ADDENDUM F
EVIDENCE BASED TREATMENTS

This Addendum F 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"), as the case may be, hereinafter referred to as the "Buyer" and the Provider, noted on the Provider Contact Sheet, hereinafter referred to as the "Provider". Where there exists any inconsistency between the Agreement and Addendum F the provisions of Addendum F control.

This Addendum F reflects those evidence-based treatments which the Provider agrees to make available to the Buyer as specified on the Provider's individualized Rate Sheet. The Provider will offer services as defined below. Any services offered that are not defined below will be 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.

Provider agrees to the following provisions:

I. EVIDENCE-BASED TREATMENTS

A. **Applied Behavior Analysis (ABA)** is the design, implementation, and evaluation of environmental modifications to produce socially significant improvement in human behavior. ABA includes the use of direct observation, measurement, and functional analysis of the relations between environment and behavior. ABA uses changes in environmental events, including antecedent stimuli and consequences, to produce practical and significant changes in behavior.

ABA uses research-based methods to help teach skills systematically and modify behaviors that act as barriers to an individual's quality of life and goals. ABA includes the use of direct observation, measurement, and functional analysis of the relations between environment and behavior. It is data driven where clinical decisions are made objectively through data analysis.

<u>Practice Model</u>
ABA is effective across ages (i.e., childhood, adolescence, adulthood) with treatment provided in in-home/community, clinic, and telehealth settings. There are different models in ABA. Clinical titles are designated and certified by the governing board based on education requirements specific to each certification.

Sole Provider Model: Board Certified Behavior Analyst (BCBA)/ Board Certified Behavior Analyst with a doctoral degree (BCBA-D)/Licensed Behavior Analyst (LBA): All services include direct services, treatment planning, and caregiver engagement

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provided by a master's or doctorate level certified clinician (BCBA/BCBA-D/LBA).

Tiered Models:

- Registered Behavior Technician (RBT)/Behavior Technician: Direct services provided by a behavior technician (certification not required) with clinical oversight by a BCBA/LBA.
- Board Certified Assistant Behavior Analyst (BCaBA)/Licensed Assistant Behavior Analyst (LABA): Direct services and/or clinical oversight of behavior technicians provided by a bachelor's level certified clinician (BCaBA/LABA) with ongoing supervision from a BCBA/BCBA-D/LBA regarding clinical decisions and practice.

License Requirement: Individual clinicians licensed by the Virginia Department of Health Professions to practice as behavior analysts

Medicaid Status: Medicaid reimbursable

Additional Requirements

Setting: Hours in each setting need to be approved separately and documented in monthly reports. Additional justification will be needed for clinic-based or telehealth settings.

Clinic-based and telehealth settings must be approved on a case-by-case basis prior to service initiation.

Caregiver Engagement: Caregivers should be involved in treatment in all settings and participation should be outlined in reports. Progress and barriers to caregiver involvement should be documented in reports and discussed with the case manager.

Additional Reporting Requirements

In addition to the reporting requirements for evidence-based practices included, ABA providers shall also include the following:

- Initial assessment/treatment plan: ABA providers may choose to combine the initial assessment and service/treatment plan to be completed and submitted within thirty (30) days of initiation of clinical services. At least one of the reports shall include the following along with full reporting requirements for all evidenced-based practices.
    1. Functional behavior assessment
    2. Planned settings and associated hours
    3. Summary of planned treatment interventions (e.g., behavior intervention plan)
    4. Plan for caregiver participation
- Progress Reporting: Reports shall include the following along with full reporting requirements for all evidence-based practices.
    1. Summary of caregiver participation to include progress and/or barriers
    2. Any significant updates to treatment interventions

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3.Baseline data for all goals

B. **Dialectical Behavior Therapy (DBT)** is a cognitive behavioral treatment program to develop emotion regulation skills, coping mechanisms and mindfulness practices that improve unhealthy thoughts and behaviors for 13- to 18-year-old youth. Treatment is provided by a nationally certified DBT therapist, or by a therapist working toward DBT certification under the supervision of a certified DBT therapist. The treatment program has a typical duration of six months to one year.

Full fidelity DBT includes four components: Individual Therapy, Skills Group, Phone Coaching, and Consultation with the therapist. For adolescents, this may also include Family Therapy. Individual therapy begins with a comprehensive assessment of the client to identify problems, strengths, history, and former treatment. Individual therapy sessions typically occur weekly for 45 minutes to one hour and run concurrently with skills group that generally meets weekly for 2 hours. Skills group includes a 24-week curriculum which is often repeated. Phone coaching provides clients with in-the-moment coaching on how to use skills to effectively cope with difficult situations that arise in their everyday life. Clients can call their individual therapist between sessions to receive coaching at the times when they need help the most. The DBT therapist consultation team is composed of individuals and group leaders who share responsibility for each client's case; the team typically meets weekly to support the DBT therapist.

