DEPARTMENT OF HEALTH AND SOCIAL SERVICES

OFFICE OF CHILDREN'S SERVICES

RESIDENTIAL BEHAVIORAL REHABILITATION SERVICES HANDBOOK 2010

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PURPOSE AND APPLICABILITY OF HANDBOOK

This Residential Behavioral Rehabilitation Services (RBRS) Handbook is intended to provide guidance for providers, and to set out requirements that are in addition to the provisions of the applicable statutes and regulations that govern residential care for children and youth (RCCY) facilities.

See Appendix 2 for a list of applicable statutes and regulations referred to in this handbook. The statutes and regulations apply to all providers of residential care for children and youth. The requirements of this handbook are additional requirements that apply to RBRS providers who provide services for children/youth who are utilizing a RBRS funded bed.

The handbook also refers to forms that are to be used by RBRS providers. Those forms are available on the OCS/RCCY Web site:
http://www.hss.state.ak.us/ocs/ResidentialCare/

The handbook includes procedures developed by the Department of Health and Social Services (the department) which may require change over time. Because the handbook is adopted by reference in department regulations, it is itself a regulation. Thus, any change to the handbook must follow the same process as a change to the regulations, including public notice, opportunity for public comment, adoption by the department, approval by the Department of Law, and filing by the Lt. Governor.

Providers are encouraged to submit proposed changes and suggestions for improvement to the department at any time. The department welcomes such participation in making the handbook an easy-to-use resource for providers, and will give serious consideration to all such suggestions when developing a revision for the public review process.

Please check the OCS/RCCY Web site http://www.hss.state.ak.us/ocs/ResidentialCare/ for current information about the handbook, applicable forms, provider meeting schedules, and other provider information.

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RESIDENTIAL CARE SYSTEM HISTORY

Since 1984, the Department of Health and Social Services (DHSS) has purchased residential care for children and youth (RCCY) services through grants governed by statute under AS 47.40.011 – 47.40.091 and by regulation under 7 AAC 53.900 – 7 AAC 53.999 for certain facilities required to be licensed under AS 47.32 and 7 AAC 50. (The regulatory grant provisions now set out in 7 AAC 53 were formerly located in 7 AAC 50.)

Under those grant agreements, DHSS purchased a fixed number of RCCY beds from qualified nonprofit agencies across the state. The amount of each grant was related to the number of funded beds and the per day payment rate. This daily rate was based on the category of care provided and any applicable and approved geographic differential.

During state fiscal year (FY) 2001, the payment structure for DHSS funded RCCY was changed to incorporate a Medicaid funded service called Residential Behavioral Rehabilitation Services (RBRS) into the daily rate paid to providers. RCCY had historically been financed with state general funds and reimbursement through the federal Title IV-E program. While Title IV-E still plays a small role in funding care, state general funds continue to provide substantial funding.

Medicaid funding for RCCY now involves using RBRS, not Mental Health Rehabilitation Services. This change created more leverage for federal funds and allows a more simplified process for billing Medicaid. Essentially, RBRS bundled all services provided in residential child/youth care facilities licensed under 7 AAC 50, including services that were previously paid under augmented foster care rates.

In FY 2006, RBRS was defined in 7 AAC 43.481and extended to child/youth Medicaid recipients who are not in department custody. Through the *Bring the Kids Home Initiative*, children or youth not in department custody and/or not Alaska Medicaid recipients may also qualify for RBRS. Facilities serving these non-custody children/youth may receive RBRS funding as long as

> (1) no other form of payment is available, such as third party insurance or paid community beds purchased by another RBRS provider; and
>
> (2) general fund allocations are available to DHSS for this purpose. If general fund allocations cannot sustain core payments for non-custody children/youth, those payments will be discontinued until funding is made available to DHSS by the Legislature.

BEHAVIORIAL REHABILITATION SERVICES (RBRS)

Residential Behavioral Rehabilitation Services (RBRS) are residential services dealing with behavioral rehabilitation, provided by residential care for children and youth (RCCY) facilities licensed under AS 47.32 and 7 AAC 50. An RCCY facility is defined at AS 47.32.900 as "a place, staffed by employees, where one or more children who are apart from their parents receive 24-hour care on a continuing basis." AS 47.40.091 defines residential services as "24-hour care and supervision of minors in residential child care facilities that are commonly known as group homes or institutions."

Facilities operating under the grant program governed by AS 47.40 and 7 AAC 53 are required to be in compliance with state licensing requirements under AS 47.32 and 7 AAC 50. Children or youth placed in residential facilities can either be in the legal custody of the Department of Health and Social Services (the department) or in the custody of a parent or other legal guardian. In either case, there must be a demonstrated need for treatment in a highly structured and supervised placement.

The purpose of RBRS is to remediate specific dysfunctions which have been explicitly identified in an individualized written treatment plan that is regularly reviewed and updated. These services are provided to children/youth in residential settings to treat debilitating psychosocial, emotional, and behavioral disorders. RBRS provide early intervention, stabilization, and development of appropriate coping skills upon the recommendation of a mental health professional within the scope of their practice as prescribed by applicable law. These services are "client-centered" and can be provided within the residential care system either individually or in groups.

When possible and appropriate, services should include the child/youth's biological, adoptive, or foster family. Treatment is focused upon the needs of the individual child or youth, not the family unit; but the family should be involved during the treatment process if family reunification is the desired result. These services may be in conjunction with or in support of any other professional treatment services the child/youth may be receiving as required by the diagnosed condition.

Service Components Provided in Residential Care

These services may be provided in a variety of settings and consist of interventions to help children/youth acquire essential skills. Service components include:

Milieu Therapy

Milieu therapy are those daily activities performed with children/youth to normalize their psychosocial development, promote the safety of the child/youth, and stabilize their environment. The child/youth is monitored in structured activities that may be developmental, recreational, academic, rehabilitative, or a variety of productive work activities. As the child/youth is monitored, planned interventions are provided to remediate behaviors identified in each child/youth's plan of care and to promote pro-social behavior.

Crisis Counseling
Crisis counseling must be provided on a 24-hour basis to stabilize the child/youth's behavior until the problem is resolved, or until the child/youth can be assessed and treated by a qualified mental health professional or licensed medical practitioner. Crisis counseling means counseling provided to a recipient who is experiencing a short term crisis and provided by a staff member of the facility who is working within the scope of that staff member's job description, education, training and experience.

RBRS non-clinical crisis intervention is not the same as "crisis intervention" described under Medicaid clinical services, which must be provided by a qualified mental health professional who assesses a recipient's danger to self or others during an acute episode of a mental, emotional, or behavioral disorder and provides short-term mental health services to reduce symptoms and prevent harm. If a child/youth needs clinical crisis intervention, RBRS providers are required to provide or arrange for it. A RBRS provider that is also enrolled in the Medicaid program as a community mental health clinic may bill Medicaid for clinical crisis intervention as provided under Medicaid program requirements.

Counseling
Counseling must be provided individually and/or in groups to remediate each specific behavioral dysfunction that has been explicitly identified in the child/youth's individual treatment plan of care. Counseling provided under RBRS is not the same as "psychotherapy," which is a clinical service under Medicaid. A person may provide counseling with less than a Master's degree. These services must be coordinated with psychotherapeutic services provided by a professional mental health clinician.

Skills Training
Skills training means actively teaching a recipient to exhibit appropriate social and emotional behavior, develop healthy peer and family relationships, provide self-care, engage in conflict resolution. Skills Training includes skill instruction, skill practice, re-direction, feedback, positive praise, role modeling, promoting, encouraging, and coaching;

Target Population
The target population includes:

- Children/youth between the ages of 0-18
- Children/youth in department custody and Alaska Medicaid eligible
- Children/youth not in department custody and Alaska Medicaid eligible*
- Children/youth not in department custody and not eligible for Alaska Medicaid*

** Through the Bring The Kids Home Initiative, children or youth who are not Alaska Medicaid recipients and/or not in department custody must have written approval by the OCS Residential Care Program Manager to receive RBRS.*

Children/youth in the target population may have primary mental, emotional, and behavioral disorders and/or developmental disabilities that prevent them from functioning at developmentally appropriate levels in their home, school, or community. They may exhibit symptoms such as (1) anti-social behaviors that require close supervision and intervention and structure, (2) mental disorders with persistent non-psychotic or psychotic symptoms, (3) drug and alcohol abuse, or (4) sexual behavior problems that severely or chronically impair their ability to function in typical family, work, school, or other community roles. Children/youth may be

victims of severe family conflict, behavioral disturbances often resulting from substance abuse and/or mental illness of the parents. These children/youth may have physical and mental birth defects from prenatal maternal alcohol use or alcohol related neurological defects. They may be medically compromised or developmentally disabled children/youth who are not otherwise served by the Division of Behavioral Health.

RESIDENTIAL LEVEL OF CARE I-V OVERVIEW

The department has established levels of care for RBRS. A detailed description of each level follows the summary overview set out in the following table.

