

Smoky Mountain Center LME
Clinical Plan for State Funded Services
Updated: February 15, 2011

I. Purpose, Values and Objectives

SMC Philosophy

Smoky Mountain Center (SMC) believes that services provided to persons with mental health, intellectual or developmental, or substance use needs must be:

- Readily accessible to persons in need.
- Of high quality.
- Demonstrated to be clinically effective.
- Cost effective—the right services, provided in the right amount, at the right time for individuals in need.
- Person-centered.
- Developed in collaboration with service users and their families, with providers, and with community stakeholders.

SMC Mission, Vision and Values

The following Smoky Mountain Center Vision, Mission and Values have guided the development and implementation of this Clinical Plan:

Vision: Individuals in our region with developmental disabilities, mental health, and substance abuse need have access to timely, evidence-based, and culturally sensitive prevention, treatment, and support services in their communities.

Mission: Smoky Mountain Center is a regional organization that coordinates high quality prevention, treatment, and support services for individuals and families in our communities with developmental disabilities, mental health, or substance abuse needs.

Values:

- *Responsibility:* Our actions are transparent, consistent, and accountable.
- *Integrity:* We are honest. We do what we say we will do.
- *Quality:* We are pro-active and consistent in our work, using practices that are proven to be effective.
- *Caring:* We are compassionate, culturally sensitive, and empathetic with one another and those we serve.

DHHS Goals

In developing this Clinical Plan, Smoky Mountain Center has concentrated on the three primary goals that the North Carolina Department of Health and Human Services (DHHS) has articulated for the statewide expansion of the 1915 (b) (c) Medicaid waiver:

- Improved access to services
- Improved quality of all services

- Improved cost benefit.

Goals and Objectives of the SMC Clinical Plan

The Goals of the SMC Clinical Plan are to:

- Support a clinical model that is the foundation for all SMC activities. This plan must be continually and consistently supported through a variety of activities including Care Management and Utilization Review of culturally competent recovery, self-directed, and system of care principles and practices. Service authorization practices, clinical protocols and evidence-based practices, and the provision of feedback/training to providers all support this plan.
- Develop a more comprehensive continuum of care by developing and training a highly qualified and comprehensive network of providers.
- Use funding to encourage the development and provision of services based on cultural competence, recovery, self-direction and system of care principles and practices. These services are based on clinical evidence and have been demonstrated to have desired consumer outcomes.
- Apply the principles of cultural competence, and person-centered care to ensure equitable access to, engagement with, and benefit from services for all persons served.
- Ensure that the Clinical Plan promotes timely access to care and service engagement consistent with SMC and Division of MH/DD/SAS performance standards.
- Involve consumers and families in ways that ensure their ownership and satisfaction, and which engender a feeling of shared responsibility, with services provided.
- Develop a sense of community ownership that comes from communication, collaboration and a commitment to people of the local communities, including providers.
- Use data that can be translated into knowledge in order to demonstrate accountability, efficiency, need, quality, outcomes, and awareness of cultural and ethnic variations and to identify areas for change and improvement.

The Objectives of the SMC Clinical Plan are to:

- Articulate the principles and values in supporting the goals and values in the provision of mental health, developmental disability and substance abuse services.
- Identify the desired service array for each geographic region within the LME.
- Identify and prioritize the development and expansion of evidence-based practices that will be delivered in the services described in this plan throughout the SMC service area.
- Prioritize the development and expansion of services not currently available in the SMC service area or in geographic regions within the SMC service area.
 - Currently available services;

- Additional services identified as being needed and desired for the regions.
- Describe the processes through which this Plan is developed and changed, through continually community involvement and input, and how changes are made based on this input.

This Clinical Plan is a living document that is reviewed and updated at least annually under the guidance of the Medical Director and the Director of Clinical Operations.

II. Guiding Principles Service Provision

Smoky Mountain Center has identified guiding principles that are central to the service that the LME promotes and manages. Those principles include:

- A. *Recovery Principles*: Services should support each individual's potential for recovery, instill hope, empower consumers and support social inclusion. Providing supports and providing opportunities for personal development contribute to restoration of a meaningful life. Peer Support is often an integral component of recovery-based services.¹
- B. *Person-Centered Thinking, Planning and Services*: Person-centered service planning is a process that empowers individuals to be in charge of defining direction for their own lives. Person-centered thinking and planning enable people with disabilities to choose their own goals and methods for achieving them.² Smoky Mountain Center has committed to becoming a Person-Centered organization and has embarked on a process to transform our system to become more consistent with Person Centered values and practices through participation in the Real Choice Systems Change Program sponsored by the US Department of Health and Human Services (DHHS) and the Centers for Medicare and Medicaid Services (CMS).
- C. *Self-Direction*: Self-direction is a philosophy and orientation to service-delivery whereby informed individuals assess their service needs, determine how and by whom these needs should be met, and monitor the quality of services received. Self-direction offers people choice and control over the type of services, where and when, and by whom services are delivered. Self-direction is formally a component of the CAP-MR/DD Supports Waiver and it is also a philosophy endorsed by SMC for all persons with disabilities who receive services.
- D. *Systems of Care*: System of care is a philosophy for child and family services that is child-centered, family-focused and family driven. Services are predominantly community-based. Services are culturally competent and responsive. System of care supports the provision of services in the least restrictive environment and family participation in all aspects of planning, service delivery and evaluation.

¹ For more information about recovery principles, see the consensus statement from the National Consensus Conference on Mental Health Recovery and Mental Health Systems Transformation on December 16-17, 2004. (<http://store.samhsa.gov/shin/content//SMA05-4129/SMA05-4129.pdf>)

² See DMHDDSAS Person Centered webpage: <http://www.ncdhhs.gov/mhddsas/pcp.htm>

- System of care emphasizes integrated services with coordinated planning across the child-serving systems.³
- E. *Family Focus*: Smoky Mountain Center believes that inclusion of family members of individuals receiving services in planning, delivering and evaluating services is essential to consumers' recovery and achievement of their goals. This is particularly important for children, adolescents and others depending on family members for physical as well as emotional support, but also applies to many individuals not currently living with their families.

III. Key Elements for Service Development and Delivery

A. Evidence-Based Practices

Smoky Mountain Center has endorsed the position that persons served through the public system of behavioral and intellectual/developmental disability services shall receive excellent care that is consistent with our scientific understanding of what works (New Freedom Commission on Mental Health, 2003). SMC is committed to focusing on the content and quality of services and supports that it manages through adherence to proven models and through demonstrated fidelity to those selected programs.

Smoky Mountain Center has reviewed and endorsed numerous evidence-based practices (EBPs) for use in its provider network when providing mental health, intellectual/developmental disability, and substance abuse services. This list is not exhaustive and is frequently updated. Providers are requested to become familiar with these practices and to incorporate them into their services. SMC welcomes suggestions from providers and stakeholders of additional evidence-based practices to consider for endorsement.

SMC providers are expected to learn and to implement evidence-based practices regularly in the services that they provide. SMC recognizes that adopting evidence-based practices requires significant time, energy and financial resources for provider staff to learn desired practices and to receive supervision in those practices. The LME wishes to partner with providers in identifying applicable best practices, in prioritizing which EBPs to implement, and in identifying training resources. While SMC cannot assume the responsibility of all EBP training, we will work to assist providers in various ways including subsidizing some training.

In addition to facilitating the provision of evidence-based practices, SMC through its Quality Management Department endorses providers for the provision of enhanced services to all three disability groups. This process ensures that providers have appropriate policies and procedures, staffing consistent with the service definitions, and the capacity to provide these high-level services. SMC also monitors the

³ See DMHDDSAS System of Care webpage: <http://www.ncdhhs.gov/mhddsas/childandfamily/index-new.htm>

providers of enhanced services to ensure ongoing appropriate delivery of services, and intervenes through technical assistance and corrective action requirements when providers fail to meet the expected high standards for delivery of enhanced services. On rare occasions, SMC withdraws endorsement from providers unable to perform at the expected levels.

The Evidence Based Practices (EBPs) currently endorsed by SMC are described later in this document and are linked to the primary Age/Disability Group for which they are intended. Note, however, that many of these practices are applicable to multiple groups.

