



Title:	Child Focused Assertive Community Treatment (Child ACT)	Code	H0040 U5 HA H0040 U5 HA EN-Encounters
Type:	In Lieu of Service (ILOS)	Group Code	Tailored Plan and Medicaid Direct
Effective Date:	3/31/2026	Units	1 unit = 1 week

Service Description
Child Focused Assertive Community Treatment (Child ACT) is a team-based multi-disciplinary approach to serve children in their community-based home setting. This includes homes, kinship placements, Department of Social Services (DSS) foster homes, or may begin during transition from a Therapeutic residential setting. Child ACT uses a community-based team approach to meet the needs of youth with Serious Emotional Disturbance (SED). Child ACT meets the needs of youth who meet criteria listed below: • Are at high risk for out-of-home residential treatment due to a Mental Health (MH) or Substance Use (SU) diagnosis, or are preparing to step down from Residential Treatment Services and/or Psychiatric Residential Treatment • Have a history of multiple psychiatric hospitalizations or History of one or more long term (greater than 30 calendar days) psychiatric hospitalization(s) at a state facility • Have a history of multiple episodes of Residential Treatment Services and/or Psychiatric Residential Treatment Facility (PRTF) services • Conventional outpatient treatment (Outpatient Therapy, Intensive In-Home services, etc.) has not been effective in reducing symptom severity • Symptoms meet criteria for admission to Psychiatric Residential Treatment Facility services would be recommended. Services include the member, family or natural supports, community supports as needed, and school/work supports as needed. Services include individual therapy, family therapy, skills interventions, nursing evaluation and health supports, medication evaluation and management (if appropriate), and care coordination. The team shall assess the overall needs of the family to ensure that all necessary treatment and supports are in place for the entire family system. Service frequency will vary, depending on current needs of the member. It is expected that frequency of visits will increase as needed to promote community stay and prevent hospital and/or other placements. As members stabilize, services will titrate. For example, if a youth is escalating and at risk for hospitalization, a minimum of three direct contacts a week is recommended. Alternately, a youth nearing step-down to a lower level of care may require only one direct contact a week. Targeted length of service is six months or until the time the family and youth are assessed to be eligible for step down to a lower level of care. Treatment interventions will be individualized and based on evidence-based practices, with

methodologies selected according to each member's unique clinical needs. The following are examples of approaches that may be utilized; however, this is not an exhaustive list, and additional modalities may be incorporated as clinically appropriate:

- Trauma Systems Therapy (underlying agency-wide treatment model)
- Trauma Focused Cognitive Behavioral Therapy (TF-CBT)
- Dialectical Behavior Therapy (DBT)
- Cognitive Behavioral Therapy (CBT)
- Family Systems Approach (Teaching Family Model or other modalities)
- Motivational Interviewing (MI)
- Attachment Self-Regulation and Competency (ARC)
- Wellness Recovery Action Plan (WRAP) (If the team has a Youth Peer Support Specialist)
- Seeking Safety
- Zones of Regulation
- Other models as determined by youth/family need.

Utilization Management

- **Unit of service:** 1 unit = 1 week
- **Anticipated Units of Service per person:** 24 units (6 months)

Encounters will be reported under service code: H0040 U5 HA EN as a weekly unit of service.

Child ACT is a flexible service provided in an individualized manner. As such, service frequency and intensity will vary across beneficiaries. However, when considering caseload averages, the treatment team must see beneficiaries, on average, 1.5 times per week and for at least 60 minutes per week.

The median rate of service frequency and the median rate of service intensity will be the key elements for monitoring Child ACT services. The median rate of service frequency is the mean number of face-to-face contacts the team has with a given beneficiary in a week. It is calculated by totaling the number of such contacts in a 4-week period and dividing by 4. The weekly averages (means) across all beneficiaries are then rank-ordered low to high, and the middle beneficiary is selected to represent all beneficiaries.

