ADDENDUM E
OUTPATIENT SERVICES

This Addendum E amends, modifies, and supplements that certain Agreement for Purchase of Services ("Agreement") between the Fairfax-Falls Church Community Policy and Management Team ("CPMT") or the Fairfax County Department of Family Services ("DFS") or the Fairfax-Falls Church Community Services Board, as the case may be, hereinafter referred to as the "Buyer" and the provider identified on page 3 of the Agreement for the Purchase of Services, hereinafter referred to as the "Provider". Where there exists any inconsistency between the Agreement and Addendum E the provisions of Addendum E control.

This Addendum E reflects those services in the outpatient and evaluation services typically purchased by the buyer. Services offered by the Provider are defined on the Provider's individualized Rate Sheet.

Terms not otherwise defined herein or on the Rate Sheet shall have the same meanings ascribed to them in the Agreement.

SPECIFIC SERVICE DESCRIPTIONS & REQUIREMENTS

Provider agrees to the following provisions:

I. Evidence Based and Evidence Informed Practices:

The CPMT promotes the use of EBPs in purchased outpatient services and providers agree to be evidence informed in their services and to use EBPs. It is expected that clinicians will use Evidence Based Treatments with fidelity whenever possible. Specific EBT requirements are found in Addendum F: Evidence Based Treatments and is issued to providers qualified to offer the specific service.

II. OUTPATIENT THERAPY-Scheduled therapeutic meetings between the therapist and the individual, generally in an office setting, provided to children and their caregivers or adults assessed as capable of utilizing the intervention. Specific treatment goals and objectives are developed to improve behavior and functioning, reduce symptoms**,** strengthen coping skills, and promote positive emotional growth and development. The therapeutic approach will be consistent with standards of practice for the identified difficulties and diagnoses and be solution-focused and outcome oriented. Each type of therapy has different rate structures based on the credentials of clinician.

A. Treatment Modalities:

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1. **Individual therapy:** Treatment provided to individuals on an hourly schedule, usually in a clinic or similar facility. Interventions are initiated following a mental health assessment with a report provided to the referral source. The assessment shall include a trauma screening. When the client is a child or youth, it is expected that there is a family component to be included at the conclusion of each session. Individual therapy is billed on a per session basis, based on clinician's time. Joint or co-therapy sessions are considered one session and based on one clinician's time.

2. **Family Therapy:** Treatment provided to two or more individuals from an identified family system with the focus of the interventions being to strengthen family relationships and patterns of communication, improve interpersonal boundaries, encourage responsible behaviors, and improve parenting skills. The goals and objectives developed will be implemented in a focused and skill-building manner. Examples of family therapy include but are not limited to parent-child, sibling dyad, and couples. Family therapy is billed on an hourly basis, based on clinician's time, regardless of number of family members in the session.

3. **Group Therapy:** Provided to the individuals who share similar issues or concerns who can benefit from the group process. Recommended group size ranges from 5 to 10 participants depending on the age of participants and focus of the group. Group therapy may be process-oriented, psychoeducational, or curriculum based. Group therapy may be Open (that members may join at any time) or Closed (with participants sharing the same start and end dates). Group Therapy is billed on a per participant per session basis, generally at a lower rate than individual or family sessions. Per session fee remains the same regardless of the number of facilitators/clinicians.

4. **Partial Hospitalization/Day Treatment:** An intensive treatment intervention for either adults or youth with acute psychiatric problems who can be safely maintained on an outpatient level of care. Often when individuals are experiencing a crisis, they are unable to attend school or work. The goal of the intervention is to stabilize the individual in order to return to school and/work and a lower level of care as quickly as possible.

5. **Intensive Outpatient Treatment (IOP):** Intensive Outpatient Treatment programs are a type of specialized outpatient program that provides more structure and a more intensive level of care than standard outpatient therapy while still accommodating the person's home and

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work life. Group and individual sessions are provided more than once per week. IOP is typically offered for individuals with co-occurring disorders such as mental health conditions, eating disorders and/or substance use disorders that are interfering with their functioning at home, school, work, or community.

