

# Revised Alternative or “in Lieu of” Service Description Template

## MCO Submitting: Sandhills Center

### 1. Service Name and Description:

**Service Name:** Family Centered Treatment®

**Procedure Code:** H2022 Z1 - Engagement and transition; H2022 HE - reimbursed per month - Core

*In response to COVID-19, adding H2022 Z1 U4, H2022 HE U4 and H2022 Z2 U4 to allow telehealth and virtual health services to be offered remotely*

### Definitions:

- **Therapist:** Associate or licensed therapist responsible for providing treatment to the child and family
- **Team:** Multi-disciplinary team of therapists charged with guiding treatment and fidelity to the FCT model
- **FCT Certification:** All FCT Clinicians undertake and successfully complete a competency-based, standardized training/certification process. Certification given by FCT Foundation and renewed every two years.

### Description:

Family Centered Treatment® (FCT©) is a comprehensive evidence-based model of intensive in-home treatment for at risk children and adolescents and their families. Designed to promote permanency goals, FCT treats the youth and his/her family through individualized therapeutic interventions. Children and adolescents eligible for FCT may be facing involvement in the juvenile justice system, out-of-home placements, and/or reunification and may display severe emotional and behavioral challenges due to maltreatment (neglect, abuse), trauma (from domestic violence, sexual abuse, substance abuse), and/or serious mental health disorders. By improving youth and family functioning, FCT provides an alternative to out-of-home placements or, when it is in the youth’s best interest to be placed out of the home, to minimize the length of stay and reduce the risk of recidivism. FCT is delivered by an assigned therapist with a caseload of 4-6 individuals/families. FCT is supervised by a trained FCT supervisor.

### The FCT difference:

***FCT is a researched, viable alternative to residential placements, hospitalization, correctional facility placement and other community-based services.*** A distinctive aspect of FCT is that it has been developed as a result of frontline practitioners’ effective practice. FCT is one of few home-based treatment models with extensive experience with youth with severe emotional and behavioral challenges, dependency needs, and mental health diagnosis as well as histories of delinquent behavior,

otherwise known as crossover youth. In addition, FCT is extremely cost-effective and stabilizes youth at risk and their families.

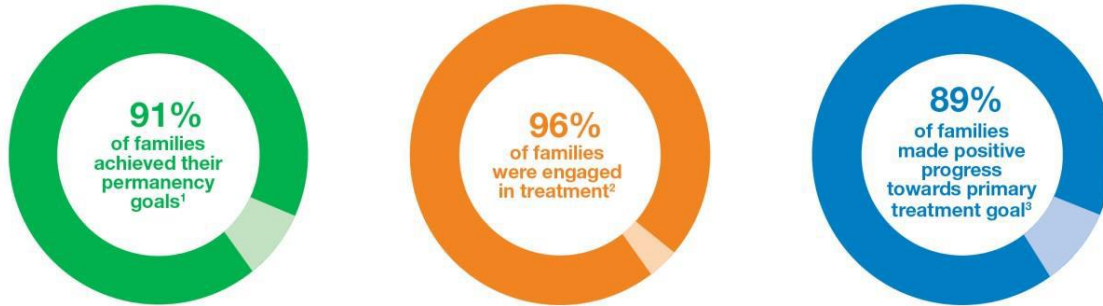
FCT is based on eco-structural therapy and emotionally focused therapy. It focuses on getting to the root of problem behaviors and internalizing change, thus **creating sustainable change and decreasing the likelihood of recidivism**. Based on the understanding that families requiring such services may have experienced trauma, all phases incorporate **trauma-focused treatment**. Other characteristics of the model that set FCT apart are highlighted below.