Child ACT team services may be billed for up to 30 days in accordance with the Person-Centered Plan for beneficiaries who are transitioning to or from Intensive In Home, Day Treatment, Residential levels 2-4, TASK, MST A discharge SAR should be submitted at the time of discharge.

Tailored Care Management will not be provided during the same authorization period as Child ACT to avoid duplication. The provider is required to fulfill all care management duties, including coordinating with physical health providers, with the exception of delivering interventions related to Healthy Opportunities and prevention and population health programs. A care coordinator may be assigned to member to ensure there are no gaps in member care.

Inpatient, Facility-Based Crisis, and emergency department services can still be accessed as medically necessary for crisis stabilizations.

Entrance Process

A comprehensive clinical assessment (CCA) that demonstrates medical necessity must be completed prior to provision of this service. If a substantially equivalent assessment is available, reflects the current level of functioning and contains all the required elements as outlined in community practice standards as well as in all applicable federal and state requirements, it may be used as a part of the current CCA. Relevant diagnostic information must be obtained and included in the Person-Centered Plan (PCP).

A signed service order must be completed by a Medical Doctor (MD), Doctor of Osteopathic Medicine (DO), Doctoral level Licensed Psychologist, Physician Assistant (PA), or a Nurse Practitioner (NP) according to his or her scope of practice. Each service order shall be signed and dated by the authorizing professional and shall indicate the date on which service was ordered. A service order must be in place prior to or on the day the service is initially provided to bill for the service.

The service order is valid for one year from the date of the original service order. Service orders may not be backdated.

Services are based upon a finding of medical necessity, must be directly related to the member's diagnostic and clinical needs and are expected to achieve the specific rehabilitative goals detailed in the member's Person-Centered Plan.

Documentation Requirements:

Treatment Plan

- Each individual receiving Child ACT services is required to have a Person-Centered Plan (PCP) that is fully complete prior to or on the first date of service. The PCP must meet all the requirements, including an enhanced crisis plan, as outlined in the NC PCP Instruction Manual. The amount, duration, and frequency of the service must be included in the PCP.

Service Documentation

A full-service note, that meets the requirements outlined in the NCDHHS Record Management and Documentation Manual, is required for each contact or intervention (such as individual session, case management, crisis response) for each date of service, written and signed by the person(s) who provided the service, will contain the following information:

- Recipient's name
- Service record number
- Medicaid identification number (as applicable)
- Name of service provided
- Full date of service

- Place of service
- Type of contact (face to face, telephone call, collateral, etc.)
- Purpose of contact as it relates to the goal(s) on the PCP
- Description of the interventions provided
- Time spent providing interventions (i.e., duration)
- Assessment of effectiveness of intervention and/or the recipient's progress towards the goal(s)
- Signature and credentials of the staff member(s) providing the service.

Discharge Planning

Discharge Planning Beginning at the time of admission, all interventions/activities regarding discharge planning and transition with youth, family/caregiver, and child and family team will be documented. A documented discharge plan shall be discussed with the individual and included in the service record. A discharge SAR should be submitted at the time of discharge.

Continued Stay Criteria

Medicaid shall cover a continued stay if the desired outcome or level of functioning for the beneficiary or family has not been restored, improved, or sustained over the time frame outlined in the beneficiary's PCP or the beneficiary or family continues to be at risk for relapse based on current clinical assessment, history, or the tenuous nature of the functional gains; **AND** one of the following applies:

- A.** The beneficiary or family has achieved current PCP goals and additional goals are indicated as evidenced by documented symptoms;
- B.** The beneficiary or family is making satisfactory progress toward meeting goals and there is documentation that supports that continuation of this service will be effective in addressing the goals outlined in the PCP;
- C.** The beneficiary or family is making some progress, but the specific interventions in the PCP need to be modified so that greater gains, which are consistent with the beneficiary's premorbid or potential level of functioning, are possible;
- D.** The beneficiary or family fails to make progress or demonstrates regression in meeting goals through the interventions outlined in the PCP. {In this case, the beneficiary's diagnosis must be reassessed to identify any unrecognized co-occurring disorders, and treatment recommendations should be revised based on the findings}; or
- E.** If the beneficiary is functioning effectively with this service and discharge would otherwise be indicated.