Level and Description	Staff Levels	Defining Characteristics	Length of Stay
Level I **Day Treatment**	1:6	An intensive daytime program of structured, supervised, rehabilitative activities for children/youth with behavioral and emotional problems. This category also includes payment for Therapeutic Foster Care	Daily as needed
Level II **Emergency Stabilization & Assessment Center**	1:5 If under 30 Mo 1:3 Awake Night 1:12	Provides RBRS and temporary residential care for children/youth who are in immediate danger or need stabilization and assessment of needs services. Services include crisis stabilization, diagnosis, family mediation, individual and group counseling. The emphasis in this setting is on diagnostics and future placement based on therapeutic needs of the child/youth.	Not intended for longer than 30 days
Level III **Residential Treatment**	1:5 Awake Night 1:12	Provides 24-hour RBRS and treatment for children/youth with emotional and behavioral disorders. This level is for children/youth in need of and able to respond to therapeutic intervention, who cannot be treated effectively in a less restrictive environment.	Up to 18 month / 24 months for SO program
Level IV **Residential Diagnostic Treatment**	1:3 Awake Night 1:12	Small therapeutic facilities providing structured supervision 24 hours per day in a more restrictive environment. Intensive treatment services include crisis intervention, accurate diagnosis (behavioral, health, mental health, substance abuse, other), behavioral stabilization and management.	Up to 18 month / 24 months for SO program
Level V **Residential Psychiatric Treatment Center**	1:3	RPTC programs provide 24-hour interdisciplinary, psychotherapeutic treatment in a "secure" or "semi-secure" facility for children/youth with severe emotional or behavioral disorders and complex, multi faceted diagnoses who present a high risk of harm to self or others.	As determined by medical necessity

The appropriateness of placement in a Level II, III, IV or V facilities is determined by the structure, staffing patterns, and security to maintain the safety of the child/youth. The degree of intensity of the behaviors exhibited and the need for restriction of activities are the critical factors in determining appropriateness of placement.

Consequently, prospective children/youth may not be excluded solely on behavioral issues but must be clinically evaluated for the degree of structure, staffing, and security necessary to provide safety, while maintaining the child/youth *in the least restrictive, most normative environment possible.*

Placement length of stay parameters noted above are outer limit time frames but the individual needs of the child/youth are the primary concern with regard to length of stay in treatment. The length of stay may vary according to the child/youth's needs.

RESIDENTIAL LEVELS: DETAILED DESCRIPTIONS

Level I - Day Treatment Programs

(Note: No Level 1 programs are currently funded in FY2009-10)

Day treatment is an intensive daytime program of structured, supervised, rehabilitative activities for children/youth with behavioral and emotional problems. Coordinated services shall be provided to the child/youth and the family in order for the child/youth to be maintained in their own home or in foster care, either as an alternative to residential/institutional placement, or as part of a continued plan.

Level I Goals

The goals of a day treatment program must include but are not limited to:

1. Maintain placement at home or in foster care;
2. Encourage education and improve academic performance;
3. Improve interpersonal relationships;
4. Decrease behavioral and emotional problems;
5. Provide counseling for the child/youth, and their family or foster parents, that is directed at alleviating behavioral or emotional problems and improving family relationships.

Level I Services

Services must be available on a routine, continuous basis for not less than eight hours per day, for not less than 255 days per year. Treatment components must include:

1. Individual and group counseling for the child/youth, family members, and foster parents conducted by a qualified counselor;
2. Support staff and programming for an enhanced educational program;
3. Training and counseling in basic living skills, interpersonal skills, problem solving skills, and anger management;
4. Physical and academic education;
5. Recreation;
6. Structured summer activity program.

Level II - Emergency Stabilization and Assessment Centers (ESAC)

Emergency Stabilization and Assessment Centers provide Residential Behavioral Rehabilitation Services and temporary residential care for children/youth who are in immediate danger in their present environment, need short term, temporary placement, or may need stabilization and assessment of their needs.

These children/youth may be in crisis due to recent disclosure of abuse, neglect, or commission of a delinquent act and may have recently been removed from their family home, foster home, or other placement. The ESAC program is responsible for assisting and resolving the crisis, stabilizing the child/youth and assisting in the planning for the child/ youth's return home or placement in alternative care.

Level II Goals

The goals of emergency stabilization and assessment centers must include but are not limited to:

1. Stabilize the child/youth's behavior and assess for treatment needs;
2. Assist the child/youth in dealing with the crisis of emergency placement;
3. Assure the child/youth is available for scheduled court appearances (if applicable);
4. Provide a comprehensive assessment of the child/youth's care and treatment needs if in care for five days or longer;
5. Provide coordination of medical treatment and supervision of medication delivery;
6. Maintain the child/youth's education;
7. Participate in the post ESAC placement planning.

Level II Services

The ESAC facility must have a planned program of group living, community experience, and educational opportunities. ESAC must provide awake night staff. The following in-house services must be provided, as identified in the individual treatment plan:

1. Stabilization and assessment;
2. Crisis intervention;
3. Family mediation;
4. Individual and group counseling.

Level II Admissions

The RBRS provider must accept or reject a completed referral within five business days of its receipt and provide written statements to the referral agent outlining the specific reasons for any rejection. A RBRS provider may refuse a placement only if the program cannot appropriately serve the child/youth with reasonable accommodations due to the child/youth's special needs or because the facility lacks capacity.

During the admission process, the admitting ESAC staff member shall determine whether the child/youth is in need of immediate medical or psychiatric attention. If the admitting ESAC staff member finds the child/youth to be incapacitated by drugs and/or alcohol or in immediate need of medical or psychiatric attention, the staff member shall advise the referring party to arrange for emergency medical assessment and care. The admission process may be deferred until the referring party produces a physician's statement certifying that the child/youth has received medical or psychiatric attention and that the child/youth's medical or psychiatric condition does not preclude placement in an ESAC. Children/youth who appear to be ill or injured or under the influence of alcohol, narcotics, or similar agents, but not in need of immediate medical attention must be given medical attention as soon as practical after admission. A written record must be kept of the admission interview, health assessment, and physician statement if applicable.

Level II Risk Screen

A risk screen for mental health needs and suicide/self-harm risk should be administered at intake to determine the child/youth's level of risk. A clinical staff member should review this screen as soon as possible or at the time of assessment. If no immediate needs are identified through the risk screen, a child/youth in placement for less than five calendar days who receives this screen does not need further assessment.

Level II Brief Plan of Care

Facility staff must develop a Brief Plan of Care (BPOC) within five calendar days of admission of a child/youth. The BPOC is an assessment of the child/youth's immediate and specific needs and must be conducted by qualified staff supervised by a mental health professional or by contracted providers such as a local community behavioral health center. The BPOC must be signed by the mental health professional when conducted by staff. The BPOC must include but is not limited to:

1. Short-range goals and tentative long-range goals for the child/youth and the child/youth's family;
2. Plans for family involvement, as appropriate;
3. The specific services to be provided by the facility and other resources to meet the child/youth's needs; and
4. The anticipated discharge date.

If a Level II facility is unable to complete a BPOC by the fifth day, the facility must notify the Residential Care Program Manager and explain why the BPOC could not be completed in the required time frame and specify the date when the BPOC will be completed. The Residential Care Program Manager will send an e-mail granting an extension and confirming the completion date by which an assessment will be completed. Such extensions may not become standard operating practice.

Level II Assessment and Treatment Planning

Within 15 days of the admission of a custody or non-custody child, a mental health professional shall conduct an assessment of the child/youth's specific behavioral rehabilitation needs, measuring the following areas:

- Behavioral/functional
- Educational
- Medical
- Social/emotional issues

RBRS providers may use assessments completed within six months prior to admission to satisfy this requirement if the mental health professional reviews and provides an update to the previous assessment within 15 days after admission.

Upon completion of the assessment, a treatment plan based on the assessment and developed in collaboration with the treatment team shall be developed within 30 days after admission. The treatment plan may be created by qualified facility staff, but must be reviewed and approved by a mental health professional.

Facility staff must review and renew the treatment plan every 15 days thereafter. This review must adequately explain:

1. The reason for continued care;
2. Plans for other placement; and
3. Barriers to other placement and plans to eliminate the barriers.

Level II Length of Stay

To the extent it provides emergency shelter care, a residential care facility may not maintain a child/youth in care for longer than 30 days unless there is documentation that continued care is necessary (see 7 AAC 50.610 (k)).

Children/youth may not be maintained in care beyond 60 days unless approved by the Residential Care Program Manager prior to exceeding 60 days. It is the department's goal to not allow children/youth to remain in a facility more than 90 days, with 60 days as the preferred limit.

If the provider anticipates that a child/youth will remain at the facility longer than 60 days, an extension must be requested of the Residential Care Program Manager. Before approval of an extension, facility staff shall call the treatment team together before the 45th day of treatment to inform the team that the allowable length of stay (60 days) is coming to an end, and to help facilitate timely discharge. The facility will provide the Residential Care Program Manager with the discharge plan resulting from this meeting with any necessary extension request.

The Residential Care Program Manager will also review and approve or deny extension requests for non-custody children/youth who occupy a RBRS funded bed.

If a determination is made that the child/youth is difficult to place and may need long term residential treatment, a referral must be made to the Regional Placement Committee. The Regional Placement Committee consists of department representatives with authority to place children in residential care.

Distinguishing Between Level II and Level III

Level II RCCY's are short term, emergency stabilization and assessment units that provide an interim placement for children or youth. By definition, treatment is short term in that a placement is intended for up to 30 days and rarely appropriate for a longer period unless arrangements are being made for an alternative placement that is taking more time.