B. Stakeholder Input

Smoky Mountain Center believes that development of the best system of services involves input from key stakeholders including: consumers and families, service providers, and key community constituents and referral sources. Key stakeholders involved in service planning include:

- Consumer and Family Advisory Committee (CFAC)
- County Boards of Commissioners
- Department of Social Services
- Law Enforcement
- Juvenile Justice
- Court officials
- Local Education Agencies
- Hospitals and other healthcare providers
- Providers

SMC obtains input from stakeholders in a variety of forums, including CFAC meetings, provider meetings, community stakeholder meetings, etc. Input from these groups is invited at any time, and special planning meetings are conducted in developing UM Plans and UM Budgets.

C. Rapid and Easy Access to Services

Persons in need of services must be able to access appropriate services within a timeframe consistent with the urgency of their needs: emergency within two hours, urgent within 48 hours, and routine within 14 days. Persons requesting services may directly contact any SMC provider or may call the toll-free SMC Access line 24/7 (1-800-849-6127).

With some services for I/DD consumers (e.g., CAP-MR/DD, residential services) funding is insufficient to serve all consumers that need and request services. SMC maintains an electronic Wait List of such requests—providers submit requests to the LME electronically, and the database is used for tracking and reporting, and to identify eligible consumers as services become available.

D. Geographic Access to Services

Needed services should be available within a reasonable distance and time from recipients' home communities. Routine, ongoing services should be available within 60 minutes from one's home community. Higher intensity services that cannot be provided in each county should be accessible to consumers that need the service, but may not meet the 30 minute guideline—e.g., inpatient service should be provided as close to consumers' home communities as possible but it is not possible to always provide the service within 30 minutes. Mobile crisis services should be available in every county and available to see consumers in community settings when safe to do so. Transportation should be provided or facilitated for those unable to access services without such assistance.

E. Culturally Competent Services

Smoky Mountain Center serves culturally diverse individuals and communities, and services provided to our residents are expected to be informed, sensitive and respectful to those differences. Per the DHHS Cultural Competency Advisory Group: *'The journey towards developing cultural competence within the public mental health, developmental disabilities and substance abuse service system is a dynamic and evolutionary process. The fundamental precepts of cultural competence include developing respect for differences, cultivating successful approaches to diversity, increasing awareness of one's self and of unstated institutional cultural norms and practices and working knowledge of the history, culture, beliefs, values and needs of diverse consumers and communities. A culturally competent approach to services requires that agencies examine and potentially transform each component of mental health, developmental disabilities and substance abuse services, including assessment, treatment, habilitation and evaluation.'*⁴

SMC has a diverse mix of cultures across its fifteen counties, including the Eastern Band of Cherokee Indians and persons living in rural Appalachian mountain communities. SMC endeavors to be knowledgeable about and sensitive to the diverse cultural practices and beliefs in its region, and asks its providers to demonstrate cultural competence in working with individuals of different cultures.

SMC produces communications to consumers and to the community that reflect cultural sensitivity and respect to all persons in our region. Such documents are written so as to be readily understood by persons with an eighth-grade education whenever possible.

SMC subscribes to a translation service capable of translating into Spanish and numerous other languages. The Access Center and other SMC services are able to engage this service whenever talking with persons who request or require communication in a language other than English.

⁴ [Htte://www.ncdhhs.gov/mhddsas/announce/commbulletins/culturallinguisticcompetencyactionplan-10-23-06.pdf](http://www.ncdhhs.gov/mhddsas/announce/commbulletins/culturallinguisticcompetencyactionplan-10-23-06.pdf)

SMC contracted providers are encouraged to employ clinicians and other staff who speak Spanish and other languages. Providers are required to arrange translation services when serving individuals for whom communication in a language other than English is necessary.

SMC provides specialized Counseling and Case Management services to individuals who are deaf or hard of hearing. SMC is committed to providing culturally sensitive services in the preferred communication method of the consumer, most often American Sign Language. Provision of a Sign Language interpreter is minimally adequate, but it is preferable whenever possible to utilize a Counselor and/or a Case Manager who is proficient in American Sign Language rather than to use an interpreter. The Deaf community is traditionally underserved in behavioral health services, presumably due to both communication and cultural barriers. While the Deaf community is multi-cultural, there are cultural aspects common to deaf and hard of hearing individuals that those serving this community must be aware of and sensitive to. These include not pathologizing deafness, recognizing that the Deaf community is a minority group within the larger population, and having an understanding of the reluctance of many deaf and hard of hearing individuals to seek behavioral health services.

F. Clinical Homes

“Clinical homes” are important in addressing the range of needs of persons receiving services. A clinical home is the provider organization with primary responsibility for managing and coordinating all aspects of an individual’s services. Those responsibilities include:

- Person-centered planning
- Development of a person-centered plan
- Case management, including coordination of supports and services among all providers
- First responder for crisis and emergency needs
- Collaboration with physical health

Certain services (examples: Assertive Community Treatment Team, Intensive Outpatient Program) are specifically designated as clinical home services, and the provider of such a service is the designated clinical home for persons served. For services not formally designated as clinical home, there should always be a lead service provider that functions as the clinical home for service planning and coordination; in such situations full first responder responsibilities are not required of the provider, but all providers are required to respond telephonically 24/7 to persons they serve.

G. Critical Access Behavioral Health Agencies CABHAs)

Many mental health and substance use services (but not intellectual/developmental disability services) must be provided by certified provider organizations known as CABHAs. These agencies provide a continuum of services for adults and/or children, and have infrastructure, including designated Medical Directors, Clinical Directors

and Quality Management & Training Directors, and must have achieved national accreditation. Only CABHAs may provide MH/SA Targeted Case Management services, and they must provide psychiatric medication services for persons they serve. CABHAs are charged with collaborating with physical health providers.

The NC DHHS identified three primary goals in initiating CABHAs:

1. Ensure that critical services are delivered by a clinically competent organization with appropriate medical oversight and the ability to deliver a robust array of services.
2. Move the public system over time to a more coherent service delivery model that reduces clinical fragmentation at the local level and begins to prepare the provider community for the changes that will be required in a waiver environment.
3. Ensure that consumer care is based upon a comprehensive clinical assessment and an appropriate array of services for the population to be served. For example, a provider who will serve only children with mental health issues might offer outpatient therapy, case management, intensive in-home and day treatment. The array will vary depending upon the age and needs of the consumers to be served by the agency.

H. Use & Development of Practice Guidelines

Practice guidelines are intended to assist providers and consumers in clinical decision-making and to improve care. They also document the evidence available to determine appropriate care. Guidelines are not meant to dictate clinical practice but are evidenced-based and/or consensus based, and provide good place to go for guidance in the care of mental illness, intellectual/developmental disabilities and substance use disorders. One needs to keep in mind that each consumer is an individual and that providers have different approaches to the delivery of care. Therefore, all treatment must be individualized to the consumer. Good clinical judgment should be used in all situations and at times will supersede practice guidelines.

Smoky Mountain Center will use practice guidelines and clinical standards to evaluate effectiveness and appropriateness of care. The utilization management unit performs this function with input and advice from the Clinical Advisory Committee. Care that is deemed outside the norm will be evaluated by these guidelines. Providers may also use these guidelines as a road map for effective evidence based care. We also intend consumers to use these guidelines to help them make decisions about treatment.

Many of the practice guidelines adopted by SMC were developed by recognized professional organizations such as the American Psychiatric Association and the American Academy of Child & Adolescent Psychiatry.

I. Dissemination of Practice Guidelines to Providers and Enrollees

Practice Guidelines adopted by Smoky Mountain Center are made available to providers and enrollees for guidance in selecting recommended practices. Guidelines are posted on SMC's website and are available for anyone to review and download. When new guidelines are adopted and when guidelines are modified, SMC notifies

providers through Communication Bulletins of the changes and how to review and obtain the guidelines.

J. Clinical Advisory Committee

Smoky Mountain Center's Clinical Advisory Committee is chaired by the SMC Medical Director and is comprised of clinical representatives of various disciplines and disabilities from provider organizations and SMC clinical staff. The Committee meets regularly to discuss the clinical treatment practices that are used in the SMC provider network. The Committee reviews evidence-based practices, identifies the training needs of network providers, evaluates service utilization as related to clinical guidelines and monitors implementation of and adherence to clinical guidelines. The Committee identifies and endorses community standards of care and clinical guidelines for use by providers in the SMC provider network.