The Child ACT team services must be maintained when it can be reasonably anticipated that regression is likely to occur if the service is withdrawn. The decision must be based on either of the following:

- 1.** The beneficiary has a documented history of regression in the absence of Child ACTT team services, or attempts to titrate team services downward have resulted in regression; **or**
- 2.** There is an epidemiologically sound expectation that symptoms will persist and that ongoing outreach treatment interventions are needed to sustain functional gains

Discharge Criteria

Members shall meet at least one of the following:

- The member and team determine that Child ACT Team services are no longer needed based on the attainment of goals as identified in the person-centered plan and a less intensive level of care would adequately address current goals;
- The member moves out of the catchment area and the Child ACT Team has facilitated the referral to either a new Child ACT Team provider or other appropriate mental health service in the new place of primary private residence and has assisted the member in the transition process;
- The member and, if appropriate, the legally responsible person, choose to withdraw from services and documented attempts by the program to re-engage the member with the service have not been successful; or
- The member and family have not demonstrated significant improvement following reassessment and several adjustments to the treatment plan over at least three months and:
- Alternative treatment or providers have been identified that are deemed necessary and are expected to result in greater improvement; or
- The member's behavior has worsened, such that continued treatment is not anticipated to result in sustainable change; or
- More intensive levels of care are indicated.

Child ACT Team services may be billed for up to 30 days in accordance with the Person-Centered Plan for members who are transitioning to or from Intensive In-Home, Family Centered Treatment, High Fidelity Wraparound, Day Treatment, Residential Levels II-IV, TASK, or Multi-Systemic Therapy.

Eligibility Criteria

MH diagnosis with and without co-occurring SU or I/DD or autism: Youth with a primary mental health diagnosis. However, individuals diagnosed with Mental Health conditions and co-occurring Moderate or Mild Intellectual disabilities or Autism will be assessed on a case-by-case basis. High risk for out of home residential treatment due to history of multiple hospitalizations, multiple placements in residential treatment, unresponsive to other forms of outpatient or enhanced behavioral health services. Symptoms at a severity level where PRTF or other intensive residential treatment would be recommended.

Children with a major depressive disorder, psychotic disorders, anxiety disorders, disruptive behavior disorders and bipolar disorder because these illnesses more often cause long term psychiatric disability. Beneficiaries with other psychiatric illnesses are eligible dependent on the level of the long-term disability, co-occurring disorders, and complex trauma. Child ACTT services are primarily provided in the community. A fundamental feature of Child ACTT is that services are taken to the member/family in his or her natural environment, rather than having the member/family come into an office or clinic setting to receive services. Services shall be delivered in various natural

environments, such as homes, schools, court, homeless shelters, libraries, street locations, and other community settings.

Members with other psychiatric illnesses are eligible depending on the level of the long-term disability, co-occurring disorders, and complex trauma. Members with a primary diagnosis of a substance use disorder, intellectual developmental disabilities, traumatic brain injury, or an autism spectrum disorder are not the intended population for this service and would be considered for Child ACT Team on a case-by-case basis. Child ACT teams shall document written admission criteria that reflect the following medical necessity criteria required for admission:

A. Has a current Mental Health and Diagnostic and Statistical Manual (DSM) 5 (or its successor) diagnosis consistent with reflecting the need for treatment and the covered treatment must be medically necessary for meeting the specific preventive, diagnostic, therapeutic, and rehabilitative needs of the beneficiary.

AND

B. Has significant functional impairment as demonstrated by at least one of the following conditions:

1. Significant difficulty consistently performing the range of routine tasks required for basic child/adolescent functioning in the community (for example, demonstrating safety skills, self-regulation, and basic social interaction) or persistent or recurrent difficulty performing daily living tasks except with significant support or assistance from others such as friends, family, or relatives.
2. Significant difficulty maintaining consistent educations/vocational performance at a self-sustaining level (such as regular attendance, regular participation without expulsion or repeated suspension).