For substance use specific programs or substance use primary tracks, providers must be in compliance with DMAS regulations for assessments, which must then be provided to CSA staff.

B. Reporting Requirements

1. Initial Assessment and Treatment Plan:

a. The Provider will complete and submit an initial assessment and treatment plan describing the interventions to be provided to the youth and the youth's family in accordance with the Individualized Family Service Plan (IFSP) within 15 business days of the fourth (4^{th}) session of services once initiated.

b. The treatment plan shall be modified, as needed, in collaboration with the Buyer's case manager, the youth, the youth's family, the provider, and other members of the youth/family's team as appropriate.

c. The initial assessment and treatment plan shall include the following components:

1. Assessment summary, DSM diagnoses, and current medications.
2. Goals that are youth, family and behavior specific using the individual and family's own words
3. Crisis safety plan to include provisions during the workday as well as after hours and emergency telephone contact numbers
4. Estimated # of contact hours and frequency of contacts per week
5. Goal of intervention and criteria for successful termination
6. Plan signed by provider and individual and family member(s).

d. The Buyer's case manager serves as the point of contact for the team-based planning process and is responsible for decisions about services rendered in a manner consistent with the service authorization and team-based planning process.

2. Quarterly Progress Reports

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a. The Provider will complete and submit quarterly progress reports every 3 months due by the 15th day of the month following the end of the third month services were delivered.

b. Reports shall be submitted to the Buyer's case manager. Electronic submission via a secure email transmission is strongly encouraged.

c. The report submitted on the Provider's letterhead shall include the following:

1. Provider's legal name, email, and phone number
2. Clinician's legal name, email, and phone number (if different from the biller)
3. Identifying client information to include name of youth and family
4. Progress on goals; Progress towards discharge/transition
5. Significant incidents affecting the youth, including any suicide risk assessments completed
6. Change in therapist, medication and/or agencies/service involvement with youth
7. Current functioning in major life domains (e.g., school, home, community, legal)
8. Dates of service
9. Duration/times of service
10. Location of service
11. Individuals present for service

3. Termination Reporting

a. The Provider will complete and submit a termination report within ten (10) business days after the end of service.

b. The termination report submitted in the Provider's letterhead shall include the following:

1. Provider's legal name, email, and phone number
2. Clinician's legal name, email, and phone number
3. Summary of progress on goals
4. DSM diagnoses and medications at time of discharge
5. Description of functioning in major life domains at end of service (e.g., school, home, community, legal)
6. Information about the clinical needs of the youth.
7. Written recommendations provided to the parent/caregiver for after-care upon discharge that will foster the youth and family's continued recovery and stability. Written recommendations will build upon treatment objectives, strengths, successes, natural supports, and other resources as well as referencing appointments with after-care providers.

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III. ASSESSMENTS & EVALUATIONS: Services to an individual, conducted by appropriately credentialed clinicians utilizing a tool or series of tools to provide a comprehensive review with the purpose to identify strengths and needs, assess function, risk level, severity of symptoms, provide diagnosis, and to make recommendations regarding treatment modalities and intensities. Assessments are not to include level of care recommendations. Assessments include comprehensive clinical evaluation that is designed to establish whether an individual meets criterion for a diagnosis or is in need of mental health services—as well as to guide treatment planning and monitoring of progress in (as well as adverse reactions to) treatment. All evaluations/assessments should include a review of background information provided by the referral source, clinical interview with the subject, and interviews with collaterals. Standardized and appropriate testing should be included for full evaluations. Resulting recommendations may include, but are not limited to, the need for therapy, educational needs, or recommendation for further evaluation. Professionals shall provide a written report including findings and recommendations. Professionals are required to offer a minimum of one debriefing session with the subject and/or guardian of the assessment/evaluation included in the rate for the assessment/evaluation.