C. **Multisystemic Therapy (MST)** is an intensive treatment to promote pro-social behavior and reduce criminal activity, mental health symptomology, out-of-home placement, and illicit substance abuse in 12- to 17-year-old youth. MST addresses core causes of delinquent and antisocial conduct by identifying key drivers of the behaviors through an ecological assessment of the youth, his or her family, school, peers, and community. Intervention strategies are personalized to address the identified drivers of behavior.

MST is delivered once a week (minimum) for an average of 3 to 5 months. Services are available 24/7, enabling timely crisis management via an on-call system staffed by MST team members, and allows families to choose which times work best for them. MST providers have small caseloads (average 4-6 per MST therapist) so they can be available to meet their clients' needs. MST is delivered in multiple settings, including home, office, school, and community.

MST is provided by organizations licensed by MST Services. MST teams use a structured fidelity assessment approach to ensure clinical service delivery is consistent with the MST model. MST teams must be licensed by the national MST Services organization. Under the Family First Prevention Services Act and title IV-E funding, MST utilizes the Identified Referral Reason: Mental Health Prevention and/or Treatment Services.

Additional Reporting Requirements for MST: MST providers shall provide copies, or a

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summary of all assessments completed as part of the MST model in the initial assessment report.

D. **Parent-Child Interaction Therapy (PCIT)** provides coaching to parents and/or primary caregivers (hereafter "caregivers") of 2- to 7-year-old children to decrease externalizing child behavior problems, increase positive parenting behaviors, and improve the quality of the caregiver-child relationship. Services are typically conducted weekly in clinical settings that provide the capability for the therapist to observe caregiver-child interactions without being in the same room with them.

   Parents or caregivers progress through treatment as they master specific competencies, thus there is no fixed length of treatment. Most families are able to achieve mastery of the program content in 12 to 20 one-hour sessions; the program is considered complete when a positive caregiver-child relationship is established, caregivers can effectively manage the child's behavior, and the child's behavior is within normal limits on a behavior rating scale.

   To become a PCIT therapist, individuals must be a licensed mental health provider with a master's degree (or higher) in a mental health field or a third-year psychology doctoral student who works under the supervision of a licensed mental health service provider. Providers must also complete 40 hours of training with approved PCIT trainers and materials. Although online-based trainings are offered, at least 30 of the 40 required hours must be in face-to-face training. Under the Family First Prevention Services Act and title IV-E funding, PCIT utilizes the Identified Referral Reason: Mental Health Prevention and/or Treatment Services *and* Substance Use Disorder Prevention and Treatment Services.

E. **Functional Family Therapy (FFT)** is a short-term, family-based intervention program to address risk and protective factors that impact the adaptive development of 11- to 18-year- old youth referred for behavioral or emotional problems. Family discord is also a target.

   The program is organized in five phases that consist of 1) Developing a positive relationship between therapist/program and family; 2) Increasing hope for change and decreasing blame/conflict, 3) Identifying specific needs and characteristics of the family, 4) Supporting individual skill-building of youth and family, and 5) Generalizing changes to a broader context.

   Treatment is provided by FFT providers who work as a supervised FFT "team" and receive ongoing support from their local team and FFT LLC. FFT Teams may be composed of a combination of Qualified Mental Health Professional (QMHP) and Licensed Mental Health Professional/Licensed Mental Health Professional-Resident (LMHP/LMHP-R) staff. QMHP's are limited to 1/3 of the FFT Team. FFT Teams must have a clinical supervisor who is a LMHP. FFT teams are actively engaged in the three-phase training program that includes a clinical, supervision, and maintenance

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phase.

FFT therapists typically spend 90 minutes face-to-face and 30 minutes over the phone with each family each week. On average, families complete the FFT program in 12 to 14 sessions over the span of three to five months. Although FFT does not provide on-call services, clinicians are available for sessions on the weekends and in the evenings to meet the scheduling needs of youth and families. Clinicians may be available by phone in the case of an emergency and will direct youth and family to the nearest emergency service provider. FFT utilizes the Identified Referral Reason: Mental Health Prevention and/or Treatment Services.

F. **Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)** Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is a treatment program for children and adolescents impacted by trauma, and their parents or caregivers. Research shows that TF-CBT successfully resolves a broad array of emotional and behavioral difficulties associated with single, multiple, and complex trauma experiences. Treatment is provided by a nationally certified TF-CBT therapist or by a therapist working toward TF-CBT certification under the supervision of a certified TF-CBT therapist.