Level III RCCY's are longer term placements intended to provide a therapeutic environment in which specific behaviors or issues are addressed in the context of a treatment plan.

Level III - Residential Treatment

Note: Levels of care for children/youth in Level III, IV and V facilities are determined by structure, staffing patterns, security to maintain the safety of the child/youth, and level of services provided. Higher levels of care result in a higher level of structure and restrictiveness.

Residential treatment programs provide 24-hour RBRS and treatment for children/youth with emotional and behavioral disorders. This level of service is provided for children/youth who are in need of and are able to respond to therapeutic intervention and who cannot be treated effectively in their own family, a foster home, or in a less restrictive and structured setting.

Level III Goals

1. Prepare the child/youth and family for the child/youth to return home, to a relative placement, to foster care, or to live independently;
2. Improve behaviors that are related to the child/youth's skill deficits identified by their DSM IV diagnosis, and reinforce positive behaviors;
3. Maintain and improve the child/youth's educational progress;
4. Develop independent living skills;
5. Participate in developing a discharge plan for subsequent placement.

Level III Services

These programs provide medium to long-term (up to 18 months; 24 months for Sex Offender program) residential care and treatment for children/youth who have emotional and mental health problems and display inadequate coping skills. A high percentage of these children/youth will have a history of being physically and sexually abused. They may have a history of delinquency and have limited impulse control.

Program components must include but are not limited to:

1. Planned group living/milieu therapy;
2. Community experiences;
3. Ongoing individual, group, and family therapy and/or counseling if identified in treatment plan;
4. An individualized educational program for each child/youth;
5. Individualized, strength based treatment plan, including crisis prevention.

Many of the children/youth placed in these programs have had multiple placements in less structured facilities. They may have a history of inability to adjust and progress in a public school and may require a self-contained classroom environment to help them develop the educational, social, behavioral, and coping skills necessary to return to a less structured placement. These children/youth may attend school in a community based educational system; however, they may require additional tutoring and a behavior modification program in order to resolve social or behavioral problems prior to going home or emancipation.

Level III Behavioral Characteristics

Behaviors of children/youth appropriately referred to a Level III facility include:

- Thought, emotional, or behavioral disorders
- Depression
- Withdrawal
- Stealing
- Running
- Inappropriate sexual acting out
- Moderate self abuse
- Mild aggression
- Mild mental retardation (suitability depending on behaviors)
- Borderline range cognitive function
- FASD (suitability depending on behaviors).

Level III Admissions

The Regional Placement Committee must refer children/youth that are in department custody to a Level III facility.

The RBRS provider must accept or reject a completed referral within five business days of its receipt and, if rejecting admission, provide written statements to the referral agent and the Residential Care Program Manager detailing the child/youth's specific behaviors and problems that are not able to be addressed in their program and any other reasons for rejection. A RBRS provider may refuse a placement only if the facility cannot appropriately serve the child/youth with reasonable accommodations due to the child/youth's special needs or the facility lacks capacity.

Level III Brief Plan of Care

A Brief Plan of Care (BPOC) must be developed within 15 calendar days of admission of a child/youth. The BPOC:

- Is an assessment of the child/youth's immediate and specific needs

- Is a description of the services that will be provided
- Must be conducted by qualified staff supervised by a mental health professional who must also sign the BPOC

Level III Assessment and Treatment Planning

Within 30 days of the admission of a custody or non-custody child/youth, a mental health professional must conduct a comprehensive assessment of the child/youth's immediate, specific behavioral rehabilitation needs, measuring the following areas:

- Behavioral/functional
- Educational
- Medical
- Social/emotional issues

RBRS providers may use assessments completed within six months prior to admission to satisfy this requirement if the mental health professional reviews and provides an update to the previous assessment within 30 days after admission.

Upon completion of the assessment, a treatment plan based on the assessment shall be developed within 30 days of admission. This plan must meet the requirements of 7 AAC 50.330. It is the responsibility of the RBRS provider to schedule a meeting with the child/youth's treatment team in order to develop a treatment plan. The treatment plan may be created by qualified staff, but must be reviewed and approved by a mental health professional. Facility staff must review and renew the treatment plan every three months thereafter and meet the review requirements of 7 AAC 50.330.

Level III Treatment Planning

In order to prepare the child/youth for returning home or a continuing relationship with his or her family, the program will integrate and facilitate service for individual, group, and family counseling and/or therapy when identified as a need in the treatment plan.

It is the facility's responsibility to notify the appropriate participants and facilitate the child/youth's treatment team meetings (to include at a minimum the youth (if appropriate), a social worker, juvenile probation officer, parent (if appropriate), legal guardian, and child/youth therapist) to develop an individual treatment plan for the child/youth. The facility shall conduct regularly scheduled, quarterly individual plan reviews. Daily progress notes must be kept for each child/youth that describe the child/youth's behavior and response to the intervention in the treatment plan.

Level III Transitional and Continued Care Components

The treatment program must include a transitional and continued care component. Transitional services include preparing the child/youth for transition from a residential setting to the next placement or release. Continued care includes development and delivery of individualized continued care and post discharge plans designed to meet each child/youth's medical, psychological, social, behavioral, educational, and developmental needs during the 90 days following discharge.

Continued care plans must include all of the following:

1. Supervision of medication by a licensed professional;
2. Referral to appropriate therapeutic services;
3. Placement in an age appropriate living situation;
4. Liaison with the child/youth 's school to continue the appropriate educational program;

5. Coordination with the child/youth's social worker or juvenile probation officer to assure appropriate placement supervision and other community services.

The RBRS provider is encouraged to use the services of the OCS Independent Living Specialist and the Family Preservation grantee if those services exist in the provider's community.

Distinguishing Between Level III and Level IV
Level III RCCY's are long-term placements intended to provide a therapeutic environment in which specific behaviors or issues are addressed within a treatment plan.

Level IV RCCY's may be short-term or long-term, but are intended to serve children/youth who (1) exhibit more serious and destructive behaviors, (2) have been identified as having more intensive needs, and/or (3) need a more structured setting with psychiatric services available and/or a more accurate diagnosis.

Level IV - Residential Diagnostic Treatment Centers
Note: Levels of care for youth in Level III, IV, and V facilities are determined by structure, staffing patterns, security to maintain the safety of the child/youth and level of services provided. Higher levels of care result in a higher level of structure and restrictiveness.

Residential Diagnostic Treatment (RDT) programs provide long-term (up to 18 months; 24 for Sex Offender treatment) residential care and treatment for children/youth who have emotional and mental health problems and display inadequate coping skills. These are therapeutic facilities that serve children/youth who have been identified as having more intensive needs prior to placement and placement may be short term if appropriate. In this more structured setting, staff are able to develop a diagnostic picture of a child/youth who may have multiple diagnoses due to placement in several facilities, or who may have been in such crisis prior to placement that a true diagnostic picture was difficult to ascertain.

RDTs provide a structured, supervised program 24-hours per day, seven days a week by professional staff. Most children/youth will continue treatment within the program once a clear diagnostic picture is obtained, however some may move to a different level of care once the assessment process is completed to ensure they are treated in the most appropriate setting for their needs.

Level IV Goals
1. To meet the multiple needs of children/youth, provide a safe, nurturing environment that facilitates successful transition to their own home, a stable foster home or a less restrictive residential facility;
2. Decrease the number and length of psychiatric hospitalizations;
3. Complete a detailed diagnosis for those children/youth who previously have not had a thorough social history, educational assessment, medical, substance abuse, and mental health evaluation;
4. Stabilize the behavior so that an individual treatment plan can be developed that addresses the child/youth's needs and follow up on this plan once the child/youth leaves the facility;
5. Remove, modify, or reduce symptoms of emotional or behavior disturbances;
6. Promote positive personal growth and development, integrating strengths into the transition plan;
7. Address the educational needs of each child/youth.

Level IV Services

1. Behavioral stabilization and management, and accurate diagnosis (i.e. chronic, episodic or manageable);
2. Comprehensive individual treatment planning focused on continued care and the child/youth's long-term needs;
3. Crisis intervention;
4. Maintain and improve the child/youth's educational progress;
5. Develop independent living skills;
6. Participate in developing a plan for subsequent placement.

Level IV Admissions

The Regional Placement Committee must refer children/youth who are in department custody to a Level IV facility and admission must be approved by the appropriate department division: OCS and/or the Division of Juvenile Justice. For other than crisis services, the referring party will be required to submit written information containing family history, social history, academic history, any previous psychological testing, and other pertinent information that is available.

The RBRS provider shall accept or reject a completed referral within five business days of its receipt and, if rejecting admission, provide written statements to the referral agent and the Residential Care Program Manager detailing the child/youth's specific behaviors and problems that cannot be addressed by the facility and any other reasons for rejection. A RBRS provider may refuse a placement only if the facility cannot appropriately serve the child/youth with reasonable accommodations due to the child/youth's special needs or the facility's lack of capacity.

Level IV Brief Plan of Care

A Brief Plan of Care (BPOC) must be developed within 15 calendar days of admission of a child/youth. The BPOC:

- Is an assessment of the child/youth's immediate and specific needs,
- Is a description of the services that will be provided,
- Must be conducted by qualified staff supervised by a mental health professional who must also sign the BPOC.