A. **Mental Health Assessments –**Use of standard assessment tools including, but not limited to, the Global Appraisal of Individual Needs- Short Screener (GAIN-SS), Multidimensional Behavioral Health Screen (MBHS), Beck Depression Inventory (BDI), Beck Anxiety Inventory (BAI), General Anxiety Disorder-7 (GAD-7), and the Columbia Suicide Severity Rating Scale (C-SSRS). Tools used should be in line with current best practice. May include a Trauma Screening (refers to a tool or process that is a brief, focused inquiry to determine whether an individual has experienced one or more traumatic events, has reactions to such events, has specific mental or behavioral health needs, and/or needs a referral for a comprehensive trauma-informed mental health assessment)

B. **Trauma-Informed Mental Health Assessments** a process that includes a clinical interview, standardized measures, and/or behavioral observations designed to gather an in-depth understanding of the nature, timing, and severity of the traumatic events, the effects of those events, current trauma-related symptoms, and functional impairment(s). Clinicians use this to understand a child's trauma history and symptom profile; to determine whether a child is developmentally on target in the social, emotional, and behavioral domains; to inform case conceptualization and drive treatment planning; and to monitor progress over time. (http://www.nctsn.org/resources/topics/trauma-informed-screeninghttp://www.nctsn.org/resources/topics/trauma-informed-screening-assessment/general-infoassessment/general-info) Includes the use of standard trauma assessment tools including, but not limited to, Child and Adolescent Trauma Screen (CATS), Clinician-Administered PTSD Scale for Children and Adolescents (CAPS-CA-5), Feifer Assessment of Childhood Trauma (FACT), and

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Child Behavior Checklist (CBCL). Tools used should be in line with current best practice.

C. **Psychosexual Risk Assessments** focus on an individual's sexual development, sexual history, paraphilic interests, sexual adjustment, risk level, and victimology. Some components include objective measures such as sexual interest tests, clinical polygraph exams or other psychological testing. It also includes a full social history, familial history, employment/school history, case formulation, and specific treatment recommendations. Are completed by a Certified Sex Offender Treatment Professional (CSOTP). Tools used should be in line with current best practice.

D. **Co-Occurring (Substance Use/Abuse) Assessments** provide a comprehensive examination of psychosocial needs and problems, including the severity of mental and substance use disorders, conditions associated with the occurrence and maintenance of these disorders, problems affecting treatment, individual motivation for treatment, and areas for treatment interventions. Tools used should be in line with current best practice. All substance use assessments should include any assessments required by DMAS regulations. As of FY26, the required assessment is the ASAM assessment (American Society for Addiction Medicine).

1. Examination of the scope and severity of mental and substance use disorders, and conditions associated with the occurrence and maintenance of these disorders
2. Identification of the full spectrum of psychosocial problems that may need to be addressed in treatment
3. Determination of the level of service needs related to mental and substance abuse problems
4. Identification of the level of motivation and readiness for treatment
5. Examination of individual strengths, areas of functional impairment, cultural and linguistic needs, and other environmental supports that are needed
6. Evaluation of risk for behavioral problems, violence, or recidivism that may affect placement in various institutional or community settings
7. Provision of a foundation for treatment planning

E. **Parent-Child Relational Assessment:** Parent-child relational assessments provide a comprehensive evaluation of parent-child relationships. The assessments gather information from parents in an intake interview as well as parental ratings of the child's behavior and their perceptions and understanding of their relationship with the child. All assessments should include direct observations of the parent interacting with the children. Tools used should be in line with current best practice. Assessments are usually completed in 3-4 sessions.

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F. **Psychological Testing** includes clinical interviews, interviews of collaterals, and record review followed by administration, scoring, and interpretation of standardized tests approved by the American Psychological Association. Psychological Assistants may be utilized in the administration of psychological testing when supervised by a licensed practitioner and so long as the supervising licensed practitioner and not the psychological assistant agrees to testify in court, if required. Choice of tools and tests shall be current for the population to evaluate:
   1. Intellectual functioning.
   2. Personality structure,
   3. Gross functioning.
   4. Educational evaluation**,** using tests measuring knowledge and achievement.

