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Virginia's Medicaid Program

VA Draft Service Definition

Community Psychiatric Support and Treatment (CPST)

Purpose

Services are goal-directed supports and solution-focused interventions intended to address challenges associated with a behavioral health need for adults and youth. CPST services must be incorporated into an individual service plan (ISP) documenting activities and interventions to prevent, correct, or ameliorate conditions discovered during the initial assessment. The conditions discovered in the initial assessment shall be associated with identified goals or objectives as set forth in the ISP developed with the individual's input. CPST interventions shall include the youth or adult individual as well as the family/caregiver or other collateral supports. This is a multi-component service that consists of therapeutic interventions such as counseling, as well as functional supports.

Intended Participants

CPST services and interventions are intended to provide clinical treatment to those individuals with significant mental illness or youth with, or at risk of developing, serious emotional disturbances. Family and collateral contacts may also be engaged in services. An adult may select the family/caregivers involved in their care. The family/caregiver of an underage youth is expected to have an integral role in the support and treatment of the youth's behavioral health need.

Note: Medical necessity criteria have not yet been developed. There will be two levels of this service (Level 1 and Level 2). There will be different criteria for each, with Level 1 representing a less intensive (moderate intensity) service that includes components 1-7 below and Level 2 representing a more intensive (high intensity) service that includes components 1-7 below as well as component 8. Component 8 represents additional time/units doing direct repetition and practice of skills in natural settings being developed through counseling, crisis planning, and restorative life skills training components of the service.

Service Components

Service components include:

1. Conducting a standardized assessment.
2. Developing an Individual Service Plan and Monitoring of progress and adjustment if progress is not being made.
3. Counseling – Individual, group and family counseling for the benefit of the Medicaid eligible individual.
4. Crisis avoidance, intervention and crisis planning for individuals on their caseload.
5. Offering Psychoeducation.
6. Providing Care Coordination.

7. Restorative Life Skills Training.
    a. Workplace or Instructional Setting Assistance
8. Rehabilitation Skill Practice and Repetition (For Level 2 CPST Services).

Staffing

All CPST services are to be recommended and overseen by a Licensed Mental Health Professional (LMHP) and a part of an individual service plan (ISP). LMHPs assess, develop ISPs, provide counseling, and monitor each individual receiving CPST, and within the structure of collaborative behavioral health services, direct the treatment and interventions provided by unlicensed staff. CPST also includes services delivered by unlicensed practitioners in a team-based approach where services are overseen by LMHPs and designed to assist the individual with compensating for, eliminating, or ameliorating the impact of functional impairment and interpersonal and environmental barriers associated with their mental illness. The LMHP shall be responsible for monitoring and adjusting the ISP over time as goals are addressed with the eventual goal of individuals achieving recovery and titration of service volume over time to address additional needs. Services can be provided in coordination with treatment interventions by a specialized provider for other needs beyond behavioral health, such as developmental disabilities or eating disorders.

Activities provided under CPST are intended to assist the individual and family/caregivers to achieve stability and functional improvement in daily living, personal recovery and/or resilience, family and interpersonal relationships in work, school and community integration. The long-term goal is to require minimal ongoing professional intervention and optimal community integration. These services shall include assisting the individual to develop and apply skills in natural settings.

Place of Service

CPST is designed to provide office-based services as well as community-based services to individuals and families who can benefit from home and/or community based rehabilitative services, including those who may have difficulty engaging in formal office settings. CPST allows for delivery of services within a variety of permissible settings including, but not limited to, office and community locations where the individual lives, works, attends school, engages in services, and/or socializes such as homes and schools. Interventions are “hands on” and task oriented, intended to achieve the identified goals or objectives as set forth in the individual’s individualized service plan.