Service Exclusion

This is intended to be a bundled comprehensive service that meets all treatment needs of the member. Other services other than previously referenced during a transition period are excluded from being provided at the same time as Child ACT Team.

Tailored Care Management services are duplicative of Child ACT Team and may not be provided during the same authorization.

Inpatient, Facility Based Crisis, and Emergency Department Services can still be accessed as medically necessary for crisis stabilizations. Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) will still be considered as necessary on an individual member basis.

Also excluded concurrently is

- Intensive In-Home Services
- Family Centered Treatment
- Multi-Systemic Therapy

- Intercept
- In Home Therapy
- Day Treatment
- TASK
- HFW
- Level II, Level III and IV group homes and PRTF are excluded from being provided with this service except in step-down transition.
- Level II Family is allowed concurrently.

If a request for authorization of this service is denied, or if an authorization of this service is terminated, suspended, or reduced, then appeal rights will be provided in accordance with applicable law.

Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age

42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiary under 21 years of age if the service is medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed Qualified Professional). This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary's physician, therapist, or other licensed Qualified Professional; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product or procedure:

1. That is unsafe, ineffective, or experimental or investigational.
2. That is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

EPSDT and Prior Approval Requirements

1. If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does NOT eliminate the requirement for prior approval.
2. IMPORTANT ADDITIONAL INFORMATION about EPSDT and prior approval is found in the *NCTracks Provider Claims and Billing Assistance Guide*, and on the EPSDT provider page. The Web addresses are specified below.

NCTracks Provider Claims and Billing Assistance Guide:

<https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html>

EPSDT provider page: <http://www.ncdhhs.gov/dma/epsdt/>

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the

provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problem.

Treatment Program Philosophy, Goals & Objectives

Child ACT Team is the first line (and generally sole provider) of all the behavioral health services that a member needs. Being the single point of responsibility necessitates a higher frequency and intensity of community-based contacts and a very low member-to-staff ratio.

- The service is designed for members ages 10-18 with a primary mental health diagnosis. However, individuals diagnosed with mental health conditions and co-occurring substance use or mild/moderate intellectual/developmental disabilities (I/DD) will be assessed on a case-by-case basis for participation in Child ACT Team.
- A member who is appropriate for this service may require assertive engagement to develop treatment motivation. The team will work to actively engage members and their families, and to assess needs for stabilization. The team will coordinate with additional supports (if any) to ensure a coordinated approach.
- The team provides person-centered services addressing all the member's behavioral health needs, helping them achieve their personal goals.
- The team includes the family/caregiver.
- Services are flexible; teams offer varying levels of care for all members and appropriately adjust service levels given a member's changing needs over time.
- Services address needs in multiple life domains, including family life and communication, social relationships, health, housing, behavioral health, substance use, medication support, financial, activities of daily living, educational/vocational, and wellness self-management/relapse prevention.

Child ACT team meets daily to wrap any needed services around the child and family. Each team includes a licensed team leader, psychiatric care provider, registered nurse, licensed clinician and a behavioral specialist. Additional staff may include a care coordinator, peer specialist, family advocate, substance use specialist, or other specialists depending on the needs of the youth served. It is recommended the team have a dedicated program assistant.

During the daily team meetings, all needs of the child and family, including Social Determinants of Health (SDOH), are addressed. Unlike other services, which provide treatment in solos, child/ACTT youth synthesizes all necessary treatment providers under one coordinate plan, therefore repairing a previously fragmented delivery system.

Goals and Objectives

- Reduce out of home placements
- Reduce use of the Emergency Department
- Increase Family resiliency

- Increase member self-determination and self-advocacy

Expected Outcomes

It is expected that children will reduce the amount of time spent in residential settings and become more integrated within their own community.