K. Adherence to DHHS Service Guidelines, Medical Necessity Criteria and Clinical Coverage Policies

SMC network providers are expected to be familiar with DHHS service guidelines, Medical Necessity Criteria and Clinical Coverage Policies that direct the expectations and standards for Medicaid and state-funded services managed by SMC. These standards and guidelines are described in the SMC Provider Manual available on SMC's website. Providers are notified of updates and changes to these criteria and guidelines in periodic provider meetings and through SMC Communication Bulletins. SMC Utilization Reviewers and Quality Management staff are familiar with guidelines, employ them in reviewing providers' services and in providing feedback and guidance to providers about services.

L. Confidentiality and Adherence to HIPAA Privacy & Security Rules

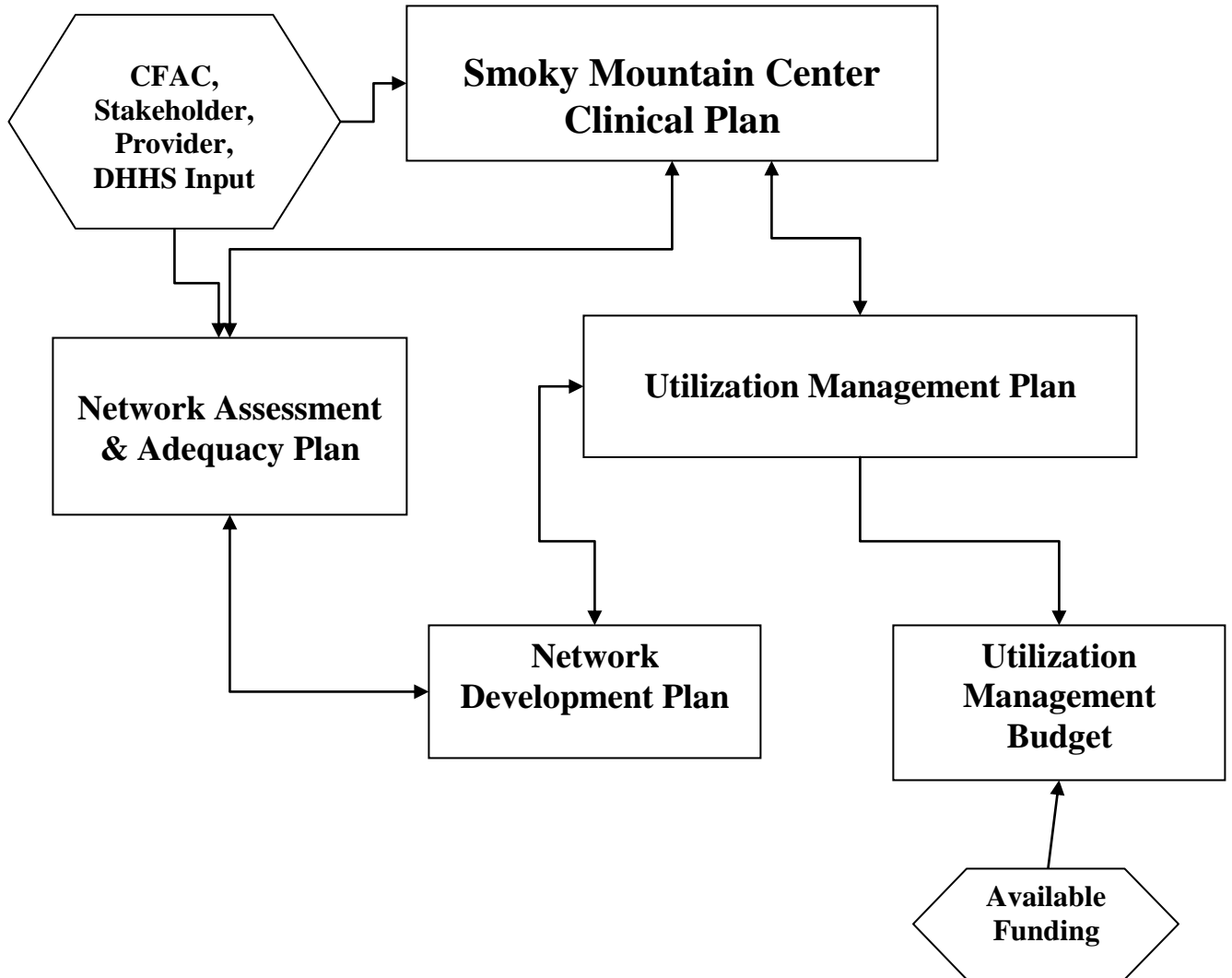
SMC has adopted policies and procedures to ensure the confidentiality of all consumer-identifying information in compliance with federal and state privacy and security regulations. Policies and procedures include privacy policies that direct staff practices to ensure that staff working with individuals' health information use and disclose information appropriately, and security policies to ensure the protection of paper and electronic health information. These policies and procedures apply to all SMC employees, individuals and organizations contracted with SMC, and temporary employees, interns, students or volunteers in their use of and disclosure of confidential information.

SMC has appointed a Privacy Officer and a Security Officer to direct SMC's policies and practices in handling confidential health information. These officers lead the SMC Privacy and Security Committee comprised of SMC employees from various departments in reviewing SMC practices, recommending appropriate policies and procedures, and in planning staff training and oversight. The Privacy Officer and Security Officer work with all SMC departments in conducting annual organization-wide risk assessments to identify and address potential risks to the appropriate use and security of individuals' health information.

New staff are trained in SMC Privacy and Security policies and procedures, and all staff receive periodic (at least annual) refresher training in these policies and procedures.

SMC Privacy and Security policies have been adopted to detect, report and address any violation of Privacy and Security policies and regulations in a manner that fairly, reasonably and systematically protects the privacy of consumers that SMC serves.

IV. Clinical Plan and Related Processes



A. The Clinical Plan describes the array of services and the manner in which those services are provided. This plan is developed with input from multiple sources, and is updated at least annually.

B. The Network Assessment & Adequacy Plan assesses the provider network regarding its ability to deliver services in the Clinical Plan, and drives the Network Development Plan to make changes in the network needed to deliver the desired services. This plan is based on review of much information including treated prevalence data for the LME and by county, provider and stakeholder surveys, and input from SMC staff. See the Community Development Plan on SMC's website for details of this plan with supporting documentation:

<http://www.smokymountaincenter.com/orgplans.asp?plan=cdp>.

- C. The Clinical Plan and the Network Development Plan provide input into the Utilization Management Plan, the document that describes the menu of services available for each Age/Disability Group across four different levels of need.
- D. The Utilization Management Budget is generated from the UM Plan based on available funding, and projects services to be funded by category in each of SMC's three geographic regions.
- E. Each of these plans is a living document that is regularly updated based on changing needs of the community and input from other parts of this system.
- F. Clinical Plan Organization
SMC's Clinical Plan is organized into two sections:
 1. Clinical Framework: Describes the processes and values that SMC uses in implementing the Clinical Plan and in ensuring that identified services are available.
 2. Age/Disability Continuums of Care: For each of the six Age/Disability Groups, the guiding principles of service provision, the core services that are to be made available and the applicable evidence-based practices are presented.