G. **Psychological Evaluations for young children** shall be provided to assess growth and development and begin with review and assessment of history from parents, care givers and other appropriate individuals, as well as the child. Evaluation is to address motor skills development, adaptive function, and social/emotional functioning. This information shall be combined with the following:
   1. Standardized tests and tools that align with current best practice
   2. Both observation and interactive techniques.

H**. Parenting Capacity Evaluation** shall be provided to evaluate parenting strengths and weaknesses, include a thorough parent-child interactional assessment using a standardized, structured technique. They are a thorough and comprehensive evaluation of a parent's risk for neglect and/or abuse. It combines specific and extensive interviewing, psychological testing, records review, and other data as necessary into a concise and complete evaluation. Report should include comments on risk factors that may jeopardize current placement, barriers that may impact reunification, treatment recommended to address risk factors and barriers, and recommendations for visitation. The evaluation process includes:
   1. Interviews with, and assessment of parent(s) and children using structured and unstructured methods. Tools used should be in line with current best practice.
   2. Where appropriate, psychological testing of one or all of the parties with the cost of the psychological testing at the agreed upon rate appearing on the "Therapist Services and Rates Sheet".
   3. Formal observation of parent/child interaction and interpretation of these observations in the context of assessment of each individual.
   4. The written report shall include both individual evaluation results, as well as an integrated summary of those results for all family members.

I. **Neuropsychological Evaluation** shall be administered by a licensed clinical psychologist with specialized training in this area, and a minimum of one year of experience. A neuropsychological evaluation is a testing method through which a

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neuropsychologist can acquire data about a subject's cognitive, motor, behavioral, linguistic, and executive functioning. These data can provide information leading to the diagnosis of a cognitive deficit or to the confirmation of a diagnosis, as well as to the localization of organic abnormalities in the central nervous system (CNS). Service can be provided if there is evidence from an earlier mental health assessment or psychological evaluation that there are deficits which can only be properly assessed with this type of testing. The content of the battery of tests are chosen to address the specific referral questions and should be in addition to, or subsequent to, a standard battery of tests to assess cognitive and personality functioning. The professional shall provide a written report indicating the tests administered, findings and recommendations, and shall participate in development of the treatment plan if requested.

K. **Reports. For all assessments and evaluations, a** written report shall be provided to the referring case manager within thirty (30) calendar days upon completion of the clinical interview for the evaluation. This report shall be concise, reflect all results, impressions, and interpretations, and be written in language that is understandable to non-mental health professionals. Delays must be communicated to the referring case manager. Evaluation reports on minors must be provided to the referring case manager and legal guardian. Evaluation reports on adults must be provided to the referring case manager, the subject adult and their attorney, if applicable. The report format shall include the following:

1. Reason for referral and referral source;
2. Techniques and tests used in the evaluation or assessment;
3. Test results and interpretation, including a description of strengths and weaknesses;
4. Recommendations regarding treatment modalities and intensities.

III. PSYCHIATRIC AND MEDICATION SERVICES

A. Psychiatric Evaluation shall be provided by a Psychiatrist, a physician licensed to practice psychiatry and skilled in the evaluation, diagnosis, and treatment of youth and adults. The evaluation has its central component an interview with the patient. The interview-based data are integrated with information that may be obtained through other components of the evaluation, such as a review of medical records, a physical examination, diagnostic tests, and history from collateral sources. A general evaluation usually is time intensive. The amount of time necessary generally depends on the complexity of the problem and the patient's ability and willingness to work cooperatively with the psychiatrist. Language competence needs to be assessed early in the evaluation so that the need for an interpreter can be determined. The evaluation shall include, but not be limited to:

1. Review of the record.

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2. Collateral interviews with parents, teachers, referring worker, and others as appropriate.
3. Written report

B. Medication Assessment is an initial one-hour appointment by a Psychiatrist to assess the need for medication and begin the prescribing of medication, if appropriate. A phone call to the Case Manager, followed up by a written report, is required to provide the results of the assessment.