In addition, the following outcomes are expected:

- Increased engagement in services and treatment goals.
- Development of skills to stabilize behaviors in the community setting.
- Increased adherence to treatment/service plan
- Vocational/educational gains
- Increased stay/stability in their community residence with family or natural supports
- Family and natural supports Increased involvement/engagement with youth's treatment.
- Increased engagement in positive supportive activities

Provider Requirements

Provider Organization Requirements

- Provider is enrolled in NC TRACKS and is on the PEF file received by the Health Plan.
- Provider must be credentialed and enrolled as a network provider with the Partners Health Management Provider Network, in good standing, and contracted to deliver the service.

All employees must meet the minimum education, experience and licensure criteria established for their position as required in rules or service definitions, whichever is most restrictive. While the composition of the team is established, the team members providing the direct interventions to the child and family may be varied based on the needs of the individual.

While the composition of the team is established, the team members providing the direct interventions to the child and family may be varied based on the needs of the individual. The team will have daily meetings to prioritize activities, share information, and discuss individual members. All children and youth would be staffed each week.

The team will be available to respond 24/7 for crisis de-escalation and assessment, inclusive of availability by phone within 15 minutes and face to face within no more than 2 hours. This will include face-to-face assessment by a clinician, or nurse if this is determined to be needed for the individual.

The psychiatric provider will be available minimally by phone 24/7 for consultation and treatment recommendations. The team will assess the overall needs of the family to ensure that all necessary treatment and supports are in place for entire family system.

Program and Staff Supervision

Mandatory staff:

1. Team Lead (1 FTE) with full or associate-level licensure. Associate licensed team lead will be licensed within 30 months of their start date and one year of clinical experience with severe and persistent mental illness pre or post graduate school.
2. Psychiatric Care Provider (.25 FTE) who is a board-certified psychiatrist for children and adolescents; or a psychiatric mental health nurse practitioner; or a physician's assistant
3. Registered Nurse (1 FTE)
4. Clinician (1 FTE) with full or associate-level licensure
5. Behavioral Specialist (1 FTE) who is a qualified professional

The Psychiatric Care Provider is not counted in the minimum FTE but one must always be assigned to a team. Additional staff will be added based on the caseload served by the team or the clinical needs of the members. Not all members being served by the team will interact with all staff, but all will be seen by the Psychiatric Care Provider.

For licensed professionals:

Provider will ensure that all licensed staff complete the required MCO credentialing process and maintain their licensure. Provider organization will complete CAQH, and if needed NCTRACTS, NCID, and NPI and submit credentialing application to MCO.

For unlicensed staff:

Provider organization completes primary source verification for education and verifies experience. Final determination of paraprofessional, associate professional, or qualified professional must follow all applicable agencies policies and procedures and NC General Statutes. The provider organization is responsible for ensuring staff have the knowledge, skills, and abilities required by the population and age to be served.

Additional staff who may be any combination of the following: Case Coordinator, Substance Abuse Specialist; Youth Peer Specialist; Family Advocate; a second Behavioral Health Specialist who is an associate professional; and other specialists per needs of the youth served.

A team will always have a minimum of 5 FTE staff and a .25 Psychiatric Care Provider. The team must always maintain a team lead, a nurse, a clinician, behavioral specialist, and a psychiatric practitioner. The 5th staff can be an FTE or combination of part time FTEs fulfilling the roles most needed based on the members being served by the team or areas that the existing staff do not have sufficient experience and or expertise in. For example, if the team lead and/or clinician have experience with substance use disorders it may not be necessary to have an additional SUD clinician even if members on the team have this as an identified treatment need. However, if neither of those individuals have this background it may be necessary to have an SUD on the team if the members have this as an identified treatment need. The Case Coordination activities may also be provided by a combination of individuals on the team or may be done by a designated staff member.

It is recommended that Child ACT teams serve on average 24 members and maintain a direct staff service ratio of no more than 1:6. If a team is going to accept more than 24 members, it is recommended that additional staff be added.