VI. Clinical Plan Framework

Component	Description
Access to Care	<p>At the point of initially requesting services, the urgency of each person's need is determined:</p> <ul style="list-style-type: none"> • <i>Emergency</i>: service to be provided within 2 hours • <i>Urgent</i>: service to be provided within 48 hours • <i>Routine</i>: service to be provided within 14 days • <i>Post-hospital After-care</i>: to be provided within 7 days <p>Whenever a person requests services, SMC offers choice of all available providers for that service, payer and geographic area.</p>
Care Coordination	<p>SMC staff that support community stakeholders, consumers and providers through education and technical assistance regarding LME services and local resources. Provide monitoring, linkage and case planning and management for high risk and/or high cost consumers regardless of age or disability with particular focus on individuals not engaged with a Clinical Home. Includes:</p> <ul style="list-style-type: none"> • Community Based Teams • Geriatric & Adult MH Specialty Teams

	<ul style="list-style-type: none"> • Housing Coordination • Prevention • Emergency Service Coordination • Hospital & State Facility Liaisons • Guardianship
<p>Standardized Functional Assessment Tools/ Determination of Medical Necessity</p>	<p>Standardized functional assessment tools are used to determine the level of care needed by the individual and to determine the medical necessity for requested services.</p> <p><u>Level of Care</u></p> <ul style="list-style-type: none"> • For mental health services, the DSM-IV-TR Global Assessment of Functioning (GAF) • For substance abuse services, the American Society of Addiction Medicine Patient Placement Criteria (ASAM) • For Intellectual/Developmental Disabilities, the NC-Support Needs Assessment Profile (NC-SNAP) <ul style="list-style-type: none"> ○ SMC is participating in a pilot project with the Supports Intensity Scale (SIS) that may eventually replace the NC-SNAP in determining levels of care for I/DD services <p><u>Medical Necessity</u></p> <ul style="list-style-type: none"> • SMC has adopted the NC Medicaid definition of Medical Necessity for use in reviewing state-funded services <p><u>Service Definitions</u></p> <ul style="list-style-type: none"> • SMC uses the NC DHHS Service Definitions for state-defined services, and generates internally service definitions for locally-developed services
<p>Levels of Care</p>	<p>Four levels of care (LOC) are used to authorize services for individuals with different levels of intensity of need with “A” being the lowest and “D” being the highest need:</p> <p><u>Mental Health</u></p> <ul style="list-style-type: none"> • LOC A = GAF >70 • LOC B = GAF 51-70 • LOC C = GAF 31-50 • LOC D = GAF <31 <p><u>Substance Abuse</u></p> <ul style="list-style-type: none"> • LOC A = ASAM I or Opioid Maintenance • LOC B = ASAM II.1 – II.5 • LOC C = ASAM III.1 – III.7 • LOC D = III.9 or higher <p><u>Intellectual/Developmental Disabilities</u></p> <ul style="list-style-type: none"> • LOC A = SNAP Index 11-44

	<ul style="list-style-type: none"> • LOC B = SNAP Index 45-78 • LOC C = SNAP Index 79-92 <p>LOC D = 92-230</p>
<p>Service Planning/ Person-Centered Thinking and Planning (PCP) and Least Restrictive Interventions</p>	<p>The consumers “Clinical Home” (lead clinical agency/ or Critical Behavior Health Agencies-CABHAs) is responsible for the service planning process. The service plan is a document that reflects the goals of the person receiving services and the strategies that will be implemented to reach those goals. Service Plans use the values and principles identified by the individual. Person Centered Thinking and Planning, determination of medical necessity and least restrictive interventions determine the service options. Individuals may choose a provider of a particular service that best matches their treatment needs based on provider availability for the service.</p>
<p>Medical Necessity for State and Medicaid Services</p>	<p>Medicaid and state-funded behavioral health services must be medically necessary. SMC has adopted the NC Division of Medical Assistance (DMA) medical necessity criteria that define medically (or clinically) necessary services as those that are necessary and appropriate for the prevention, diagnosis or treatment of a mental health, developmental disability, or substance abuse condition. Medically necessary services are:</p> <ul style="list-style-type: none"> • Consistent with SMC-adopted service definitions and other service guidelines. • Individualized, specific and consistent with symptoms or confirmed diagnosis of the condition under treatment, and not in excess of the recipient’s needs. • Able to be safely furnished, and no equally effective and more conservative or less costly treatment is available. • Furnished in a manner not primarily intended for the convenience of the recipient, the recipient’s caretaker, or the provider. • Not for experimental, investigational, unproven or solely cosmetic purposes. • Furnished by or under the supervision of a practitioner licensed (as relevant) under NC state law in the specialty for which they are providing service and in accordance with federal and state laws and regulations, the Medicaid State Plan, the North Carolina Administrative Code, Medicaid clinical coverage policies, and other applicable federal and state directives. • Sufficient in amount, duration and scope to

	<p>reasonably achieve their purposes. Reasonably related to the diagnosis for which they are prescribed regarding type, intensity, duration of service and setting of treatment.</p>
<p>Least Restrictive Intervention</p>	<p>The least intrusive and restrictive intervention determined to be safe and effective for an individual should always be used. Using a more restrictive intervention than necessary may restrict consumer choice and freedom and is inconsistent with Recovery principles. For example, it is preferable to provide intensive community-based services rather than to hospitalize someone in crisis when those services provided in the community are deemed to be safe and effective in providing support and stabilization</p>
<p>Utilization Review: Pre-authorization, authorizations, re-authorization (continued stay), non-authorized services.</p>	<p>SMC funds and approves services under two different arrangements:</p> <ol style="list-style-type: none"> 1. Prior authorization of services based on review of the initial assessment and person-centered plan; and 2. Self-management by select providers, with standards established and monitored by the LME, <p>When conducting prior authorization of services, SMC makes every effort to ensure that the service approved is the right service, in the right amount, to meet the individual's needs. When service requests cannot be authorized, Care Managers communicate with the provider to review the consumer and his or her needs, and to mutually agree on services that are medically necessary and meet the consumer's needs. In the small percentage of cases in which such agreement is not achieved, a clinical non-certification is issued, with written notice sent to the consumer that includes recommended services and appeal rights.</p>
<p>Clinical Guidelines</p>	<p>Evidence-based practices (EBPs) that have been demonstrated to consistently produce specific, intended outcomes for age/disability/diagnosis groups are endorsed by SMC and are disseminated to providers (see EBPs listed with core services for each Age/Disability Group).</p> <p>Service Definitions also provide specific requirements and guidance for the provision of each covered service. For some services, these guidelines also include required and recommended EBPs.</p> <p>SMC also adopts clinical guidelines for certain consumers and services (e.g., see the Juvenile Justice Treatment Continuum).</p>

Utilization Review	Concurrent and Retrospective review of treatment plans and service documentation to ensure care was provided as authorized and medically necessary. Post payment reviews and Targeted Monitoring are also used to develop strategies for service improvement to affected populations.
Consumer Affairs	Response to complaints, review of incidents and the processing of appeals related to all services delivered. Findings reviewed and used to implement system improvements where needed. Facilitation of consumer choice of providers for the desired services.

VII. Continuums of Care

The Continuums of Care described in the SMC Clinical Plan are based on the SMC Values for Service Provision and the Evidence-Based Practices endorsed by the LME. Evidence-based practices are incorporated into Clinical Guidelines developed under the auspice of the Clinical Operations Committee. It is important to note that SMC works in collaboration with providers to imbue the service system with core treatment values and related evidence-based practices, and service delivery will be driven to embody both principles and practices.

This SMC Clinical Plan defines the core services for the six Age/Disability Groups that the LME endeavors to make available in all regions—this includes both Medicaid-funded services and state-funded services. In addition to the core services other services, both state-funded and Medicaid may be provided as needed and available. The *Current Table of Services Available in SMC Provider Network* is a comprehensive directory of the core and other services available in the SMC service area, with indications as to the applicable funding sources and regional availability.

A plan to monitor the compliance with the Clinical Plan and related outcomes of any service should be in place to ensure consistency in implementation and attainment of expected service delivery modalities and consumer outcomes. The Continuum of Care reflects a range of services and supports from the least restrictive, and least costly, to the most restrictive and most costly services. Along the continuum, consumers must be directed to the most appropriate services to address the needs identified during the assessment and urgency reflected during the access process. Services are grouped into SMC’s Level of Care Continuums.

These levels reflect least restrictive to most restrictive levels of intervention. Within the continuum services are arranged along six tracks reflecting disability specific needs and associated evidenced based practices:

1. Child Mental Health
2. Child Substance Abuse
3. Adult Mental Health
4. Adult Substance Abuse

5. Child Developmental Disabilities
6. Adult Developmental Disabilities

A. Child Mental Health Services

Guiding Principles to Child Mental Health Services

System of Care (SOC): SOC is a philosophy for child and family services that is child-centered, family-focused and family driven. (See SMC Values for Service Provision section above)

SOC Practices Include:

- Child and Family Teams are teams which consist of professionals, children and their families, and that develop and “own” the intervention plan. This is an essential component of all treatment models for children. Plans must be developed in the context of the family’s culture, and be based on strengths, values, norms and preferences of the child, family, and their community.
- Increased Collaboration with school systems and community agencies serving children to assist them in supporting children at school. This team approach is critical to the SOC approach to care.