Level IV Assessment and Treatment Planning

Within 30 days of the admission of a custody or non-custody child/youth, a mental health professional must conduct a comprehensive assessment of the child/youth's immediate, specific behavioral rehabilitation needs, measuring the following areas:

- Behavioral/functional
- Educational
- Medical
- Social/emotional issues

Upon completion of the assessment, a treatment plan based on the assessment must be developed within 30 days of admission and must meet the requirements of 7 AAC 50.330. It is the provider's responsibility to schedule a meeting with the child/youth's treatment team in order to develop a treatment plan. The treatment plan may be created by qualified staff, but must be reviewed and approved by a mental health professional. Facility staff must review and renew the treatment plan every three months thereafter and must meet the review requirements of 7 AAC 50.330. Appropriate participants in the child/youth's treatment team meetings will include, at a minimum, the youth (if appropriate), a social worker, juvenile probation officer, parent (if appropriate), legal guardian, and child/youth therapist.

Level IV Behavioral Characteristics

Children and youth referred to a Level IV facility will exhibit thought disorders, emotional disorders, or behavioral disorders that include oppositional and conduct disorders. A high percentage of these children/youth will have a history of being physically and/or sexually abused. They may have a history of delinquency and have limited impulse control.

In addition to behaviors listed above for Level III facilities, examples of the behavior problems include but are not limited to:

- Patterns of excessive aggressive/assaultive behavior towards peers and/or adults
- Destruction of property
- Self-abusive behavior
- Cruelty to animals
- Fire setting history
- Severe withdrawal and/or depression
- Developmental issues / FASD
- Inappropriate sexual activity
- Other behaviors not capable of being addressed in lower level treatment setting

Level IV Treatment Planning

It is the facility's responsibility to schedule a meeting with the child/youth's treatment team in order to develop a plan of care. Some programs may require a longer placement due to treatment needs of the child/youth.

The facility should staff at least one full-time professional mental health clinician (Masters Level MSW, MS, etc.). The facility shall have available psychiatric services for emergency care, evaluation, medication prescription and monitoring. The facility shall provide home-based services when appropriate to each child/youth's identified family, providing training, support, and resources to enable the family to assume care of the child/youth after discharge. The department encourages and supports organizations providing home-based services for follow-up outpatient care as a best practice.

Level IV Transitional and Continued Care Components

The facility's treatment program must include a transitional and continued care component. Transitional services include preparing the child/youth for transition from a residential setting to the next placement or release. Continued care includes development and delivery of individualized continued care and post discharge plans designed to meet each child/youth's medical, psychological, social, behavioral, educational and developmental needs during the first 90 days after discharge.

Continued care plans must include all of the following:

1. Supervision of medication by a licensed professional;
2. Referral to appropriate therapeutic services;
3. Placement in an age appropriate living situation;
4. Liaison with the child/youth 's school to continue the appropriate educational program;
5. Coordination with the child/youth's social worker or juvenile probation officer to assure appropriate placement supervision and other community services.

The RBRS provider is encouraged to use the services of the OCS Independent Living Specialist and the Family Preservation grantee if those services exist in the provider's community.

Distinguishing Between Level IV and Level V

Level IV RDT's may be short-term or long-term but are intended to serve children/youth who exhibit more serious and destructive behaviors, have been identified as having more intensive needs, need a more structured setting, and/or need a more accurate diagnosis.

Level V programs provide long-term, intensive services to children or youth at the highest level of need in a residential care context. Level V Residential Psychiatric Treatment Centers are for children/youth who exhibit extreme functional impairment and are experiencing a serious emotional disturbance that requires a 24-hour interdisciplinary, psychotherapeutic treatment in a "secure" or "semi-secure" facility. Behaviors include thought disorders, emotional disorders, or behavioral disorders that include patterns of excessive aggressive, destructive or assaultive behavior, as well as excessive withdrawal or depression.

Level V - Residential Psychiatric Treatment Centers

Level V Residential Psychiatric Treatment Centers are not funded by the RCCY grant program. For more information, please see the department's Web site at http://qualishealth.org/cm/alaska-medicaid/behavioral-health/tools.cfm

GENERAL PROGRAM REQUIREMENTS

Acceptance of Referrals

A residential child care facility must comply with all statutes and regulations that apply to the operation of a residential child care facility.

The RBRS provider must accept children/youth referred by the department for placement when the child/youth referred meets the target population criteria and the criteria for the applicable level of care. The provider may also accept non-custody youth upon approval by the OCS Residential Care Program Manager.

Placement of OCS and DJJ custody children/youth will be highest priority. At no time may a non-custody child/youth be placed in a RBRS bed when a custody child/youth remains on the facility's wait list unless the facility has received written permission from the OCS Residential Care Program Manager.

Referrals of non-custody children/youth can come from biological parents, police department, the RBRS Provider community, the department's Division of Behavioral Health and the Division of Juvenile Justice, an out-of-state facility, etc. The RBRS provider must request and receive approval from the OCS Residential Care Program Manager, using the Authorization for Non-Custody Placement form found on the OCS/RCCY Web site at http://www.hss.state.ak.us/ocs/ResidentialCare/ to request approval from the OCS Residential Care Program Manager. The facility must receive written authorization from the program manager before the non-custody child/youth can be placed in a facility.

Non-custody children/youth may not be removed prematurely from a facility in order to make room for a custody child/youth. Once a custody or non-custody child/youth enters a facility, they will be given every opportunity to succeed and finish their treatment plan.

Youth who are waitlisted for services will retain their place in line for services and will not be displaced or given less consideration than for youth living in closer proximity to the facility or for any other reason. The status of a youth on a waitlist is determined in priority, based on the date of Regional Placement Committee approval for youth in the custody of the state or approval of the RCCY Program Coordinator for youth in parental custody. Youth on the waitlist shall have a completed application packet and all necessary paperwork on file with the program. In the event of an emergency placement request involving a disruption of the waitlist, the program administrator and clinician will contact the RCCY Program Coordinator and the DJJ Residential (BTKH) Program Coordinator and request a joint meeting with both DHSS agencies and the provider prior to any such occurrence. In situations in which youth are retained in care after program completion due to a lack of residential alternatives, facility staff are encouraged to call the RCCY Program Coordinator for assistance in finding alternative residential options for youth.

Within five business days of receiving a referral for placement, the RBRS provider shall determine whether a referral packet is complete and, if not, notify the referral agent of the specific omissions. The provider shall accept or reject a completed referral within five business days of its receipt and, if rejecting the referral, provide written statements to the referral agent and the Residential Care Program Manager outlining the specific criteria for refusing the referral.

A RBRS provider may refuse a placement only if the facility cannot appropriately serve the child/youth with reasonable accommodations due to the child/youth's special needs or the facility's lack of capacity.

Residential care is operated on an unconditional care model, and RBRS providers are not to discharge children/youth or refuse their placement unless the child/youth presents an imminent risk of harm to themselves or others for which the provider is not qualified to respond under the level of care for which the provider has entered into an agreement.

A RBRS provider shall limit emergency discharges to situations where the health or safety of a child/youth, other residents, or staff would be endangered by continued placement in the facility. Disruptive or runaway behavior does not constitute grounds for rejection or discharge of a child/youth who is otherwise appropriate for the program. Acceptance or rejection of a placement shall not be contingent upon the child/youth's legal status or the child/youth's stated willingness to agree to placement and/or participate in a designated treatment plan.

Admission Requirements

All RBRS providers must publish clear admission and exclusion criteria for their programs. If placement of a child/youth who is referred by the department is rejected, the administrator of the facility must submit a denial letter to the referral agent and the OCS Residential Care Program Manager detailing the child/youth's specific behaviors and problems that are not able to be addressed in their program and any other reasons for rejection.

RBRS providers with a utilization rate of custody and non-custody clients below 80 percent in any month must submit a report for that month to the Residential Child Care Program Manager, detailing the reasons for low utilization.

If a provider refuses to accept referred children/youth who meet the RBRS criteria, or repeatedly delay acceptance for unnecessary and unreasonable periods of time, the department may perform an on-site review of the facility's program, including policies and practices. This may include developing a plan of correction, and may mandate additional requirements, followed by reducing or terminating funding to enforce the grant agreement or taking other actions to ensure proper utilization of RBRS beds.

Required Approval for Admitting a Child/Youth to Residential Child Care

- Approval to place a custody child/youth in residential care is required by the department staff responsible for the child/youth in custody (OCS or DJJ).
- For referrals received on behalf of children/youth who are not in department custody, the referring guardian, parent, community facility, out-of-state treatment facility, or other state agency must request an authorization for Non-Custody Placement to the OCS Residential Care Program Manager, using an approved form provided by OCS before a child/youth can be placed at the facility.
- Written documentation of the approval for a child/youth to be placed in residential child care must be kept in each child/youth's file.

Admissions Approval for Level II

- For Level II Emergency Assessment and Stabilization Centers, a child/youth may enter placement on his/her own or may be brought by police, a parent, a community RBRS provider, or an OCS or DJJ worker.