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REPORTING REQUIREMENTS FOR ALL PROVIDERS

II. INITIAL ASSESSMENT

A. The Provider will complete and submit a written initial assessment within thirty (30) days of initiation of clinical services.
B. Providers of ABA will complete and submit an initial written assessment and treatment plan describing the services to be provided to each youth and the youth's family in accordance with that youth's Individualized Family Service Plan (IFSP) within thirty (30) days of services being initiated.
C. The initial assessment shall include the following information:
   1. Provider's name, credentials, and contact information
   2. Identifying client information to include the name of the youth and family
   3. Current or preliminary DSM diagnoses for youth
   4. Youth strengths and needs
   5. Youth functioning in major life domains (e.g., school, home, community, legal)
   6. Current family structure and functioning - strengths and needs
   7. Other current treatment/ services including medication management
   8. Summary of service and treatment history
   9. Case conceptualization summary
   10. Behaviors to be addressed - focus of the intervention

III. SERVICE/TREATMENT PLAN:

A. The Provider will complete and submit an initial service/treatment plan based on the initial assessment describing the services to be provided to each youth and the youth's family in accordance with that youth's Individualized Family Service Plan (IFSP) within thirty (30) days of services being initiated.

The service/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. Any significant changes proposed to the service/treatment plan will reflect the consensus of the youth, family, and team.

B. The service/treatment plan shall include the following components:

1. Short-term and long-term goals that are youth, family, and behavior specific with measurable objectives and performance timeframes
2. Crisis Safety Plan to include provisions during the workday as well as after hours and emergency telephone contact numbers. The child and family team shall review/revise crisis plans as applicable and document if it was only reviewed and not revised following a serious incident
3. Plan to transition youth to less restrictive and natural supports
4. Plan signed by provider, youth, and youth's guardian

C. 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.

IV. PROGRESS REPORTING

A. Providers of ABA, MST, and FFT will complete and submit a **monthly** report by the 15th day of the month after the end of the month services were delivered.

B. Providers of DBT, PCIT and TF-CBT will complete and submit a **quarterly** report by the 15th day of the month after the end of the third month services were delivered.

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

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

1. Provider's name, credentials, and contact information
2. Clinician's name, credentials, and contact information
3. Identifying client information to include name of youth and family
4. Progress on goals
5. Progress towards transition to less restrictive and natural supports
6. Significant incidents affecting the youth
7. Change in providers/agencies/services

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8. Change in medication and/or diagnoses
9. Current functioning in major life domains (e.g., school, home, community, legal)
10. Dates of service
11. Duration/times of service
12. Location of service
13. Individuals present for service
14. Itemized administrative/indirect vs. direct service hours
15. Hours of service remaining on current authorization
16. Description of interventions used by the clinician in addressing the identified needs, including any significant updates to treatment plan
17. Description of collaborative efforts in working with previous, current, and planned aftercare providers.

V. DISCHARGE/TRANSITION REPORTING

A. The Provider will complete and submit a discharge/transition report **within 10 business days of termination of services.**

B. Discharge/transition reports shall be submitted to the Buyer's case manager. Electronic submission via a secure email transmission is strongly encouraged.

C. The discharge/termination report submitted on 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 towards goals, including successes, challenges, and any anticipated continued needs
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. 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.
7. Provide information about the clinical needs of the youth and family.

VI. REIMBURSEMENT FOR SERVICES:

A. The Provider will initiate services (e.g., first contact with youth/family) within five (5) business days of receipt of the purchase order/service request for services, unless a different start date has been negotiated with the Buyer's case manager.

B. Services must be provided within the number of units and timeframes authorized, as specified on the purchase order/service request. The purchase order/service request defaults to even distribution of units per month. However, units may be front or back loaded as clinically appropriate and must be approved in advanced by the Buyer. An

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increase in the agreed upon hours of service must be approved in advance by the Buyer. Approval is conveyed through a revised Purchase of Service Order.

C. For ABA, MST, and FFT services billing hourly rates, no more than twenty (20) percent of the Provider's agreed upon billable hours shall include supervision, writing of reports, internal staffing, writing notes, Family Partnership Meeting (FPM)/Family Resource Meeting (FRM)/Youth and Family Team Meeting (YFTM) attendance, or telephone calls/emails with the Buyer. Twenty percent will be calculated looking at the time period covered by the service authorization. Billable hours for these specific "administrative/indirect services" shall be labeled as such on the invoice and on the monthly report. The remaining billable hours must be direct service contact with the youth and/or family present. Direct service contact with the youth and/or family can include telephone calls or emails. If notes/graphing is completed in the presence of the youth/family, this can be reported as a direct service.