Child Mental Health Core Service Menu

Service	Service Description
Crisis Services	
Mobile Crisis Management	Rapid 24/7 response team to assess needs, stabilize crisis, and refer to needed services
Walk-In Centers	Easy access to assessment & identification of needed services: emergency, urgent & routine access
Psychiatric Evaluation and Med- Management	Psychiatric evaluation and medication management services, including via telepsychiatry if needed
Child Crisis Beds	Brief, out-of-home crisis placement for children & adolescents as alternate to inpatient care
Inpatient & Residential Services	
Psychiatric Inpatient	Hospitalization for psychiatric crises (only available out-of-region); State or private hospitals
Psychiatric Residential Treatment Facility (PRTF)	
Child Residential Care	Out-of-home residential treatment service for psychiatric or substance abuse problems; Medicaid-funded only
Intensive Community-Based Services	
Intensive In-Home	Intensive, wrap-around team services to stabilize child & family & allow child to remain in family home
Respite Care	Offers in-home or out-of-home relief to family care givers

Offender Services	
Juvenile Justice Treatment Continuum (JJTC)	Specialized assessment and treatment continuum for court-adjudicated youth
Sexual Abuse Intervention Program (SAIP)	Specialized assessment and treatment intervention for sexual abuse offenders
DSS MH Services- Child Treatment Continuum: (To be developed; similar to JJTC Model)	
Basic Outpatient Services	
Comprehensive Clinical Assessment	Initial clinical assessment to determine treatment needs
Individual Therapy	Individual counseling/therapy
Family Therapy	Therapy with child & family
Group Therapy	Group counseling/ therapy
Case Management	Planning, facilitation and coordination of services
Specialized Counseling and Case Management for Deaf and Hard of Hearing individuals	Services provided by professionals proficient in American Sign language and knowledgeable about and sensitive to the culture of the Deaf community.
Psycho-educational Services: Parent Training	
Nurturing Families	Basic parenting model for high need families
Love & Logic	Basic parenting model for lower need families
Divorce Care: Children in the Middle	Supports parents & children in divorcing families
All Stars	Addresses experimenting with substances, fighting, bullying, and initiating sexual activity.

Evidence-Based Practices in Child Mental Health

Following are the Evidence Based Practices (EBPs) currently endorsed by SMC for child mental health services.

Name	Trauma Focused Cognitive Behavior Therapy (TF-CBT)
Description	Components-based model of psychotherapy that addresses the needs of children with PTSD symptoms, depression, behavior problems, and other difficulties related to traumatic life experiences.
Population	Children with significant psychological symptoms related to trauma exposures.
Reference	http://www.nctsn.org/nctsn_assets/pdfs/TF-CBT_Implementation_Manual.pdf

Name	Parent-Child Interactive Therapy (PICT)
Description	Treatment model with emphasis on improving the quality of the parent-child relationship and changing parent-child interactions.
Population	Conduct-disordered young children

Reference	http://pcit.phhp.ufl.edu/
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Name	Cognitive Behavioral Therapy for Adolescent Depression
Description	Developmental adaptation of the classic cognitive therapy model developed by Aaron Beck and colleagues. More emphasis is placed on (1) the use of concrete examples to illustrate points, (2) education about the nature of psychotherapy and socialization to the treatment model, (3) active exploration of autonomy and trust issues, (4) focus on cognitive distortions and emotional shifts that occur during sessions, and (5) acquisition of problem-solving, affect-regulation, and social skills.
Population	Male & female adolescents and young adults
Reference	http://www.starcenter.pitt.edu/DownloadManuals/54/Default.aspx

Name	Multi-Systemic Therapy (MST)
Description	MST is a pragmatic and goal-oriented treatment that specifically targets those factors in each youth's social network that are contributing to his or her antisocial behavior. Thus, MST interventions typically aim to improve caregiver discipline practices, enhance family affective relations, decrease youth association with deviant peers, increase youth association with prosocial peers, improve youth school or vocational performance, engage youth in prosocial recreational outlets, and develop an indigenous support network of extended family, neighbors, and friends to help caregivers achieve and maintain such changes.
Population	Serious juvenile offenders with mental health problems
Reference	http://www.mstservices.com/index.php

B. Child Substance Abuse Services

Guiding Principles to Child Mental Health Services

System of Care (SOC): SOC is a philosophy for child and family services that is child-centered, family-focused and family driven (See SMC Values for Service Provision section above)

SOC Practices Include:

- Child and Family Teams are teams which consist of professionals, children and their families, and that develop and “own” the intervention plan. This is an essential component of all treatment models for children. Plans must be developed in the context of the family’s culture, and be based on strengths, values, norms and preferences of the child, family, and their community.
- Increased Collaboration with school systems and community agencies serving children to assist them in supporting children at school. This team approach is critical to the SOC approach to care.

Child Substance Abuse Core Service Menu

Service	Service Description
Crisis Services	
Mobile Crisis Management	Rapid 24/7 response team to assess needs, stabilize crisis, and refer to needed services
Walk-In Centers	Easy access to assessment & identification of needed services
Psychiatric Evaluation and Med- Management	Psychiatric evaluation and medication management services, including via telepsychiatry if needed
Child Crisis Beds	Brief, out-of-home crisis placement for children & adolescents as alternate as alternative to inpatient care
Inpatient Services	
Psychiatric Inpatient	Hospitalization for psychiatric crises (only available out-of-region); Not state-funded
Psychiatric Residential Treatment Facility (PRTF)	
Child Residential Care	Out-of-home residential treatment service for psychiatric or substance abuse problems; Medicaid-funded only
Intensive Community-Based Services	
Intensive In-Home	Intensive, wrap-around team services to stabilize child & family & allow child to remain in family home
Offender Services	
Juvenile Justice Treatment Continuum (JJTC)	Specialized assessment and treatment continuum for court-adjudicated youth
Basic Outpatient Services	
Comprehensive Clinical Assessment	Initial clinical assessment to determine treatment needs
Individual Therapy	Individual counseling/therapy
Family Therapy	Therapy with child & family
Substance Abuse Group Therapy	Group therapy for substance abuse
Case Management	Planning, facilitation and coordination of services
Specialized Counseling and Case Management for Deaf and Hard of Hearing individuals	Services provided by professionals proficient in American Sign language and knowledgeable about and sensitive to the culture of the Deaf community.
Psycho-educational Services	
Family education and training	(To be developed)
Prevention Services	
Prime for Life	For youth and adults to help them understand their risk for experiencing alcohol or drug problems throughout life. To be developed.
Prime Solutions	For adjudicated youth and adults who do not meet criteria for substance dependence. Can bridge between prevention

	intervention and treatment. To be developed.
All Stars	Addresses experimenting with substances, fighting, bullying, and initiating sexual activity.
Project Alert	A school-based, social resistance approach to drug abuse prevention. The curriculum specifically targets tobacco, alcohol, marijuana, and inhalant use.
Project Towards No Drug Abuse (PTND)	Classroom-based substance abuse prevention program that focuses on three factors that predict tobacco, alcohol, and other drug use, violence-related behaviors, and other problem behaviors
Positive Action	Program for improving <u>academics</u> , <u>behavior</u> , and <u>character</u> . Includes curriculum for classroom (K-12), school counselors or therapists, parents and community that can be used separately or in combination.

Evidence-Based Practices in Child Substance Abuse

Following are the Evidence Based Practices (EBPs) currently endorsed by SMC for child substance abuse services.