- When a child/youth is self-referred for emergency placement in a Level II facility, the RBRS provider shall notify OCS, DJJ or the caregiver, as appropriate, of the placement.
- For children/youth in department custody, placement in a Level II facility must be approved by the child/youth's OCS or DJJ worker within 24 hours of placement.
- For children/youth who are not in department custody, the RBRS provider must request authorization from the department by submitting an Authorization for Non-Custody Placement form (see OCS/RCCY Web site http://www.hss.state.ak.us/ocs/ResidentialCare/) to the Residential Care Program Manager within 24-hours of the child/youth being placed at the facility.

Admissions Approval for Levels III and IV

- All children/youth in department custody who are placed in Levels III and IV Residential Care must be referred by the OCS Regional Placement Committee (RPC).
- Before a child/youth in custody may be placed in residential child care, the Regional Placement Committee, chaired by the OCS psychiatric nurse, must review the need for the child/youth's placement and give written approval for residential care.
- Approval for non-custody placement in residential child care must have pre-approval from the Residential Care Program Manager for Levels III and IV, and Level II as indicated below.

Other required approvals are summarized in the following table.

Approval Matrix for Additional Staff, Held Beds & Non-Custody Child/Youth
(Forms are available at the OCS/RCCY Web site http://www.hss.state.ak.us/ocs/ResidentialCare/)

Request	Additional staff or funding for additional staff needed to maintain youth in care	Held Bed Prior to Placement Note: Facility must be at 80% capacity or higher to qualify for held bed days.	Placement of Non-Custody Children in Level II, III or IV
Approval	0-7 days – Social Worker IV or Juvenile Probation Officer III Over 7 days - RCCY Program Manager	0-3 days - in Level II: Social Worker IV or Juvenile Probation Officer III 0-7 days - in Level II, III or IV: Children's Services Manager or Juvenile Probation Officer IV 0-7 or over 7 days RCCY Program Manager	Social Worker, Probation Officer, RBRS provider, parent or legal guardian may make request 0-7 days - in Level II: Children's Services Manager or Juvenile Probation Officer IV All others - approval by RCCY Program Manager
Services	A supplemental rate to be paid in addition to the daily rate to meet staffing ratios, to meet special needs, or to ensure safety	Ability to "hold" a bed while arranging for the child/youth's placement and payment eligibility	Placement of a non-custody child/youth and approval for payment
Timeframe	Only once per placement for no more than 7 days RCCY Program Manager must approve any time that exceeds 7 days	15 days total during the placement in the facility. Under unique and temporary circumstances, additional funding beyond 15 days may be requested of the RCCY Program Manager.	Level II: prior to placement or if after hours or weekend, accept youth and submit the request for authorization form within 48 hours to RCCY Program Manager Level III and IV: prior to placement
Documentation	Submit treatment plan approved by supervising Social Worker or Juvenile Probation Officer. Justification must accompany attendance sheet for period in question	Submit treatment plan approved by supervising Social Worker or Juvenile Probation Officer. Justification must accompany attendance sheet for period in question	Non-custody placement form must be signed by parent or legal guardian Must apply for Medicaid immediately upon placement
Forms	**Additional Staff Request Form** must accompany attendance sheet for period in question	**Hold Bed Request Form** must accompany attendance sheet for period in question.	**Authorization for Non Custody Placement Form** must accompany attendance sheet for period in question

Basic Care Requirements

All levels of residential child care programs must employ or otherwise provide for the services of a mental health professional, social worker, or psychologist for the purpose of providing consultation to staff, training, client assessment, and individual treatment planning. All other staff must meet the requirements as outlined in the section of this handbook dealing with Staff Qualifications.

Service activities and supervision for each child/youth are based on an assessment and individual treatment plan of care that is monitored for beneficial behavioral changes in the child/youth's life, and effectiveness in reducing the need for supervision, rehabilitation services, and residential care.

All RBRS providers of 24-hour residential child/youth care and Residential Behavioral Rehabilitation Services must deliver services at the basic care level. Basic care for children or youth is planned, structured supervision by professionally trained staff for 24-hour services. Behavioral modification approaches such as token economy systems, positive peer culture, or family reengineering are provided by professional staff able to include working with either the biological, foster, or adoptive family to aid in the transfer of the child/youth to their home or an alternate permanent residence.

Basic services for children/youth in residential child care treatment contain elements common to all levels of residential care regardless of size, location, program category, or treatment modality. These elements include:

1. Provide medical, psychiatric, dental, and psychological evaluation and therapy as needed;
2. Assess each child/youth placed in care and verify whether a health examination has been performed within one year before placement, or arrange for completion of a health exam within 30 days of placement;
3. Provide continuing medical and dental services according to the EPSDT schedule set forth in 7 AAC 43.452 after 30 days in placement;
4. Obtain evidence of immunization records no later than 30 days after a child/youth is placed in care;
5. Assist in preservation of biological or foster families who are caring for children/youth with severe emotional or behavioral problems and promote timely reunification when appropriate and when children/youth are removed from the home or other types of placement;
6. Maintain children/youth as close to their family, community, and region as possible when planning subsequent care;
7. Provide healthy food, including healthy meal preparation and nutritional oversight;
8. Provide clothing as needed during the term of stay in care;
9. Provide personal incidentals including resident allowances and school supplies;
10. Provide daily supervision at a minimum as prescribed in 7 AAC 50.410;
11. Provide vocational, educational, and employment services either in the community or by service agreements – providers are strongly encouraged to work with their local community behavioral health centers to obtain assessments and continued care services;
12. Provide liability insurance with respect to the child/youth;
13. Provide administrative oversight of the program of care and services for residents, as well as for management;
14. Provide appropriate personnel, fiscal, and staff supervision;
15. Provide intake, individual treatment planning, case review, resident supervision, counseling, and discharge planning;

16. Develop and maintain linkages with providers of ancillary services such as medical care, education, and community mental health services;
17. Ensure compliance with individual treatment plan reporting and monitoring requirements;
18. Provide group recreation and informal educational activities and the equipment and personnel to conduct such activities;
19. Provide tutoring and/or supervised study and learning for school age residents;
20. Provide youth ages 14 and older and who are in their care for longer than three months in completion of the Ansell Casey Skills Assessment. Assessment results should be used in case planning to identify services to improve life skills.

Required Staff to Child/Youth Ratios

Level	**Level of Care**	**Staff: Child/youth Ratio**
II	Emergency Stabilization & Assessment Shelter (ESAS) ESAS for children under 30 months Awake Night Staff Awake Night Staff for under children 30 months	1:5 1:3 1:12 1:5
III	Residential Child/youth Care Treatment Awake Night Staff	1:5 1:12
IV	Residential Diagnostic Treatment Awake Night Staff	1:3 1:12

Incident Reports

All RBRS providers at all levels must document behavioral incidents of child/youth residents. The child/youth's file must contain incident reports that impact any level of treatment (i.e. a child/youth's level of freedom, change in treatment plan, etc.)

Death or a suicide attempt of a child/youth while in care must be reported immediately (within a minimum of 24 hours) to the Residential Care Program Manager and appropriate members of the child/youth's treatment team which include the parent, the OCS Social Worker/DJJ Probation Officer (or both if appropriate), Licensing and Behavioral Health. Other members of the child/youth's treatment team may be included as appropriate.

Providers must report death, suicide, and all other behavioral incidents, using a form provided or approved by the department, and must follow the instructions on the form. Forms are available on the OCS/RCCY Web site http://www.hss.state.ak.us/ocs/ResidentialCare/.

Suicide Prevention

Children/youth in need may sometimes pose a heightened risk of self-harm. The RBRS provider must maintain a suicide prevention program that provides for the identification and response to individuals at risk of self-harm and suicide. The program must include: staff training, identification/referral, assessment, communication, facility safety check, levels of observation, intervention, reporting, and follow-up mortality review.

The department provides training and guidance regarding Suicide Prevention through the department's RCCY Training Grant. RBRS providers may use the Gateway Model or another equivalent model that must be approved by the OCS Residential Care Program Manager.

Discharge Planning
Discharge planning for a child/youth in care starts at the time of placement and should focus on a community-based discharge aimed at family reunification or alternative long-term placement. Resources may be available in a community that will assist with family reunification, transitioning youth to another facility or to independent living. RBRS providers are strongly urged to be aware of the resources available in their community and to use those services that are available for transitioning activities.

Discharge
RBRS providers may not discharge children/youth from their program without "successfully completing treatment" as agreed upon by the department staff (i.e. Social Worker, Probation Officer). Any other discharge will be considered noncompliance with the grant agreement and RBRS provider agreement. Under 7 AAC 78.090 and 7 AAC 78.100, this is a mandatory consideration and may jeopardize future funding.

When a child/youth presents an imminent risk of harm to themselves or others for which the RBRS provider is unqualified to respond under the level of care for which the program has entered into an agreement, the RBRS provider must contact the OCS Residential Child Care Program Manager within 24 hours upon discharge of the child/youth.

A RBRS provider shall limit emergency discharges to situations where the health or safety of a child/youth, other residents, or staff would be endangered by continued placement in the facility. Disruptive or runaway behavior does not constitute grounds for rejection or discharge of a child/youth that is otherwise appropriate for the program. Acceptance or rejection of a placement may not be contingent upon the child/youth's legal status or the child/youth's stated willingness to agree to placement and/or participate in a designated plan of care.