The Psychiatric Care Provider is not counted in the minimum FTE, but one must always be assigned to a team. The amount of time a psychiatric care provider is allocated to a team should be informed by needs of the members on that team and frequency of medication management visits. It is understood that not all youth are appropriate for medication management. All Child ACT youth will receive a medication evaluation within 2 weeks of admission to Child ACT. Following this evaluation, the psychiatric care provider will determine frequency of medication management visits (i.e., some youth not on medications may not be seen ongoing unless new symptoms, behaviors present). Additional staff will be added based on the caseload served by the team or the clinical needs of the members. Not all members being served by the team will interact with all staff, but all will be seen by the Psychiatric Care Provider.

Note: Movement on and off the teams may result in temporary breaches of caseload. Therefore, teams shall be required to maintain an annual average not to exceed the limits above.

Supervision

Supervision is provided according to supervision requirements specified in 10A NCAC 27G .0104 and according to licensure/certification requirements of the appropriate discipline. All team members receive ongoing clinical and administrative supervision from team leadership, with the team leader as the primary clinical supervisor. Frequency of supervision should be based on experience level of staff, for best practice and may occur more often than once per month. All staff will receive a minimum of monthly supervision. Agency must ensure staff are in compliance with the supervision requirements of their respective licensure boards as applicable. As part of the service, a team meeting occurs daily which will also serve as a method for overall supervision of the team facilitated by the team lead or designee in the absence of the team lead.

Service Type/Setting

This service is provided in the community and in homes.

The majority (minimum of 80%) of Child ACT Team services must be provided in the home or other community settings. The team members providing the direct interventions to the child and family may vary based on the needs of the individual.

Child ACT Team services are primarily provided in the community. A fundamental feature of Child ACT Team is that services are delivered in the member/family's natural environment, rather than the member/family going to an office or clinic setting to receive services. Services shall be delivered in various natural environments, such as homes, schools, court, homeless shelters, libraries, street locations, and other community settings. Some supportive coordination activities, such as researching community supports, may be delivered through Child ACT Team. Obtaining progress updates from other treatment providers may be done from the provider's office setting. Child ACT Team also includes telephone time with the member and the member's family or caregivers, as well as collateral contact with people who assist the member in meeting the goals as specified in the person-centered plan. Child ACT Team includes participation and ongoing clinical involvement with the Child and Family Team and meetings for the planning, development, implementation, and revision of the member's person-centered plan.

Child ACT may be delivered virtually in situations where the youth/family is unable to participate directly in-person due to illness or other extenuating circumstances that require virtual

service delivery. Virtual service delivery may continue as long as clinical gains are being made and/or until the extenuating circumstance resolves.

Position	Minimum Staffing	Staff Qualifications
Team Leader – Required (This position is to be occupied)	1 FTE	Full or associate licensed clinician. If associate licensed, must receive clinical supervision monthly and have one year of clinical experience with SPMI pre- or post-graduate school. Training Requirements: • Crisis Response (3 hours), • Person Centered Thinking (12 hours), • Introductory Motivational Interviewing (13 hours), • System of Care (11 hours), • PCP Instructional Elements (3 hours), • Alternatives to Restrictive Interventions (8 hours), • Training in at least one model of care with empirical evidence 50 Hours Total (plus any specific training required for the treatment modality being used by the team)
Psychiatric Care Provider – Required	0.25 FTE	Board-eligible or board-certified psychiatrist licensed in NC; child and adolescent psychiatrist preferred. Psychiatric NP or PA may be used if appropriately licensed and with at least three years of full-time experience treating children with SED. Training Requirements: • Person Centered Thinking (12 hours) • Alternatives to Restrictive Interventions (8 hours) 20 Hours Total
Nursing – Required	1 FTE	Registered Nurse (RN) or Advanced Practice Registered Nurse (APRN) with at least one year of experience working with children with SED and a working knowledge of psychiatric medications. Training Requirements: • Alternatives to Restrictive Interventions (8 Hours) • Person Centered Thinking (12 Hours) 20 Hours Total
Licensed Clinician – Required	1 FTE	Licensed mental health professional with at least one year of experience working with children with SED. May include LCSW,