Child/Adolescent Substance Abuse

Name	Adolescent Community Reinforcement Approach (ACRA)
Description	A behavioral intervention that seeks to increase the family, social, and educational/vocational reinforces of an adolescent to support recovery.
Population	Adolescents with alcohol & other substance use problems
Reference	http://www.chestnut.org/LI/acra-acc/index.html#Description

Name	Seven Challenges
Description	Challenges is a counseling program designed to assist youth with their drug problems as well as co-occurring psychological problems and life skill deficits.
Population	Male and female adolescents with substance use disorders
Reference	http://www.ncpic.net/2010/sa5-the-seven-challenges/

Name	Motivational Interviewing (MI)
Description	Motivational interviewing is a directive, client-centered counseling style for eliciting behavior change by helping clients to explore and resolve ambivalence
Population	Adults and adolescents with substance use disorders
Reference	http://www.motivationalinterview.org/clinical/index.html

C. Adult Mental Health

Guiding Principles in Adult Mental Health

Recovery Principles. Services should support each individual's potential for recovery, instill hope, empower consumers and support social inclusion. (See SMC Values for Service Provision section above)

Adult Mental Health Core Service Menu

Service	Service Description
Crisis Services	
Mobile Crisis Management	Rapid 24/7 response team to assess needs, stabilize crisis, and refer to needed services
Walk-In Centers	Easy access to assessment & identification of needed services: emergency, urgent & routine access
Psychiatric Evaluation and Med- Management	Psychiatric evaluation and medication management services, including via telepsychiatry if needed
Facility Based Crisis	Residential crisis stabilization facility
Inpatient Services	
Psychiatric Inpatient	Hospitalization for psychiatric crises: local community-based hospitals, state hospitals, private hospitals
Intensive Community-Based Services	
Community Support Team	Intensive, team-based short-term intervention to stabilize crisis
Assertive Community Treatment Team (ACTT)	Intensive, team-based long-term wrap around service for individuals with serious mental illness
Offender Services	
Domestic Violence Intervention Program (DVIP)	Specialized assessment & treatment program for adjudicated and non-adjudicated domestic violence offenders
Sexual Abuse Intervention Program (SAIP)	Specialized assessment and treatment intervention for sexual abuse offenders
DSS MH Services- Adult Treatment Continuum (To be developed; similar to JJTC Model)	
Basic Outpatient Services	
Comprehensive Clinical Assessment	Initial clinical assessment to determine treatment needs
Individual Therapy	Individual counseling/therapy
Family Therapy	Therapy with family
Group Therapy	Group therapy
Recovery Education Center (REC)	Recovery-based program integrating clinical and Peer Support Services; evidence-based classes
Peer Support Service	New service not yet implemented except in RECs

Case Management	Planning, facilitation and coordination of services
Specialized Counseling and Case Management for Deaf and Hard of Hearing individuals	Services provided by professionals proficient in American Sign language and knowledgeable about and sensitive to the culture of the Deaf community.

Evidence-Based Practices in Adult Mental Health

Following are the Evidence Based Practices (EBPs) currently endorsed by SMC for adult mental health services.

Name	Seeking Safety
Description	Therapy for trauma/posttraumatic stress disorder (PTSD) and substance abuse. Treatment designed for flexible use in different formats.
Population	Adults with trauma/PTSD symptoms from trauma and substance abuse
Reference	http://www.seekingsafety.org/

Name	Dialectical Behavior Therapy (DBT)
Description	System of therapy originally developed to treat persons with borderline personality disorder. Combines cognitive-behavioral techniques for emotion regulation and reality-testing with concepts of distress tolerance, acceptance and mindfulness.
Population	For adolescents and adults with borderline personality disorder, substance abuse and related problems.
Reference	http://behavioraltech.org/index.cfm?CFID=32522018&CFTOKEN=23721850

Name	Illness Management and Recovery
Description	The Illness Management and Recovery program strongly emphasizes helping people to set and pursue personal goals and to implement action strategies in their everyday lives.
Population	Consumers with mental illness who wish to learn about their illness and how to manage & live with it.
Reference	http://mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/illness/

Name	Assertive Community Treatment Team (ACTT)
Description	Wrap-around continuous, comprehensive, community-based services from a team of mental health professionals.
Population	Adults diagnosed with a serious mental illness needing significant, ongoing support.
Reference	http://mentalhealth.samhsa.gov/cmhs/CommunitySupport/toolkits/community/default.aspx

Name	Family Psychoeducation (FPE)
Description	Structured approach for partnering with consumers and families to support recovery. Consumers and families receive information about mental illness and learn problem-solving, communication and coping

	skills.
Population	Persons with serious mental illness and their families.
Reference	http://mentalhealth.samhsa.gov/cmhs/CommunitySupport/toolkits/community/default.aspx

Name	Wellness Recovery Action Plan (WRAP)
Description	A method to facilitate people with mental health challenges taking charge of their lives and their mental health issues. Methods include: <ul style="list-style-type: none"> • Wellness Toolbox • Daily Maintenance Plan • Identifying Triggers and an Action Plan • Identifying Early Warning Signs and an Action Plan • Identifying When Things Are Breaking Down and an Action Plan • Crisis Planning • Post Crisis Planning
Population	People who experience mental health challenges
Reference	http://www.mentalhealthrecovery.com/aboutus.php

Name	Duluth Model for Domestic Violence
Description	Specialized assessment and treatment for domestic violence offenders
Population	Adult domestic violence offenders
Reference	www.theduluthmodel.org

Name	Integrated Treatment for Co-Occurring Disorders
Description	For adults with serious mental illness and co-occurring substance use disorders.
Population	Consumers receive combined treatment for mental illness and substance use disorders from the same practitioner or treatment team. They receive one consistent message about treatment and recovery.
Reference	http://mentalhealth.samhsa.gov/cmhs/CommunitySupport/toolkits/community/default.aspx

D. Adult Substance Abuse Services

Guiding Principles to Adult Substance Abuse Services

Substance Dependence is a brain disorder. Individuals with addiction are more likely to have predisposing genetic and environmental factors whose addictions are triggered by the use of substances. Services should primarily support abstinence from drugs and alcohol however SMC recognizes the value of harm reduction services (ex. methadone maintenance) in supporting an individual in their journey to recovery. Recovery principles focus on a reduction of relapse, family preservation for families at risk of out-of-home placement by Department of Social Services or reunification, improvement of parenting skills and improvement in the well-being and functioning of his or her children.

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In addition, recovery should also support an individual and improve interpersonal relationships, service engagement for the individual and/or his or her family, and reduction in criminal activity (if applicable). As addiction affects the entire family, SMC supports the inclusion of the family in treatment wherever appropriate.

Adult Substance Abuse Core Service Menu

Service	Service Description
Crisis Services	
Mobile Crisis Management	Rapid 24/7 response team to assess needs, stabilize crisis, and refer to needed services
Walk-In Centers	Easy access to assessment & identification of needed services: emergency, urgent & routine access
Psychiatric Evaluation and Med- Management	Psychiatric evaluation and medication management services, including via telepsychiatry if needed
Facility Based Crisis	Residential crisis stabilization facility; provides detoxification
Inpatient Services	
Psychiatric Inpatient	Hospitalization for psychiatric crises: local community-based hospitals, state hospitals, private hospitals
Substance Abuse Detox (ADATC)	Residential detoxification service in state facility
Substance Abuse Residential Rehabilitation (ADATC)	Residential rehabilitation for substance abuse—provided following detoxification
Intensive Community-Based Services	
Substance Abuse Intensive Outpatient Program (SA IOP)	Intensive, community-based treatment program for substance abuse; may include specialized services for stimulant addiction
DSS SA Services- Adult Treatment Continuum (To be developed; similar to JJTC Model)	
Basic Outpatient Services	
Comprehensive Clinical Assessment	Initial clinical assessment to determine specific substance abuse treatment needs
Individual Therapy	Individual counseling/therapy
Family Therapy	Therapy with family
Group Therapy	Group substance abuse therapy
Recovery Education Center (REC)	Recovery-based program integrating clinical and Peer Support Services; evidence-based classes
Case Management	Planning, facilitation and coordination of services
Specialized Counseling and Case Management for Deaf and Hard of Hearing individuals	Services provided by professionals proficient in American Sign language and knowledgeable about and sensitive to the culture of the Deaf community.

Evidence-Based Practices in Adult Substance Abuse Health

Following are the Evidence Based Practices (EBPs) currently endorsed by SMC for adult substance abuse services.