- An evidence-based model, FCT is an improvement on many models of treatment used as part of community-based services because it is a systemic model that works intensively and collectively with family members, thereby positively impacting the family system and decreasing the likelihood of further involvement into the system by any family member.
- FCT was designed to be flexible to meet the needs of youth, family, and their community. The practitioner-based model in large part had its formative years of development in North Carolina and has since been successfully established in several other states (currently MA, MD, OH, IN, FL, VA, RI).
- FCT is provided by only by credentialed staff who must complete the rigorous FCT certification program.
- A distinct and meaningful difference of FCT is in determining whether a family is truly engaged in treatment or not. Other models typically define engagement as two to three sessions. FCT, however, defines engagement in treatment as the completion of five sessions.
- Transitional indicators are utilized to assist the family in recognizing how they are moving through the treatment process. Unlike others models, the indicators are determined by the family's progress and not by designated timeframes. This allows the family system to move through treatment at a pace specific to their needs. It also enables the family to feel empowered in the FCT process.
- Fifteen fidelity measures indicate progression through the phases of FCT treatment.
- A unique feature of FCT is the Giving Back Project. As part of the FCT phases, the family engages in a project that strengthens their ties to the community, builds their self-esteem, and provides an opportunity to bond further and to practice the skills they've learned.

FCT outcomes compare favorably with the best in the field, especially on such key dimensions such as

- Success in preventing out of home placement
- Reunification
- Engagement rates
- Customer satisfaction and
- Recidivism

The MENTOR Network's national outcomes utilizing this model demonstrate FCT's effectiveness.



Based on The MENTOR Network's FCT outcome data trends averaged from 2009 - 2013 for engaged clients.

<sup>1</sup> Clients who at the time of discharge either remain at home, are reunited with their family, live independently, or are in a planned discharge placement.

<sup>2</sup> Engaged clients are those who had more than five direct contacts with their clinician; who did not transfer, relocate or run away; and whose funding did not end during treatment.

<sup>3</sup> As reported by families and clinicians.

Specific treatment techniques are integrated from empirically supported behavioral and family therapies including eco-structural and emotionally focused treatment. In addition to focusing on the youth, FCT also engages the family in treatment. FCT therapists strengthen the family's problem-solving skills and operant family functioning systems, including how they communicate, handle conflict, meet the needs for closeness, and manage the tasks of daily living that are known to be related to poor outcomes for children/youth. The therapist, in conjunction with the youth, family, and other stakeholders, develops an individualized treatment plan. Using established psychotherapeutic techniques and intensive family therapy, the therapist works with the entire family, or a subset, to implement focused interventions and behavioral techniques designed to:

- Enhance problem-solving
- Improve limit-setting
- Develop risk management techniques and safety plans
- Enhance communication
- Build skills to strengthen the family
- Advance therapeutic goals
- Improve ineffective patterns of interaction
- Identify and utilize natural supports and community resources for the youth and parent/caregiver(s) in order to promote sustainability of treatment gains

FCT's personalized interventions are designed to strengthen the family's capacity to improve the youth's functioning in the home and community with a goal of preventing the need for a youth's admission to an inpatient hospital, psychiatric residential treatment facility, or other treatment setting. FCT utilizes sessions with greater frequency and intensity than other in-home services. FCT therapists provide a minimum of two multiple-hour sessions per week and increase this as indicated by the youth and family's evolving needs. Frequent, intensive therapy in the context of the family/home setting facilitates sustainable change via immediate and on-site enactments or coaching to parents, offering support where and when suggestions are most needed. Phone contact and consultation are provided as part of the intervention. In addition, unlike other in-home models, the first and last month of FCT treatment—joining and discharge respectively—are not tied to the minimum standard due to the titration up and

down of service provision. With FCT, a therapist is available 24 hours a day, seven days a week during each phase of FCT to provide additional support and crisis services as indicated.

**2. Information About Sandhills Center Population to be Served:**

| Population                                   | Age Ranges | Projected Numbers                                       | Characteristics  |
|--|------------|---|--|
| Child with behavioral and/or emotional needs | 3-20       | 1,185 Intensive In-Home members served last fiscal year | <p>a. there is a mental health or substance use disorder diagnosis (as defined by the DSM-5, or any subsequent editions of this reference material), other than a sole diagnosis of intellectual and developmental disability; <b>and</b></p> <p>b. there is significant family functioning issues that have been assessed and indicated that the beneficiary would benefit from family systems work (to include access to service issues and family multi-stress situations) <b>as evidenced by one or more of the following:</b></p> <ul style="list-style-type: none"> <li>• a step down from a higher level of care</li> <li>• there has been DSS involvement in the last year</li> <li>• there has been Juvenile Justice involvement in the last 6 months</li> <li>• there has been a behavioral health Emergency Room visit and/or hospitalization in the last 6 months</li> <li>• there have been multiple school suspensions</li> <li>• there have been crisis intervention in the last 6 months to include (but not exclusive of) law enforcement involvement, crisis line calls, mobile crisis service, emergency crisis bed stay</li> <li>• physical abuse</li> <li>• verbal abuse</li> <li>• sexual abuse</li> <li>• physical neglect</li> <li>• emotional neglect</li> <li>• parent or caretaker that abuses substances</li> <li>• parent or caretaker that is the victim of domestic violence</li> </ul> |

