
- 4) Copy of DCS/Probation case plan, informal adjustment documentation, or documentation of requests for documents given to DCS/Probation

XI. Service Access

All services must be accessed and pre-approved through a referral form from the referring DCS/Probation staff. In the event a service provider receives verbal or email authorization to provide services from DCS/Probation an approved referral will still be required. Referrals are valid for a maximum of six (6) months unless otherwise specified by the DCS/Probation. Providers must initiate a re-authorization for services to continue beyond the approved period. A referral from DCS does not substitute for any authorizations required by the Medicaid program.

XII Adherence to the DCS Practice Model

Services must be provided according to the Indiana Practice Model, providers will build trust based relationships with families and partners by exhibiting empathy, professionalism, genuineness and respect. Providers will use the skills of engaging, teaming, assessing, and planning and intervening to partner with families and the community to achieve better outcomes for children.