Name	Matrix Model of Intensive Outpatient Substance Abuse Treatment
Description	Multi-element package of therapeutic strategies to treat substance use disorders. Originally developed for cocaine addiction, the model uses cognitive behavioral therapy, relapse prevention techniques, motivational interviewing and psychoeducational teaching.
Population	Persons with stimulant and other substance use disorders
Reference	http://www.matrixinstitute.org/

Name	Motivational Interviewing (MI)
Description	Motivational interviewing is a directive, client-centered counseling style for eliciting behavior change by helping clients to explore and resolve ambivalence
Population	Adults and adolescents with substance use disorders
Reference	http://www.motivationalinterview.org/clinical/index.html

Name	Contingency Management
Description	The use of small rewards applied contingently to reinforce participation in treatment and accomplishment of goals
Population	Persons receiving substance use disorder treatment
Reference	http://seab.envmed.rochester.edu/jaba/jaba-contingencies.html

Name	Integrated Treatment for Co-Occurring Disorders
Description	For adults with serious mental illness and co-occurring substance use disorders.
Population	Consumers receive combined treatment for mental illness and substance use disorders from the same practitioner or treatment team. They receive one consistent message about treatment and recovery.
Reference	http://mentalhealth.samhsa.gov/cmhs/CommunitySupport/toolkits/community/default.aspx

Name	Dialectical Behavior Therapy (DBT)
Description	System of therapy originally developed to treat persons with borderline personality disorder; combines cognitive-behavioral techniques for emotion regulation and reality-testing with concepts of distress tolerance, acceptance and mindfulness; for co-occurring disorders
Population	For adolescents and adults with borderline personality disorder, substance abuse and related problems

Reference	http://behavioraltech.org/index.cfm?CFID=32522018&CFTOKEN=23721850
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E. Child Intellectual/Developmental Disability Services

Guiding Principles to Child Intellectual/Developmental Disability Services

Promotion of Choice/ Self Determination

Promoting choice is based on the following principles:

- The presumption that all people are competent to make choices about their lives
- Individuals who have difficulty expressing their preferences need to be surrounded by a core group of people who know them well in order to provide assistance with making choices
- Family members can play an important role in supporting people with developmental disabilities but are not entitled to substitute their own interests and wishes for those of a family member with a disability
- Individuals with disabilities do not choose institutions or mini-institutions when they have real knowledge and experience of alternatives
- People with disabilities sometimes make ineffective or harmful choices, like other members of society; disability is not a reason for depriving an individual of the right to make the same choices other people have the right to make, but, choice should never be used to justify neglect
- The best safeguard against ineffective or harmful choices is a network of trusted, caring relationships; choice is not typically a solitary activity and is usually undertaken within the context of a network of close relationships of people

Self-determination is an approach (rather than a model or program) to helping individuals create meaningful lives with effectual opportunities for developing and attaining valued life goals. It offers people the right to select and direct their own services and providers within a personal budget based on needs (rather than available services), make decisions regarding their health and welfare, and freedom from involuntary treatment. Self-determination also promotes consumers' roles in the design, delivery, and evaluation of services and supports. The development of a personal-centered plan and an individualized budget to procure services and supports are hallmarks of self-determination.

Principles of Self-Determination	
Freedom	The ability of an individual together with freely chosen family and friends to plan a life with necessary support rather than purchase a program
Authority	The ability of a person (with a social support network or circle if needed) to control a certain sum of dollars in order to purchase services
Support	The arranging of resources and personnel, both formal and informal, that will assist an individual to live a life in the community rich in community affiliations
Responsibility	The acceptance of a valued role in a person's community through competitive employment, organizational affiliations, spiritual development, and general caring of others in the community, as well as accountability for spending public dollars in ways that are life-enhancing
Confirmation/ Participation	The opportunity for service recipients

Child Developmental Disability Core Service Menu

(See also CAP-MR/DD Services in Table of Current Services below)

Services listed below exclude services for Prevention and Early Childhood Interventions or Education Based services (such as TEACCH) provided or managed by Child Development Service Centers rather than the LME.

Service	Service Description
Crisis Services	
Mobile Crisis Management	Rapid 24/7 response team to assess needs, stabilize crisis, and refer to needed services
Walk-In Centers	Easy access to assessment & identification of needed services: emergency, urgent & routine access
Psychiatric Evaluation and Med- Management	Psychiatric evaluation and medication management services
Inpatient Services	
Psychiatric Inpatient	Hospitalization for psychiatric crises when no more appropriate option is available
ICF-MR	For diagnosis, treatment and rehabilitation for persons with I/DD; provides, in protected residential setting ongoing evaluation, planning, 24-hour supervision, coordination and integration of health or rehabilitative services
Intensive Community-Based Services	
Respite Care	Offers in-home or out-of-home relief to family care givers

Basic Outpatient Services	
Comprehensive Clinical Assessment	Initial clinical assessment to determine treatment needs
Psychological Testing	For determining intellectual capacity and other diagnostic needs
Group Developmental Therapy	Provides skills training in group format
Personal Assistance	Provides supports and assistance to enable individuals to participate in activities in home and community
Personal Care Service	To assist with activities of daily living; only for children >age 13
Individual Therapy	Individual counseling/therapy
Family Therapy	Therapy with child & family
Group Therapy	Group therapy
Targeted Case Management	Planning, facilitation and coordination of services

Evidence-Based Practices in Child Developmental Disability Services

Name	Personal Assistance Services
Description	Personal assistance services encompass a range of human and mechanical supports for individuals who require help with routine activities of daily living and health maintenance. Some individuals require minimal personal assistance to help them live independently and maintain employment, while others need intensive medical interventions, life-sustaining therapies and technologies, ongoing therapeutic services (e.g., physical therapy), and immediate access to emergency medical support
Population	Persons with I/DD
Reference	http://www.sccmha.org/quality/A%20Guide%20to%20Evidence-Based%20Practices%20for%20Individuals%20with%20Developmental%20Disabilities%20V%20%201%2000.pdf

Name	Applied Behavioral Analysis (ABA)
Description	ABA is one of the most widely used and well established methods for treating behavioral excesses and deficits associated with <u>autistic spectrum disorders</u> and <u>pervasive developmental disorders</u> . ABA principles have been found to be applicable to a range issues including developmental delays, significant behavioral problems, and undesirable habits or behaviors. It is used to increase communication, play, social, academic, self-care, work, and community living skills and decrease problem behaviors. The approach teaches social, motor, verbal behaviors and reasoning skills through behavioral observation and positive reinforcement or prompting for each step of a behavior

	Applied behavior analysis interventions (e.g., <u>Functional Communication Training</u> , choice-making, noncontingent reinforcement, and <u>extinction</u>) have a robust base of evidence.
Population	Persons with I/DD
Reference	http://www.sccmha.org/quality/A%20Guide%20to%20Evidence-Based%20Practices%20for%20Individuals%20with%20Developmental%20Disabilities%20V%20%201%2000.pdf

Name	Discrete Trial Training (DDT)
Description	The discrete trials method is a therapy for children with developmental delays and <u>autistic spectrum disorders</u> that is designed to assist with the acquisition of a variety of skills. Discrete trials entail breaking a behavior down into its most basic functional units and presenting these units in a series. A discrete trial typically consists of an antecedent, sometimes combined with a prompt (i.e., a non-essential element used to assist learning or correct responding), the behavior, and a consequence. If the behavior is desired, the consequence is positive (e.g., food, candy, a game, or praise, etc.). If the behavior is not correct, the correct answer is offered, the trial is repeated, and more prompting is provided if needed. An inter-trial interval of a few seconds to separate each trial is provided to allow for processing the information, teaching participants to wait, and to make the onset of the next trial more discrete. Discrete trials can be used to develop most skills including cognitive, verbal communication, play, social, and self-help skills
Population	Persons with I/DD
Reference	http://www.sccmha.org/quality/A%20Guide%20to%20Evidence-Based%20Practices%20for%20Individuals%20with%20Developmental%20Disabilities%20V%20%201%2000.pdf