		LCMHC, LMFT, Psychologist, Psychological Associate, Psychiatric NP, or CNS. Associate-level licensed professionals must obtain full licensure within 30 months of hire. Training Requirements: • Crisis Response (3 hours), • Person Centered Thinking (12 hours), • Introductory Motivational Interviewing (13 hours), • System of Care (11 hours), • PCP Instructional Elements (3 hours), • Alternatives to Restrictive Interventions (8 hours), • Training in at least one model of care with empirical evidence. 50 Hours Total (plus any specific training required for the treatment modality being used by the team)
Behavioral Specialist – Required	1 FTE	Must qualify as a QP or AP and have at least one year of experience working with children/adolescents with SED. Training Requirements: • Crisis Response (3 hours), • Person Centered Thinking (12 hours), • Introductory Motivational Interviewing (13 hours), • System of Care (11 hours), • Alternatives to Restrictive Interventions (8 hours), • Training in at least one model of care with empirical evidence Total Hours 47 (plus any specific training required for the treatment modality being used by the team model)
Substance Abuse Specialist	As Needed	If serving youth with a primary SUD diagnosis, the team must include a Qualified Professional with SUD credentials (CCS, LCAS, LCASA, or CSAC) if expertise is not otherwise available on the team. Training Requirements: • Crisis Response (3 hours), • Person Centered Thinking (12 hours), • Introductory Motivational Interviewing (13 hours), • System of Care (11 hours), • PCP Instructional Elements (3 hours), • Alternatives to Restrictive Interventions (8 hours),

		• Training in at least one model of care with empirical evidence Total 50 Hours (plus any specific training required for the treatment modality being used by the team)
Peer Specialist – Youth	As Needed	The team includes Peer Specialist(s). Minimum age is 18. To ensure that the experience of the peer specialist is commensurate with those served by team for this position, the individual must have “lived experience” and a personal recovery story specific to child/adolescent SED. Training Requirements: • Peer to peer training providing by NC Families United (32 hours) 32 hours total.
Family Advocate	As Needed	To ensure that the experience of the family advocate is commensurate with those served by the team, for this position, the individual must have “lived experience” and a personal recovery story specific to being a caregiver for an SED child/adolescent. Training Requirements: • Family Partner 101 provided by NC Families United (24 hours) 24 hours total.
Case Coordination	As Needed	Staff providing this service meet requirements as an associate licensed professional or licensed professional and must have one year of experience with children with serious emotional disturbance. An associate level licensed professional must be fully licensed within 30 months from the date of hire. Training Requirements: • Crisis Response (3 hours), • Person Centered Thinking (12 hours), • Introductory Motivational Interviewing (13 hours), • System of Care (11 hours), • PCP Instructional Elements (3 hours), • Alternatives to Restrictive Interventions (8 hours), • Training in at least one model of care with empirical evidence

		Care Management training to understand care management functions and responsibility related to whole health care (5 hours) 55 Hours Total (plus any specific training required for the treatment modality being used by the team)
Additional Staff	As Needed	Additional staffing should reflect program size, member needs, and team expertise. Examples include care coordination, family liaison, housing, financial management, SUD, legal/forensic, or other specialty roles.

Minimum Team Composition

Required Role	Minimum FTE
Team Leader	1.0
Nursing	1.0
Licensed Clinician	1.0
Behavioral Specialist	1.0
Additional Staff Needed	1.0
Total Minimum Staffing	5.00 FTE + Psychiatric Coverage

Note: A team must always maintain at least five FTE staff members and have a Team Leader, Nurse, Licensed Clinician, Behavioral Specialist, and Psychiatric Care Provider assigned. The psychiatric care provider does not count toward the minimum FTE staffing requirement.

Targeted Length of Stay
24 units (5-6 months)