ADMINISTRATION & PERSONNEL

Governance

If a facility is not governed by a board or other body, policy for the operation and management of the facility shall be determined by the operator of the facility or by the administrator if the authority to determine policy is delegated to the administrator by the operator.

Responsibilities of a Governing Body of Residential Child Care Facilities

Governing entities of a Residential Child Care Facility must comply with 7 AAC 50.100. If a residential child care facility is governed by a board or other body, the board or other body shall comply with 7AAC 50.100. Implementation of the policies of the facility is the responsibility of the administrator.

Staff Qualifications

All staff having contact with children or youth in residential care must meet all statutory, regulatory and licensing requirements for staff. The general staff qualifications for residential child/youth care RBRS providers are described in the following regulations and statutes (see Appendix 2):

- 7 AAC 50.210, Qualifications and Responsibilities of Persons Having Regular Contact with Children in a Facility, and
- 7 AAC 50.220-250, Caregiver Age Requirements and Additional Staff Qualifications in Residential Child care Facilities and Additional Qualifications For Adolescent Caregivers
- AS 47.05.300 – 47.05/390 and 7 AAC 10.900 – 7 AAC 10.990 (Barrier Crimes, Criminal History, Checks, and Centralized Registry)

Note: Residential child care providers (staff) who do not meet the minimum qualification requirements may be hired with the condition that these staff will, within six months of hire, receive OCS approved core training or certification in residential childcare. OCS will contract to provide core training and/or certification in residential childcare training to residential child care staff at no cost to the employee.

Mental Health Professional

The term "mental health professional" as used in this document and in 7 AAC 50 is intended to comply with the definition of that term under AS 47.30.915 (see Appendix 1), but exceptions may be approved on a case-by-case basis in circumstances involving a unique or temporary condition. A request for an exception may be submitted to the Residential Care Program Manager within 15 days of the occurrence of the unique or temporary condition.

CPR Requirements

A residential child care facility shall have on duty at all times **at least one caregiver with a valid first aid and cardiopulmonary resuscitation (CPR) certification**, unless the courses for these certifications are not regularly available in the community in which the facility is located. If certification courses are not regularly available, the facility shall enroll one or more employees in the first available first aid and CPR certification course offered in the community. A certified emergency medical or trauma technician or duty satisfies the requirements of this subsection. Caregivers of young children shall enroll in infant and pediatric first aid and CPR in communities where infant and child first aid and CPR are regularly available.

Staff Orientation Requirements
A facility with one or more employees or contractors shall provide a minimum eight-hour orientation that must begin at the time of employment and be completed within eight weeks and include:

1. The facility's policies and procedures, including responsibilities of the caregiver;
2. Satisfying special needs of specific children/youth, where appropriate;
3. Emergency procedures and health and safety measures

Staff Training Requirements
A residential child care facility shall ensure that all employees receive a minimum of 15 hours of training a year. A caregiver may count orientation and pre-service training hours required that exceed six hours toward the 15 hour requirement. Training hours required in this section are clock hours and may include any training that is relevant to the caregiver's primary job responsibilities. A facility may count informal training that increases caregiver skills. Documentation must include the date, subject, method of training, and the name of the person who conducted the training.

Facilities are encouraged to include Core Training Components in meeting the 15-hour training requirement. Core Training Components are as follows:

- Professional role of child care workers
- Child development
- Relationship building
- Communication Skills
- Teaching Discipline
- Clinical Diagnoses
- De-escalation and crisis intervention including approved passive restraint techniques
- Clinical Issues such as FASC, trauma, substance abuse, etc

A residential child/youth care facility where passive physical restraint might be used shall ensure that a caregiver is trained in passive restraining techniques before being allowed to passively restrain any child/youth in care.

***The Office of Children's Services (OCS) recognizes that programs have unique needs and challenges that preclude a one-size-fits-all approach to care training. Programs may request approval to use alternative methods for achieving care training for entry-level child/youth care workers. OCS will contract to provide core training to RBRS providers at no cost to the employee.**

OVERSIGHT, FINANCIAL REIMBURSEMENT, AND MEDICAID PAYMENTS

There are multiple entities involved with management and oversight of residential care. The following table outlines responsible parties regarding various issues related to the program oversight of residential care facilities:

Division	Issues of Concern	Contact	Authority
DHSS, Division of Public Health	Licensing of Facility	Licensing Unit	Authorize facility licensure to operate
DHSS, Office of Children's Services	Program Oversight, budget management,	RCCY Program Manager	Authorize grant and grant budget to grantee Authorize Core Grant and RBRS payment to grantee Authorize child placement Authorize ISA payment Overall program management
DHSS, Office of Children's Services	RBRS Payment processing	RCCY Accounting Technician	Receive and process monthly RBRS payment
DOA, Grants and Contracts	Processes grant documents and core payment	RCCY Grant's Administrator	Receive and process grant documents and quarterly core payment

Medicaid Enrollment for Residential Care RBRS Providers

All OCS grantees that provide residential child care and Residential Behavioral Rehabilitation Services are enrolled as a Medicaid RBRS Provider under the Residential Behavioral Rehabilitation Services category. The Medicaid Enrollment Form is completed and signed by an authorized grantee representative and returned to the OCS Medicaid Administrative Assistant MMA along with the signed Grant Award. OCS bills Medicaid on behalf of grantees and all grant payments will come from OCS.

The department is researching and considering the possibility of requiring RBRS providers to bill Medicaid directly, but that would be implemented only after consultation, training, and collaboration with RBRS providers, and after public notice, opportunity for public comment, and review and approval by the Department of Law.

Approved Medicaid Services for RBRS Grantees

A RBRS provider that has a grant from the Division of Behavioral Health may bill for clinical mental health services provided while participating in the RBRS system. The Clinical services under Medicaid can be billed along with RBRS.

RBRS Providers	
Non-Billable Activities	**Medicaid Billable Clinic Services**
Medication Administration	Crisis Intervention
Functional Assessment	Family Psychotherapy
Case Management	Group Psychotherapy
Family Skill Development	Individual Psychotherapy
Individual Skill Development	Pharmacologic Management
Group Skill Development	Intake Assessment
Day Treatment	Psychological Testing and Evaluation
Recipient Support	Psychiatric Assessment

Other Medicaid Services Billable under this Residential Care System
The only Medicaid services that may be billed concurrently with RBRS are Clinic Services as noted above. Mental health rehabilitation services (e.g., case management, family/individual/ group skills development, day treatment or recipient support services) are included under the service components for RBRS and may not be billed at the same time as RBRS.

A RBRS provider may provide and bill Medicaid for clinical services on the same day as RBRS when these services are documented in the child/youth's individual treatment plan of care as regarded as necessary and the RBRS provider follows all Medicaid requirements including eligibility and limits for service. Those RBRS providers who will directly provide Medicaid clinical services to children/youth must also have a Medicaid RBRS Provider number, or apply to obtain one, and seek Medicaid reimbursement for clinical services. OCS will not bill Medicaid on behalf of RBRS providers for clinical services that are provided. The Medicaid reimbursements for clinical Services a RBRS provider receives in addition to RBRS grant funds must be treated as grant income, and be used to enhance services, according to the provisions of 7 AAC 78.210 (see Appendix 2).

Individual Service Agreement (ISA)
ISAs are a funding mechanism used to support youth in in-state RCCY facilities. ISA funds are negotiated annually and considered funds of last resort to be used when other funding sources are not available or allowable. RBRS providers may solicit additional ISA funds for children/youth who require enhanced services in order to maintain placement in an in-state facility. An ISA Request for Funding form may be found on the OCS/RCCY Web site http://www.hss.state.ak.us/ocs/ResidentialCare/

Payment Documentation Requirements
RBRS providers who receive payment from OCS for providing these services must document that they were provided each day to each child/youth. Documentation is required to be available upon request as follows:

1. Up Front Risk Screen
Completion Time Frame: Immediate at Intake
A risk screen should be used at the time of intake to determine the child/youth's level of risk and should be reviewed by a mental health professional. If no immediate need is identified from the Risk Screen, a child/youth in placement in a Level II facility for less than five days who receives this screen, does not need further assessment, and a brief plan of care must be developed within five calendar days of admission.

2. Brief Plan of Care/Initial Assessment
Completion Timeframe: Level II: 5 days, Level III & IV: 15 days
As specified in 7 AAC 50.330 and 7 AAC 50.610, residential child/youth care facilities must observe and assess each child/youth who is admitted for care and develop an initial Brief Plan of Care signed by a mental health professional within five days for Level II Emergency Stabilization and Assessment shelters and within 15 days after a child/youth's admission in a Level III and IV facility. RBRS providers may use assessments completed within six months prior to admission to satisfy this requirement if the program mental health professional reviews and provides an update to the previous assessment within the required timeframes.

3. Child/Youth Individualized Assessment and Treatment Plan
Completion Time frame: All Levels: Within 30 days
The formal assessment must be conducted by a mental health professional and the individual treatment plan must include: identification of child/youth's immediate and specific needs beyond fundamental care assessment of child/youth and family's strengths and weaknesses, and clearly stated goals, specific treatment objectives with services and timeframes to meet these goals. The treatment plan must include continued care planning and discharge planning for family reunification or long-term placement. The treatment plan may be developed by qualified staff but must be approved by a mental health professional.