C. Medication Management Visit means a visit which is typically 20 to 30 minutes in length with a licensed physician or other licensed health care provider with prescriptive authority for the sole purpose of monitoring and adjusting medications prescribed for mental health or substance abuse treatment. The prescriptive authority shall provide written and oral feedback of any side effects of the prescribed medication to the client and the Case Manager.

IV. APPEARANCES: It is understood that in the course of the provision of services the Provider may be called upon by the Buyer's Case Manager to appear for court hearings and Team Based Planning Meetings. A written Service Request/Purchase Order is required to pre-authorize reimbursement. Exceptions must comply with CSA policy.

A. Court Hearings

1 Information to be provided at such hearings and meetings may include, but is not limited to, assessment; evaluation; recommended services; services provided; and the progress resulting from the service interventions.

2 The billable hours for court appearances will include actual testimony time, meeting or review participation and waiting time, but will not include mileage or other traveling costs. Payment will be made in accordance with the established hourly rate as set forth on the attached Rate Sheet. The Buyer will make every attempt to notify the Provider well in advance of the Provider's requirement to appear at the court hearings. When possible, subpoenas will be provided.

B. Team Based Planning Meetings

1 It is understood that in the course of provision of services the Provider may be called upon to attend team-based planning meetings (Family Partnership Meetings (FPM), Family Resource Meetings (FRM), Youth and Family Team Meetings (YFTM), etc.) to discuss the assessment, evaluation, recommendations, services provided, and/or progress resulting from the service interventions. The Provider is responsible for participation in the team-based planning process. Attendance at required meetings may be billed for in accordance with the established hourly rates set forth on the attached Rate Sheet. Attendance may be in person or via telephone conference call when physical attendance is not possible. The billable hours for those team-based

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planning meetings will include actual meeting or review participation time and waiting time but will not include mileage or other traveling costs.

V. REIMBURSEMENT FOR SERVICES:

A. Services must be provided within the number of units and timeframes authorized, as specified on the service request/purchase order.

B. The Provider shall not invoice the Buyer for training, or the time associated with it, that employees of the Provider may receive.

C. The Provider shall not invoice the Buyer for travel time.

VI. INVOICING:

A. The Provider will submit invoices in accordance with section 26 of the APOS within ten (10) business days of the end of the month. The Buyer reserves the right to reject any invoices with incomplete data elements. Time frames for payment begin when the invoice contains all required elements.

B. The provider must submit a separate invoice for each youth served that includes the following information:

1. Provider's legal name, email, and phone number
2. Purchase order number (found on purchase order)
3. CSA case manager's name
4. Client's name and Consumer ID Number (found on purchase order)
5. Provided service as defined on the rate sheet
6. Contract unit price
7. # of units
8. Dates of service
9. Duration/times of service

VII. PAYMENT THROUGH PRIVATE INSURANCE AND MEDICAID:

A. Public child serving department case managers are required to use available client insurance and Medicaid prior to accessing CSA pool funds. Provider agrees to notify the Buyer's case manager of insurance and other third-party payers with which they participate.

B. The Provider agrees to accept the family's insurance, or Virginia Medicaid or FAMIS for payment of services, provided that the Buyer obtains the permission and signature of the parent or legal guardian of the youth. CSA will not fund services covered by the above forms of insurance without proof that of insurance denial or unavailability of other forms of payment.

C. When all or any portion of the services rendered by the Provider hereunder is covered by a policy of insurance, Medicaid, or FAMIS, the Provider shall submit claims for such service to the insurance company holding such policies. If the Provider receives Virginia Medicaid or FAMIS payments for services rendered under this Agreement, such payments shall constitute payment in full for those services.

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