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

E. Team-based planning meeting attendance, to include Individual Education Plan (IEP) meetings, may be billed when the Buyer (i.e., Buyer's case manager) requests the attendance of the Provider's case manager/clinician. The hours must fall within the existing purchase order/service request, or the case manager must obtain pre-authorization for reimbursement for the service. Information to be provided at such appearances may include, but is not limited to, goals, recommended services, the services provided, and the progress resulting from the service interventions. Verbal reports/communication with the Buyer do not substitute for the required monthly progress reports.

F. For court appearances the following conditions apply:
   1. The Provider will receive payment based on the actual number of hours the clinician is required by the Buyer's case manager to be present at the court hearings.
   2. The hours will include actual testimony and waiting time, but do not include mileage, travel time other traveling costs. Payment will be made in accordance with established hourly or daily rate set forth in 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 hearings. When possible, the Buyer will request a subpoena be issued.
   3. A written service authorization/purchase order is needed for non- Department of Family Services, Children Youth and Family related cases to pre- authorize reimbursement or the hours must fall within the existing purchase order/service request.

VII. INVOICING:

A. The Provider will submit invoices in accordance with Section 19 of the APOS and Section 6 of this Addendum F 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

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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/service request number
   3. CSA case manager's name
   4. Provided service as defined on the rate sheet
   5. Contract unit price
   6. # of units
   7. Dates of service
   8. Duration/times of service
   9. Itemized administrative/indirect vs. direct service hours

VIII. PAYMENT THROUGH PRIVATE INSURANCE AND MEDICAID:

A. The Provider agrees to accept the family's insurance (including TRICARE or its equivalent), 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 if that insurance is made available to pay for services.

B. When all or any portion of the services rendered by the Provider hereunder is covered by a policy of insurance, TRICARE (or its equivalent), Medicaid, or FAMIS, the Provider shall submit claims for such services to the insurance company holding such policies or to TRICARE (or its equivalent), as the case may be. The Buyer shall pay the balance remaining due, if any, within forty-five (45) days after the Provider furnishes satisfactory evidence to the Buyer that the payment by the insurance company or TRICARE (or its equivalent) is the full amount. 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.

IX. LICENSING AND CERTIFICATION:

A. The Provider will maintain its required licensed status with the appropriate governmental authorities and will notify the Buyer within five (5) business days of the issuance of any provisional license. This contract may be terminated in the event such licensing is suspended, withdrawn, or revoked.

B. The Provider will meet the education, training, and certification requirements for reimbursement by the Commonwealth of Virginia's Families First Prevention Services Act and/or CSA Evidence-Based Services,

C. The Provider will maintain and submit, upon request, documentation of current certification and/or applicable training with the relevant national evidence-based services accrediting bodies and training agents. The Provider will maintain its required license and certification with the relevant national evidence-based services accrediting bodies. Misrepresentation of

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possession of such license or certification shall constitute a breach of Contract and terminate this Agreement without financial obligation on the part of the Buyer to pay any open invoices.

X. CONTINUOUS QUALITY IMPROVEMENT:

A. The Provider will maintain a continuous quality improvement (CQI) process, including continuous monitoring of fidelity to the evidence-based model.

XI. IDENTIFICATION OF CANDIDATES FOR FOSTER CARE:

A. The Provider will identify the client (or child of the family if providing services to a parent or caregiver) as a candidate for foster care in their treatment/service plan.

XII. COLLABORATION:

A. The Provider will partner with the Buyer to monitor the progress of the client in the service as well as to periodically assess the risk off out of home placement for the child. The Provider shall, at minimum, collaborate with the Buyer through the following, as appropriate:

a. Participate in family partnership meetings (FPM), child and family team (CFT) meetings, and/or family assessment and planning team (FAPT) meetings.

i. Upon two weeks' notice of a meeting of the FAPT for a child, the Provider shall ensure that a representative with personal knowledge of the progress of the child attends and participates in such meeting.

b. Participate in court hearings as requested/necessary.

B. The Provider will work with representatives from the Virginia Department of Social Services (VDSS), the Office of Children's Services (OCS), and the Virginia Center for Evidence-Based Practice in the identification of outcome measures and design of data collection tools, collect data on youth participating in the project to evaluate the effectiveness of the project design, and cooperate fully with providing data and information for any evaluations. The Provider will participate in regular and, as necessary, ad hoc meetings with VDSS/the Center to exchange program and evaluation information.

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