|  |  |  |   |
|--|--|--|---|
|  |  |  | <ul style="list-style-type: none"> <li>• parent or caretaker that has a mental health diagnosis</li> <li>• the loss of a parent or caretaker to divorce, abandonment or death</li> <li>• a parent or caretaker that is incarcerated</li> <li>• a significant other traumatic event to include (but not exclusive of) watching a sibling being abused, homelessness, surviving and recovering from a severe accident.</li> </ul> |
|--|--|--|---|

**3. Treatment Program Philosophy, Goals and Objectives:  
Treatment Program Philosophy:**

**Family Centered Treatment® Philosophy**

The evidence-based model Family Centered Treatment® (FCT©) is founded in the belief that families seemingly stuck in a downward spiral can make positive, lasting changes. Resilience theory holds that children and families have the capacity to function well in the face of significant life challenges. Because of this belief, all aspects of treatment value the youth and family’s voice in the process and employ strength-based approaches that focus on hope rather than on deficits, challenges, and barriers. The intention is to promote permanency goals while preserving the dignity of youth and families within their culture and community.

FCT’s origins derive from practitioners’ efforts to find practical, commonsense solutions for families faced with forced removal of their children from the home or dissolution of the family, due to both external and internal stressors and circumstances. FCT is an alternative model grounded in the use of sound and research-based treatment. Personalized techniques are integrated from empirically supported behavioral and family therapies and services are provided frequently, with FCT therapists available 24/7 to support the youth and family when needed. Addressing needs while observing strengths and patterns of interaction as they are happening allows skilled practitioners to help families create change in the core components of family functioning.

Another guiding principle of FCT is that it is family centered. While the referred client is integral to the treatment process, FCT is a family system model of home-based treatment, and treatment can and does occur with other members when their behaviors or roles are critical to the progress of the referred family member (client). All phases of FCT involve the family intensively in treatment. During the assessment phase, the family defines their “family constellation,” and those members are invited to participate in the structural family assessment and subsequent treatment activities as directed. Other individuals who may have key roles in the youth’s wellbeing (e.g., caregivers, stakeholders, psychiatrists, etc.) are also viewed as critical to the success of FCT and are, at minimum, informed of treatment progress. They can be more integrally involved based on the family’s need.

In addition, FCT places emphasis on the value of support systems—both during and after treatment. FCT develops a system of community resources and natural supports based on the youth and family's needs and preferences to enhance the individualized treatment plan by providing opportunities for further skill development. Building a network of support will also promote sustainable outcomes by providing the youth and family with resources to utilize after discharge.

### **Objectives and Goals:**

The overarching objective of providing FCT to families is to keep children safe and thriving in their home environment. Specifically, the objective of FCT is to provide an alternative to out-of-home placements, minimize the length of stay in out-of-home placements, and reduce the risk of additional out-of-home placements by improving child/youth and family functioning. To achieve this, targeted goals for FCT include:

- Decrease in high risk placements
- Decrease in the length of stay of high risk placements
- Decrease in emergency room visits
- Successfully engage families in treatment (target = 85% of families)
- Maintain low recidivism rate (target = less than 10% of clients will require future FCT services minimally six months post discharge because of an increase in sustainability and stability due to focus on family functioning)
- Reduce or eliminate symptoms, including antisocial, aggressive, violent behaviors or those symptoms related to trauma or abuse/neglect
- Achieve permanency goals (target = 90% of clients will either remain in their home, reunite with their family, live independently or have a planned placement upon discharge)
- Improve and sustain developmentally appropriate functioning in specified life domains
- Enable family stability via preservation of or development of a family placement
- Enable the necessary changes in the critical areas of family functioning that are the underlying causes for the risk of family dissolution
- Reduce hurtful and harmful behaviors affecting family functioning
- Develop an emotional and functioning balance in the family so that the family system can cope effectively with any individual member's intrinsic or unresolvable challenges
- Enable changes in referred client behavior to include family system involvement so that changes are not dependent upon the therapist
- Enable discovery and effective use of the intrinsic strengths necessary for sustaining the changes made and enabling stability