4. Child/Youth - Daily Progress Notes
Completion Time frame: Daily
Daily progress notes are required to confirm the each child/youth was present and participated in the day's residential care service activities. Progress notes must document the services the child/youth received in addition to participation in the milieu (e.g.: individual, group or family counseling, clinical services, discharge planning, etc.). Notes must reflect each child/youth's progress toward specific behavioral goals.

PROGRAM CORE AND RBRS FUNDING

To ensure ongoing capacity in a facility, RBRS providers are eligible for Core Capacity funding without regard to occupancy in a bed. Core funds use state general funds allocated on an annual basis through the legislative process, not Medicaid funds.

Core Capacity is funded through a grant award under 7 AAC 78 (see Appendix 2). This grant ensures the RBRS provider will be reimbursed for the amount expended in a fiscal year. No funding will be reimbursed over and above the total dollar amount identified on the provider's Cumulative Fiscal Report or above their approved grant award.

Core funding is $40 per bed (x 365 days for a full year grant award) and is paid regardless of whether beds are utilized. Examples of payment structures are as follows:

Condition	Payment
Bed is not utilized by child/youth	Core $40 per day
Bed is utilized by child/youth	Core $40 per day + RBRS Rate
Bed has an approved "hold" for allowable absence	Core $40 per day + RBRS Rate
Bed has an approved "hold" in anticipation of placement of child/youth	Core $40 per day + 50% of RBRS Rate if at 80% utilization

Funds awarded are based upon the level of RBRS provided. The base rates are:

Level of Care	Core Capacity	RBRS Rate	Combined Core and RBRS for Custody or Non-Custody Child/youth
Level II Emergency Stabilization & Assessment	$40	$155	$195
Level III Residential Treatment	$40	$202	$242
Level IV	$40	$275	$315

Geographic Differential Rate

Geographic Differential Rates attempt to compensate rural RBRS providers for the difference in the cost of living in rural Alaska. Geographical differential rates are published with the Request for Proposals on an annual basis.

Examples of RCCY Funding Calculations

Each RBRS provider has an approved number of beds agreed upon in the grant agreement.

Core Funding: Each RBRS provider with a Residential Child Care Grant receives 95 percent of their Core Capacity funding at the beginning of the grant fiscal year in the amount of $40 per bed per day for 365 days in a year. The RBRS provider must submit quarterly reports of expenditures to date to provide documentation of expenditures. The remaining five percent Core funding is awarded after reviewing and approving the year-end reports that indicate that 100 percent funding is appropriate based on expenditures.

Quarterly Reports of Core grant funding expenditures must be submitted to the Grant Administrator via Egrants.

Note: The department will only pay actual expenditures; funds unexpended in any given fiscal year must be returned to the department.

The RBRS provider will receive monthly payment based upon their utilization in the previous month. A RBRS Monthly Report form must be submitted to the Residential Care Program Manager and the RBRS Accounting Technician via email. Reports include Bring the Kids Home (BTKH), 5 and Under, and community bed reporting mechanisms.

Any additional services provided to a client during the month must be pre-approved and the provider is responsible for submitting the executed approval form with their attendance sheet to the department for payment.

See Program Reporting (next page) for more information related to submission of financial information for reimbursement.

PROGRAM REPORTING REQUIREMENTS

RBRS providers must submit monthly and quarterly reports that provide information about services rendered and request for payment. These reports must be submitted on forms provided by the department. Forms referred to in this handbook are available on the OCS/RCCY Website http://www.hss.state.ak.us/ocs/ResidentialCare/

Daily Utilization Report (Submit On-Line)

RBRS providers are required to report changes to their facility population to the RCCY website via the Internet in response to the RCCY e-mail sent daily to facility staff. Information is to be input on the OCS/RCCY Web site http://www.hss.state.ak.us/ocs/ResidentialCare/

Monthly Reports (Submit: RC Program Manager and RBRS Accounting Technician)

Monthly Attendance Reports

RBRS providers are required to submit to OCS Attendance Reports within five days of the close of the previous month, indicating the child/youth was present and receiving Residential Care services. The attendance sheets must clearly indicate the total number of children/youth in attendance each day and each child/youth's status, using the following OCS attendance codes:

Attendance Codes for Payment

Code	Situation	Conditions
[P]	**Present**	at facility and receiving RBRS
[R]	**Runaway**	Payable up to 5 days per incident
[V]	**Home Visit**	Payable up to 15 days per placement – additional days require RCCY Program Manager approval **before** additional home visit days will be paid
[F]	**Youth Facility**	Payable up to 15 days per placement – additional days require RCCY Program Manager approval **before** additional youth facility placement days will be paid
[O]	**Other**	Payable up to 15 days per episode of "temporary placement out of RCCY for alternative treatment" - in order to be reimbursed for these days, documentation of this event and the effect on the child/youth's course of treatment is required and must be approved by the RCCY Program Manager
[D]	**Discharged**	No payment for this day
[M]	**Medical Hospitalization**	Payable up to 15 days per placement for acute psychiatric or other hospital care – additional days require RCCY Program Manager approval **before** additional days will be paid
[H]	**Hold**	Payable up to 7 days when a child/youth has been accepted for placement in the program and has an anticipated placement date – payment at 50% of standard RBRS Rate

In order for a RBRS provider to receive payment for the full daily RBRS rate, the child/youth must be in one of the preceding "attendance categories" with the exception of "Hold days" [H], which will be paid at 50 percent of the RBRS rate and "Discharge days" [D] which are not reimbursable. All approved authorizations must be submitted with attendance reports to ensure timely payment.

Extensions may be approved by the Residential Care Program Manager on a case-by-case basis. A request for an extension must be submitted in writing (by e-mail and/or fax), explaining the need for the extension request and how it relates to the individual's treatment plan and the discharge plan. Extensions must be approved before additional payment will be paid.

If multiple attendance categories "run together" on an attendance report and exceed 15 days, written approval must be obtained from the Residential Care Program Manager before the absence occurs, or immediately upon discovery. When there is a need to evaluate a specific child/youth's combination of attendance and absences due to repeated patterns, the RBRS provider should record the attendance and absences on the attendance sheet and submit the child/youth's treatment plan with the attendance report. The Residential Care Program Manager will review and make final approval of the number of days that will be paid.

Quarterly Reports
RBRS providers are required to turn in the following reports quarterly on forms provided by the department for submission of this information. Forms may be found on the OCS/RCCY Web site http://www.hss.state.ak.us/ocs/ResidentialCare/

1. Program Narrative reporting program general status
2. Fiscal Report reporting use of Core Funds
3. Data Reports
    a. Total number of children/youth referred, accepted, and denied admission for quarter
    b. If referral refused, DSM IV, GAF, IQ clinical rational for denial)
    c. Total discharged after completing treatment
    d. Total discharged without completing treatment
    e. Number of ISA requests, ISA requests approved and denied and number of youth maintaining placement due to ISA support
4. Individual Child/Youth Reports for any Child/Youth in Care During the Quarter
    a. Length of stay in treatment
    b. Level II – Number of FASD Clients
    c. Level III-IV
    d. Diagnosis at client discharge
    e. Increase in GAF Scores
    f. Significant progress toward individual treatment goals
    g. Average length of time from referral to admission into program
5. Staff Reporting Criteria
    a. Staff training provided since last report
    b. Report of any noncompliance with staff training requirements
6. Program Evaluation Results

NOTE: Providers are strongly urged to utilize AK Aims as a reporting mechanism for RCCY activity. Use of AK Aims will make it possible for providers to utilize AK Aims for BRS data reporting; the RCCY Logic Model for reporting staff and incident reporting information; and a program narrative to report general program status in lieu of the narrative information outlined above.

The department encourages, and intends to require in the future, that RBRS providers assess their services for effectiveness, efficiency, and customer satisfaction, and to have a plan for using that information to improve their service outcomes as documented in the facility's policy and procedures. Outcome assessment before, during treatment, at discharge, and at regularly scheduled points following discharge to determine the efficacy of the treatment model used by the program is strongly encouraged. *RBRS providers are encouraged to use those instruments adopted by Behavioral Health including:*

- *The Alaska Screening Tool (AST)*
- *The Client Status Review (CSR)*
- *The Behavioral Health Consumer Survey (BHCS)*

Further information can be found at:
http://www.hss.state.ak.us/dbh/AKAIMS/default.html

The RBRS provider must report on forms provided by the department:

a. Student Satisfaction
b. Child/youth and parent report satisfaction
   - With access to treatment planning and assistance
   - With communication with treatment and case management staff
   - With Residential Behavioral Rehabilitation Services
c. OCS/DJJ worker report
   - Referral and application process helpful
   - Access to treatment planning and assistance
   - Satisfactory communication with treatment and case management staff
   - Satisfaction with Residential Behavioral Rehabilitation Services
d. Facility accepts children/youth as described in agency proposal

Other Reports
RBRS providers are also required to provide cost reports and random moment studies based on utilization of Title IV-E funding. The Title IV-E program reimburses the State of Alaska for expenditures associated with child/youth specific maintenance (room/board/supervision) and related administrative expenditures of those children/youth in OCS custody in residential care. These expenditures are calculated from the facilities attendance records, the child/youth's Title IV-E eligibility status, and facility ratios resulting from the annual random moment time study. Children/youth served by the Division of Juvenile Justice (DJJ) and non-custody children/youth are not eligible for the Title IV-E program. Children/youth served by both DJJ and OCS, may qualify for Title IV-E if OCS has placement authority.