Name	Positive Behavior Support (PBS)
Description	Positive Behavior Support is a promising multi-component practice designed to ameliorate difficult behaviors. PBS arose from <u>applied behavior analysis</u> , <u>normalization</u> , the inclusion movement, and <u>person-centered</u> values. It is predicated on the belief that most difficult behaviors are purposeful and that people who display difficult behaviors should be treated with compassion and respect, and are entitled to lives of quality. PBS is designed to gain an understanding of the purpose of <u>challenging behavior</u> and construct a plan to promote the development of new skills and decrease the need to engage in adverse behavior. It focuses on assisting individuals to accomplish comprehensive lifestyle changes to improve their own quality of life and that of people who provide support to them. PBS is

	the antithesis of coercion (i.e., control through the use of threats or escape from unpleasant events to manage behavior) which reduces dignity, self-control, and autonomy, can provoke retaliation, requires increasing intensity due to habituation, and can cause physical or psychological harm
Population	Persons with I/DD
Reference	http://www.sccmha.org/quality/A%20Guide%20to%20Evidence-Based%20Practices%20for%20Individuals%20with%20Developmental%20Disabilities%20V%20%201%2000.pdf

F. Adult Developmental Disability Services

Guiding Principles to Adult Developmental Disability Services

Promotion of Choice/ Self Determination

Promoting choice is based on the following principles:

- The presumption that all people are competent to make choices about their lives
- Individuals who have difficulty expressing their preferences need to be surrounded by a core group of people who know them well in order to provide assistance with making choices
- Family members can play an important role in supporting people with developmental disabilities but are not entitled to substitute their own interests and wishes for those of a family member with a disability
- Individuals with disabilities do not choose institutions or mini-institutions when they have real knowledge and experience of alternatives
- People with disabilities sometimes make ineffective or harmful choices, like other members of society; disability is not a reason for depriving an individual of the right to make the same choices other people have the right to make, but, choice should never be used to justify neglect
- The best safeguard against ineffective or harmful choices is a network of trusted, caring relationships; choice is not typically a solitary activity and is usually undertaken within the context of a network of close relationships of people

Self-determination is an approach (rather than a model or program) to helping individuals create meaningful lives with effectual opportunities for developing and attaining valued life goals. It offers people the right to select and direct their own services and providers within a personal budget based on needs (rather than available services), make decisions regarding their health and welfare, and freedom from involuntary treatment. Self-determination also promotes consumers' roles in the design, delivery, and evaluation of services and supports. The development of a personal-centered plan and an individualized budget to procure services and supports are hallmarks of self-determination.

Principles of Self-Determination	
Freedom	The ability of an individual together with freely chosen family and friends to plan a life with necessary support rather than purchase a program
Authority	The ability of a person (with a social support network or circle if needed) to control a certain sum of dollars in order to purchase services
Support	The arranging of resources and personnel, both formal and informal, that will assist an individual to live a life in the community rich in community affiliations
Responsibility	The acceptance of a valued role in a person's community through competitive employment, organizational affiliations, spiritual development, and general caring of others in the community, as well as accountability for spending public dollars in ways that are life-enhancing
Confirmation/ Participation	The opportunity for service recipients

Adult Developmental Disability Core Service Menu

(See also CAP-MR/DD Services in Table of Current Services below)

Service	Service Description
Crisis Services	
Mobile Crisis Management	Rapid 24/7 response team to assess needs, stabilize crisis, and refer to needed services
Walk-In Centers	Easy access to assessment & identification of needed services: emergency, urgent & routine access
Psychiatric Evaluation and Med- Management	Psychiatric evaluation and medication management services
NC Systemic Therapeutic Assessment, Respite & Treatment Program (NC-START)	Crisis assessment, intervention and consultation service for persons with Intellectual/Developmental Disabilities; includes crisis respite
Inpatient Services	
Psychiatric Inpatient	Hospitalization for psychiatric crises when no more appropriate option is available
ICF-MR	For diagnosis, treatment and rehabilitation for persons with I/DD; provides, in protected residential setting ongoing evaluation, planning, 24-hour supervision, coordination and integration of health or rehabilitative services
Intensive Community-Based Services	

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Respite Care	Offers in-home or out-of-home relief to family care givers
Residential Services	Staffed, supervised, supported residential facilities
Basic Outpatient Services	
Comprehensive Clinical Assessment	Initial clinical assessment to determine treatment needs
Psychological Testing	For determining intellectual capacity and other diagnostic needs
Group Developmental Therapy	Provides skills training in group format
Personal Assistance	Provides supports and assistance to enable individuals to participate in activities in home and community
Personal Care Service	To assist with activities of daily living; only for children >age 13
Individual Therapy	Individual counseling/therapy ask Christina
Family Therapy	Therapy with child & family
Group Therapy	Group therapy
Targeted Case Management	Planning, facilitation and coordination of services

Evidence-Based Practices in Adult Developmental Disability Services

Name	Supported Employment
Description	Supported Employment (SE)19 has been a model for employment services since the early 1980s and is a model for assisting individuals with disabilities obtain and maintain paid, competitive, employment in a full-time or part-time job/career in integrated work settings where co-workers are persons without disabilities. Supported employment provides needed supports to insure success and has been found to benefit persons with disabilities for whom competitive employment has not typically been available, or who, due to their disability, require intensive support services or extended services to maintain gainful employment. Employment Specialists assist job seekers with disabilities in job exploration to discover their work interests and abilities. They also provide job development services to help individuals find jobs that match their interests. Employment Specialists also provide work-site job coaching to help consumers learn the skills of a particular job and ongoing job supports to assist both workers and employers with issues related to job performance in order to achieve ongoing success.
Population	Persons with I/DD
Reference	http://www.sccmha.org/quality/A%20Guide%20to%20Evidence-Based%20Practices%20for%20Individuals%20with%20Developmental%20Disabilities%20V%20%201%200.pdf

Name	Personal Assistance Services
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Description	Personal assistance services encompass a range of human and mechanical supports for individuals who require help with routine activities of daily living and health maintenance. Some individuals require minimal personal assistance to help them live independently and maintain employment, while others need intensive medical interventions, life-sustaining therapies and technologies, ongoing therapeutic services (e.g., physical therapy), and immediate access to emergency medical support
Population	Persons with I/DD
Reference	http://www.sccmha.org/quality/A%20Guide%20to%20Evidence-Based%20Practices%20for%20Individuals%20with%20Developmental%20Disabilities%20V%20%201%2000.pdf

Name	Applied Behavioral Analysis (ABA)
Description	<p>ABA is one of the most widely used and well established methods for treating behavioral excesses and deficits associated with <u>autistic spectrum disorders</u> and <u>pervasive developmental disorders</u>. ABA principles have been found to be applicable to a range issues including developmental delays, significant behavioral problems, and undesirable habits or behaviors. It is used to increase communication, play, social, academic, self-care, work, and community living skills and decrease problem behaviors. The approach teaches social, motor, verbal behaviors and reasoning skills through behavioral observation and positive reinforcement or prompting for each step of a behavior</p> <p>Applied behavior analysis interventions (e.g., <u>Functional Communication Training</u>, choice-making, noncontingent reinforcement, and <u>extinction</u>) have a robust base of evidence.</p>
Population	Persons with I/DD
Reference	http://www.sccmha.org/quality/A%20Guide%20to%20Evidence-Based%20Practices%20for%20Individuals%20with%20Developmental%20Disabilities%20V%20%201%2000.pdf

Name	Positive Behavior Support (PBS)
Description	Positive Behavior Support is a promising multi-component practice designed to ameliorate difficult behaviors. PBS arose from <u>applied behavior analysis</u> , <u>normalization</u> , the inclusion movement, and <u>person-centered</u> values. It is predicated on the belief that most difficult behaviors are purposeful and that people who display difficult behaviors should be treated with compassion and respect, and are entitled to lives of quality. PBS is designed to gain an understanding of the purpose of <u>challenging behavior</u> and construct a plan to promote the development of new skills

	and decrease the need to engage in adverse behavior. It focuses on assisting individuals to accomplish comprehensive lifestyle changes to improve their own quality of life and that of people who provide support to them. PBS is the antithesis of coercion (i.e., control through the use of threats or escape from unpleasant events to manage behavior) which reduces dignity, self-control, and autonomy, can provoke retaliation, requires increasing intensity due to habituation, and can cause physical or psychological harm
Population	Persons with I/DD
Reference	http://www.sccmha.org/quality/A%20Guide%20to%20Evidence-Based%20Practices%20for%20Individuals%20with%20Developmental%20Disabilities%20V%20%201%2000.pdf