### **4. Expected Outcomes:**

- Decrease in high risk placements
- Decrease the length of stay of high risk placements
- Decrease In Emergency Room Visits
- 85% of families will successfully engage in treatment

- Less than 10% of clients will need future FCT services minimally 6 months post discharge because of an increase in sustainability and stability due to focus on family functioning
- 90% of clients will either remain in their home, reunite with their family, live independently or have a planned placement upon discharge

#### **5. Staffing Qualifications, Credentialing Process, and Levels of Supervision (Administrative and Clinical) Required:**

In addition to being a clinical model, FCT also includes important management and supervisory components, which are integral to the fidelity and outcomes that this evidence-based practice achieves. In order to implement FCT:

- Staff must be licensed or associate licensed.
- All staff, licensed and associate licensed, must be fully certified in FCT within twelve months of their initial hire via the official FCT certification program, Wheels of Change®. Certification is granted through the Family Centered Treatment Foundation (FCT Foundation) when staff pass and show competence in required components.
- All staff must be “checked off” by demonstrating competency in 16 core skills related to the FCT model to complete the full FCT certification process. These check-offs are completed during direct observations of the therapist’s sessions with clients by the certified Family Centered Treatment Specialist (FCTS).
- All staff must complete a minimum of 10 hours per year of Continuing Education. This is monitored by the Clinical Director.
- All staff must be recertified in FCT every 2 years.

#### **Credentialing Process:**

- All staff are required to provide a professional resume Human Resources which is then used for credentialing purposes along with the staffs job application and licensure confirmation. The resume must detail prior experience, including experience with specific populations. Credentialing is reviewed and signed off by Clinical Director.
- Prior to beginning employment, staff must complete Reference Checks, including Employment Verification for the purpose of credentialing, and Primary Source verification.

#### **Supervision:**

FCT understands that for effective services to implement and perform to scale effective supervision is essential. Through rigorous training and oversight, FCT supervisors provide critical key clinical oversight to their teams and with guidance through the FCT Foundation. Both peer and individual supervision is provided as part of the FCT model. Program Directors provide supervision of therapists and regional office staff. Program Directors are selected based upon credential qualifications, experience, leadership skills, family systems orientation, and team leadership skills.

Each therapist receives an average of five (5) hours of supervision per week. This is a combination of peer supervision, individual supervision, as well as field and on call supervision support. Peer supervision occurs in FCT teams which meet no more than weekly for clinical case supervision and oversight. The Program Director, designated licensed staff members, or other FCT Directors provide individual supervision or consult. The Program Director is available on-call to each employee and may refer the employee to other FCT Directors for consultation. Each supervision session, whether provided in the field, office, or on the phone (on-call), is recorded by the FCT therapist on a supervision form indicating direction given. The form is signed by the therapist and person providing the supervision and is then entered into the therapist's personnel file.

Use of the national recognized best practices family system's case review process (family mapping, intervention, goals and strategies; aka John Edward's MIGS) is utilized and strategies determined are reviewed during the next team meeting. Weekly team meetings are comprised of Program Director, and staff who are FCT certified or are in the process of certification, and the FCTS (trainer). The mixture of expertise, licensure, certification, and experience at each team meeting provides continuity of care, alternative perspectives on treatment, allows for specialty expertise to be brought in at critical junctures AND focuses highly on effective therapist *use of self* (process that examines what the therapists are bringing into the treatment process themselves). Supervision notes, team meeting minutes and case reviews are tracked and monitored for adherence to the model via the FCT Clinical Practice Team.