Federal Title IV-E and cost allocation rules require the facility to provide annual operating expenditures and the results of an annual random moment time study (RMTS) on record. This information provides the basis or facility ratios for the quarterly Title IV-E claim.

Guidelines for Supplemental Requests
In some cases, a child/youth placed in a residential child care facility require additional supervision or beds held for them for additional days to complete a medical or detention placement. All expenditures are based on documented needs of the child/youth and authorization must be requested prior to placement.

See the Approval Matrix for Additional Staff, Held Beds & Non-Custody Children under the General Program Requirements section of this handbook to ensure appropriate approvals are in place with regard to billing for services.

ON-SITE PROGRAM REVIEW & MEDICAID AUDIT

The OCS will conduct on-site reviews of RBRS programs to ensure the statewide RCCY system of care is meeting federal funding requirements. Statewide or regional staff from OCS, DJJ, Public Health, Behavioral Health and an internal auditor may assist the OCS Residential Care Program Manager in conducting these reviews. Results obtained from these reviews will be used to support and provide technical assistance to RBRS providers, and help RBRS providers with program development as performance indicators for future funding. On-site reviews will occur at any time a report of concern is received regarding the RBRS provider, at any time the Residential Care Program Manager deems appropriate, or every other fiscal year.

RBRS providers may also be selected by the department to participate in random Medicaid Audits. The following grid outlines the items that will be reviewed and used as standards for audits and site reviews.

Standard	
1	Formal authorization for child/youth placement in a residential care facility is documented by: Level II: signed approval by child/youth's Social Worker or Juvenile Probation Officer on admitting documents. Level III & IV: signed approval from RPC or RCCY Program Coordinator for non-custody placement
2	An initial assessment (Brief Plan of Care [BPOC]) has been completed that contains the following: • Findings of evaluation of the child/youth • Identification of the child/youth's immediate and specific needs • Demonstration that the child/youth's needs meet the Medical Necessity Criteria • Signed by a mental health professional Level II: Assessment can be completed up to six months prior to intake but must be completed within five days of admission and must be signed by a mental health professional Level III & IV: Assessment can be completed up to six months prior to intake but must be completed within 15 days of admission and must be signed by a mental health professional
3	A treatment plan reflecting the findings of the initial assessment conducted by a mental health professional that complies with the following: • Treatment plans must be signed by a mental health professional • Plans must describe the interventions that will help the child/youth obtain their goals, not simply a list of services that will be provided to that child/youth • Plans must specifically address the child/youth's discharge plan such as moving to a less restrictive setting or back to a home setting. Also, anticipated discharge updates in the three-month Treatment Plan Updates should give an accurate update as to how child/youth and family (if involved) are progressing toward discharge. • The plan's goals must relate closely to diagnosis. • The goals, objectives and interventions should vary across differing diagnosis and clearly stated individual goals, specific treatment objectives, approaches or activities planned, time frames to meet goals/objectives, task assignments to meet the needs of child/youth and child/youth's family. Level II: the assessment must be completed within 15 days of admission, a treatment plan developed with a treatment team within 30 days of admission and reviewed every 15 days thereafter Level III & IV: the assessment and treatment plan must be completed within 30 days of admission and reviewed every three months thereafter

4	A Daily Attendance Record that documents one of the following: • Child/youth was present and participating in RCCY services OR • Child/youth was in another status (bed being held, run, home visit, etc)
5	Daily individual progress notes that must: • Be completed in a timely manner • Be completed for every shift on each day the service is provided • Be signed by the individual provider who worked with the child/youth • Describe the service provided by the date the service occurred, and the duration of the intervention • Describe the child/youth's progress toward identified treatment goals.
6	Treatment Progress is documented in a Quarterly Progress Review as evidenced by: • Evaluation of progress toward meeting identified specific needs and goals • Identification of any new needs or goals including strategies to meet goals • Update of child/youth's estimated length of stay • Update on discharge planning and needed resources • Reasons for retaining in program if child/youth is showing limited progress toward meeting goals and objectives • Signed by treatment team members including the child/youth and parent/guardian (or proof it was sent)
7	File document Discharge Plan with measurable outcomes: • Plan developed/outlined at intake • Planning incorporates change/progress in child/youth 's treatment • Planning includes family • Planning includes treatment team meetings with child/youth's workers • Plan includes detailed, specific followup plan, in conjunction with community agencies when child/youth is discharged from the facility

APPENDIX 1: DEFINITION OF MENTAL HEALTH PROFESSIONAL

AS 47.30.915 and 7 AAC 50.990:

> "mental health professional" means a psychiatrist or physician who is licensed by the State Medical Board to practice in this state or is employed by the federal government; a clinical psychologist licensed by the state Board of Psychologist and Psychological Associate Examiners; a psychological associate trained in clinical psychology and licensed by the Board of Psychologist and Psychological Associate Examiners; a registered nurse with a master's degree in psychiatric nursing, licensed by the State Board of Nursing; a marital and family therapist licensed by the Board of Marital and Family Therapy; a professional counselor licensed by the Board of Professional Counselors; a clinical social worker licensed by the Board of Social Work Examiners; and a person who
>
> (A) has a master's degree in the field of mental health;
>
> (B) has at least 12 months of post-masters working experience in the field of mental illness; and
>
> (C) is working under the supervision of a type of licensee listed in this paragraph;

NOTE: Definitions of other terms used in this handbook are set out in applicable statutes and regulations.

APPENDIX 2: APPLICABLE STATUTES AND REGULATIONS

APPLICABLE STATUTES

NOTES: A provider subject to this handbook may also be subject to state and federal statutory requirements that are not listed here. This list includes only those statutes referred to in this handbook.

The official version of the Alaska Statutes is the published version. An electronic version may be found in the Alaska State Legislature's infobase at http://www.legis.state.ak.us/default.htm, but that version may not always reflect recent amendments.

AS 47.40. PURCHASE OF SERVICES
Article 01. PURCHASE OF SERVICES FOR MINORS

AS 47.40.011. Purchase of services.
AS 47.40.021. Licensing and supervision.
AS 47.40.031. Required accounting procedures.
AS 47.40.041. Grants.
AS 47.40.091. Definitions.

AS 47.32. CENTRALIZED LICENSING AND RELATED ADMINISTRATIVE PROCEDURES

AS 47.32.010. Purpose and applicability
AS 47.32.020. Requirement to obtain a license
AS 47.32.030. Powers of the department; delegation to municipality
AS 47.32.040. Application for license
AS 47.32.050. Provisional license; biennial license
AS 47.32.060. License renewal
AS 47.32.070. Notice of denial or conditions; appeal
AS 47.32.080. Posting; license not transferable
AS 47.32.090. Complaints; investigation; retaliation
AS 47.32.100. Cooperation with investigation
AS 47.32.110. Right of access and inspection
AS 47.32.120. Report
AS 47.32.130. Enforcement action: immediate revocation or suspension
AS 47.32.140. Enforcement actions
AS 47.32.150. Hearings
AS 47.32.160. Immunity
AS 47.32.170. Criminal penalty
AS 47.32.180. Confidentiality; release of certain information
AS 47.32.190. Access to information
AS 47.32.200. Notices required of entities
AS 47.32.900. Definitions

APPLICABLE REGULATIONS

NOTES: A provider subject to this handbook may also be subject to state and federal regulatory requirements that are not listed here. This list includes only those regulations referred to in this handbook.

The official version of regulations in the Alaska Administrative Code is the most current version of the regulations as published by the publisher. An electronic version may be found in the Alaska State Legislature's infobase at http://www.legis.state.ak.us/default.htm, but that version may not always reflect recent amendments.

The hyperlinks provided below to that infobase are to the versions of these regulations that were available online, as amended through March 2009. The infobase is updated shortly after each quarterly publication of revisions is received from the publisher, so it will be necessary to use the search function at the infobase to find the most current version available online.

Chapter 10

7 AAC 10 - Licensing, Certification, and Approvals

Article

1. Purpose, Applicability, and Administrative Provisions. (7 AAC 10.010 - 7 AAC 10.015)

Section

10. Purpose of chapter.
15. Applicability of chapter.

2. Reserved.

3. Barrier Crimes, Criminal History Checks, and Centralized Registry. (7 AAC 10.900 - 7 AAC 10.990)

Section

900. Purpose and applicability; exceptions.
905. Barrier crimes.
910. Request for criminal history check.
915. Criminal history check.
920. Provisional valid criminal history check.
925. Monitoring and notification requirements.
930. Request for a variance.
935. Review of request for a variance.
940. Posting of variance decision required.
945. Revocation of valid criminal history check or variance.
950. Request for reconsideration.
955. Centralized registry.
960. Termination of association.
990. Definitions.

Chapter 50

7 AAC 50 - Community Care Licensing

Chapter 53
7 AAC 53 (Social Services)

Article 5 Residential Child Care Facility Grants

Chapter 78

7 AAC 78 - Grant Programs

Section