FCT Supervisors are Certified Supervisors in FCT, or enrolled in the FCT Supervisors course and have a minimum of two years of service delivery of FCT or Licensed/Associated Licensed and a Certified Supervisor in FCT, or enrolled in the FCT Supervisors course.

#### **FCT Management and Supervisory Training:**

FCT's management and supervisory components are integral to the model fidelity and client outcomes that are achieved. Therefore, all managers of frontline staff are required to complete the FCT Supervisory Certification Course which includes an experiential practice-based component. The requirements for the FCT Management and Supervisory Course also include the successful completion of the online training curriculum as well as the assignments associated with each unit. There are eight units in the online curriculum:

- 1) Supervision basics and introduction to FCT supervision
- 2) FCT supervision in Joining and Assessment Phase of treatment
- 3) FCT supervision in the Restructuring Phase of treatment
- 4) FCT supervision in the Valuing Change Phase of treatment
- 5) FCT supervision in the Generalization Phase of treatment
- 6) FCT use-of-self-development in supervision
- 7) Leading high performing teams
- 8) Overview and putting it all together

Each of these units consists of learning key concepts on how to guide staff in delivering each phase of treatment effectively. There are supervisory documents that help guide the process to ensure that supervisors are adhering to and producing high fidelity to the model.



**Additional Support for FCT Provision:**

- Clinical Director provides oversight and guidance on clinical issues.
- Director of FCT Training and Development provides intense support of State Trainer as well as consult on distinct case issues related to the model of treatment.
- Senior Director of FCT Clinical Practice provides monitoring and oversight as well as consult for cases triggered for review and when requested.
- Psychiatric consult is provided by the North Carolina Medical Director.
- Area Trainer provides direct support to the FCTS (Regional Trainer) including monthly team meetings, weekly consultation on clinical issues as well as ensuring fidelity to the FCT model
- Family Centered Treatment Foundation (FCT Foundation), owner of the FCT model, provides continuous oversight and program evaluation of FCT provision, including but not limited to regular structured monitoring of all sites.

The FCTS (Regional Trainer) works weekly with FCT therapists to ensure adherence to the fidelity of the model and assure quality services with field observation. In addition the FCTS models the skill and provides practice experiences to teach and coach therapists. They also observe therapists in the field or via videotape to assess competency in the core required FCT skills.

**Family Centered Treatment® Training:**

The FCT certification program, including Wheels of Change®, ensures that each FCT therapist is trained in the principles of youth-guided, family-driven empowerment and can identify and assess child abuse/neglect, domestic violence, and substance abuse issues, as well as how to assist families affected by past trauma in times of crisis. Wheels of Change® (WOC) is a component of a structured certification process that utilizes the five aspects of training modalities: teaching, observing, performing the required task or skill, being observed with checklists to assess competence, and evaluation. Successful completion results in certification in FCT by the FCT Foundation.

Overseen by the FCTS Trainer, therapists undertake and successfully complete an intensive competency-based, standardized training/certification process. This knowledge based portion of the certification process includes testing of knowledge, audio visual learning, discussion boards, and videos of core skills in practice. FCT staff are trained in direct mental health services, long- and short-term mental health interventions designed to maintain family stability, individual and family assessments, Community-Based Partnerships, Cultural Competency, individual, family, and group counseling, individualized service planning, 24-hour crisis intervention and stabilization, skills training, service coordination and monitoring, referrals to community resources, follow-up tracking, and coordination with local stakeholders.

**Trauma Focused Training:**

Because all families are assessed for trauma at the onset of services, all FCT therapists must maintain a level of competency in this area. In order to demonstrate the skills necessary to assess trauma, staff must undergo comprehensive trauma-based training. These skills include recognizing the presence of trauma through interactions and assessment tools and developing personalized interventions to address

trauma as identified. The subjects covered in the guided online Trauma Based Training component of the WOC program units include:

- i. Essential Elements of Trauma Treatment (Why do we utilize Trauma Treatment?)
- ii. Trauma Assessments, FCT Trauma Treatment and Creating a New Narrative
- iii. Practical Tools and Implementation

Field-based practice of the required core skills and supervision occurs simultaneously as trainees take the online course.

FCT supervisors must obtain certification as FCT supervisors. This training and development process includes successful completion of the FCT Supervisors on line, audio visual, tested training course inclusive of peer reviews, video submissions of core supervision competencies in the four phases of FCT, and live leadership training development.

**6. Unit of Service:**

| Services  | rate      | unit of service |
|---|-----------|-----------------|
| Engagement (5 sessions)*                                    | \$254.20  | day             |
| *only billed to the MCO after the 5 sessions                |           |                 |
| Core Service (length of treatment based on family progress) | \$3045.00 | month           |
| Joining/Assessment  |           |                 |
| Restructuring   |           |                 |
| Valuing Change  |           |                 |
|   |           |                 |
| Transition(Average sessions = 6)                            | \$254.10  | day             |
| Generalization  |           |                 |

**7. Anticipated Units of Service per Person:**

Engagement and Transition are broken out from the Core services in order to allow for individualized care for all clients and their families. It is expected that engagement should occur with families within 5 sessions on average, core services should be an average of 4 months/units and transition an average of 6 sessions.

**8. Targeted Length of Service:**

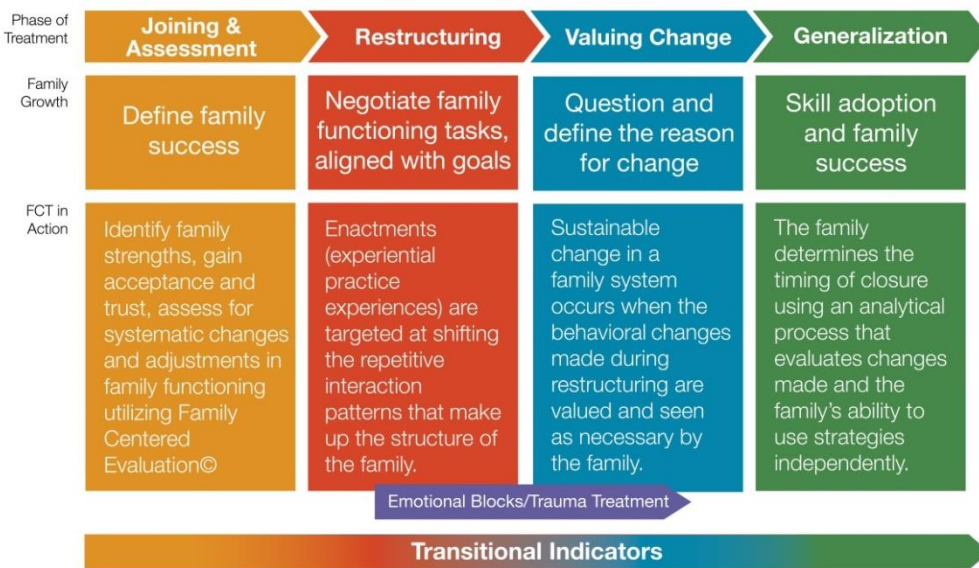
- a. National target standards are 6 months, with the national average at 6.4 months (n=>2,000 families)
- b. It is important to note that in scenarios where reunification or ‘unknown’ reunification is the objective the national benchmarks for 6 months of service differs. When permanency or reunification is in question additional time to work with the family/caregivers/child is often warranted, extending the treatment time to 9-11 months. The rationale for this is several fold:

- i. Additional time is often needed to assess safety and permanency needs in the early months
- ii. Frequently systems (courts) exceed 6 months to make a ruling surrounding permanency
- iii. The underlying complex dynamics of the systems involved: extreme distrust of the agencies and resistance to intervention and treatment require much longer treatment times for developing trust necessary for effective engagement and adjustments that often occur to the permanency plan.

**9. Describe why this service is needed and is different than any State Plan or alternative service already defined. If implemented in other states, describe successful outcomes.**

Family Centered Treatment® (FCT©) has been a structured model since 2004, and the model achieved evidence-based status in 2010. FCT is an alternative model to IIH that is grounded in the use of treatment components that are sound and research-based. FCT is comprehensive and designed to address the causes of family system breakdown. The model not only focuses on changing negative behaviors—it also emphasizes the value of positive change so that families are more likely to sustain improvements in family functioning after treatment. FCT therapists are available to families 24/7. Attending to strengths, needs, and patterns of interaction while they are happening allows skilled practitioners to help families create change in the core components of family functioning.

The FCT model consists of the following four phases:



The third phase of treatment, valuing changes, through use of paradoxical and experiential exercises, seeks to confirm and capitalize on internal changes within the family so that the family is not dependent on the therapist once services terminate.

Highlights for FCT outcomes based upon National data for 2013:

- **Engagement:** FCT achieved successful engagement of 85% for all clients served (n=1,101 and measured using a minimum threshold of 5 or more sessions).
- **Avoiding Expensive Residential Placements:** 89% of engaged clients remained in their home, were reunited with their family, were living independently or were in a planned placement at discharge.
- **Customer Satisfaction:** 87% of families that responded reported that FCT improved their family life.
- **Progress towards Treatment:** 97% of families that responded reported Positive Progress on their Primary Treatment Goal.
- **Recidivism:** 9% of all clients served have had previous MENTOR involvement. However, the previous history is most likely not FCT.

**10. Cost-Benefit Analysis: Document the cost-effectiveness of this alternative service versus the State Plan services available.**

- January 1, 2019 – December 31, 2019, an average of 192 members per month were served in IIHS with Medicaid payments of \$534,563, or an average monthly cost of \$2,784. FCT averages \$2,496 monthly, a decrease of \$288 per case served with FCT.
- NREPP cost benefit summary:

|                            |  |
|----------------------------|--|
| <p><b>Key Findings</b></p> | <p>In a retrospective study, adjudicated youth in Maryland who were eligible for both FCT (intervention group) and placement in residential treatment (comparison group) were assigned to one treatment group by the courts. The sample of youth in the FCT group was drawn from all youth discharged from FCT during the first 4.5 years of FCT field implementation in Maryland (July 2003 to December 2007), and the sample of youth in the comparison group was drawn from all youth discharged during the same timeframe from group homes, therapeutic group homes, and other residential placements offering similar types of services.</p> <p>The average program costs for each youth in group homes (\$36,630) and therapeutic group homes (\$36,348) were more than 3 times the average program cost of each youth receiving FCT (\$12,080) in 2006 (p &lt; .0001). Had FCT been unavailable, all youth would have received residential treatment, and the cost for serving those youth would have been \$16.3 million. Every \$1.00 spent on FCT services for youth saved the State of Maryland between \$2.03 and \$2.29, for a total estimated savings of \$10.9 million to \$12.3 million from July 2003 to December 2007.</p> |
|----------------------------|--|

**Description of comparable State Plan Service Payment Arrangements (include type, amount, frequency, etc.)**

| Service | Procedure Code | Unit Definition | Units of Service | Cost of Service |
|---------|----------------|-----------------|------------------|-----------------|
| IIHS    | H2022          | Per Diem        | 64               | 17,351          |
|         |                |                 |                  |                 |

**Description of Alternative Service Payment Arrangements (include type, amount, frequency, etc.)**

| Service          | Procedure Code                     | Unit Definition | Units of Service                                       | Cost of Service          |
|------------------|------------------------------------|-----------------|--|--------------------------|
| FCT - Core       | H2022 HE<br><i>H2022 HE<br/>U4</i> | Per Month       | 4  | 12,180<br>(4 X \$3045)   |
| FCT- Engagement  | H2022 Z1<br><i>H2022 Z1<br/>U4</i> | Per Diem        | *5<br><br>*only billed to the MCO after the 5 sessions | \$1271<br>(5 X \$254.20) |
| FCT - Transition | H2022 Z2<br><i>H2022 Z2<br/>U4</i> | Per Diem        | 6  | \$1525<br>(6 X \$254.10) |

**Description of Process for Reporting Encounter Data (include record type, codes to be used, etc.)**

Data will be uploaded to the state by the MCO. Per Diem used for Engagement and Transition and monthly rate for Core Services.

**Description of Monitoring Activities :**

FCT Foundation oversees and consistently performs program evaluation through data analysis (data is given to FCT Foundation on a quarterly basis for evaluation). Sandhills Center intends to receive copies of the external fidelity reviews regularly.

Respectfully Submitted by Sandhills Center