CPST Allowed Mode(s) of Delivery

1. Individual
2. Group
3. Office/on-site (including schools)
4. Off-site/community/home
5. Without Individual present (for the benefit of the Medicaid eligible individual with a family member, caregiver, or collateral contact)

CardinalCare
Virginia's Medicaid Program

Service Component Definitions

Component
Initial Assessments and Regular Reassessments ***Staff Requirements:*** LMHP-Type: LMHP, LMHP-Supervisee in Social Work (S), LMHP-Resident in Counseling (R) or LMHP-Resident in Psychology (RP) Working as a team with an LMHP-Type lead who may choose to have a Qualified Mental Health Professional (QMHP) assist with gathering information/documentation but is ultimately responsible for the quality, completeness and accuracy of the entire assessment and diagnosis. ***Description:*** Providers use a standard assessment tool for level of intensity with regular re-assessments using the Child and Adolescent Needs and Strengths (CANS)/Adult Needs and Strengths Assessment (ANSA). Assessment means the in-person interaction in which the provider obtains information from the individual or other family members, as appropriate, about the individual's mental health status. It includes documented history of the severity, intensity, and duration of mental health problems and behavioral and emotional issues. This includes diagnosis of mental health conditions. Assisting the individual and family members or other collaterals with identifying strengths and needs, resources, natural supports and developing goals and objectives to utilize personal strengths, resources and natural supports to address functional deficits associated with their mental illness.
Strengths Based Individual Service Planning and Monitoring ***Staff Requirements:*** LMHP-Type: LMHP, LMHP-S, LMHP-R or LMHP-RP ***Description:*** Developing a person-centered individual service plan (ISP) that addresses the assessed needs and personal goals of the individual. Conducting ongoing monitoring of needs including initiating an update of the individual service plan by the LMHP if needs change significantly. Development of an individual service plan in collaboration with the individual and family if applicable (or other collateral contacts) based on the specific strengths and needs, resources, natural supports and individual goals and objectives for the individual. The overarching focus is to utilize the personal strengths, resources, and natural supports to reduce functional deficits

associated with their mental illness and increase restoration of independent functioning. The individual service plan must include developing a crisis management plan.

1. Treatment Planning: Developing an individualized service plan based upon the Assessment that addresses identified barriers, includes short and long-term measurable goals, establishes the individual's approach to meeting the goal, and identifies when other providers or services may be required to meet a goal.
   - Treatment Planning means the development of a person-centered ISP that is specific to the individual's unique treatment needs and acuity levels, developed with the individual, in consultation with the individual's family (as defined by the individual), as appropriate.
   - Treatment Planning results in an ISP.
2. The ISP is a comprehensive and regularly updated treatment plan specific to the individual's unique treatment needs as identified in the comprehensive needs assessment. A comprehensive ISP is person-centered, includes all planned interventions, aligns with the individual's identified needs, including care coordination needs, is regularly updated as the individual's needs and progress change, and shows progress throughout the course of service provision.
3. The following elements must be present in the individual service planning process:
   - The individual's treatment or training needs.
   - Individual's and family's (as appropriate) strengths and personal traits that would facilitate recovery and opportunities to develop motivational strategies and treatment alliance.
   - Diagnoses, symptoms, challenges, and functional impairments indicating the need for the services.
   - A description of the functional level of the individual.
   - The individual's goals and measurable objectives to meet the identified needs.
   - Treatment objectives with short-term and long-term goals.
   - Services to be provided with the recommended frequency to accomplish the measurable goals and objectives.
   - Estimated timetable for achieving the goals and objectives.
   - Individualized discharge plan that describes transition to other appropriate services.
   - Plans for continuing care, including review and modification to the ISP.
   - The ISP is reviewed and updated as appropriate at least annually for adults and every six months for youth.
4. Managed care organization (MCO) approval of authorizations is required. The requested authorizations must tie to the ISP and assessed needs of the individual.
5. The individual must be assessed to show improvement as evidenced by progress toward meeting ISP goal and objectives, or the next ISP must propose different interventions. The expectation is that recovery will be achieved over time.
6. Monitoring of the individual by the LMHP-Type includes a face-to-face interaction with the individual before other service components by unlicensed team members begin and

at least quarterly (except under extenuating or emergent circumstances that are reflected in the supervisory notes).

Counseling

Staff Requirements:

LMHP, LMHP-S, LMHP-R or LMHP-RP

Description:

Individual, group, family counseling, supportive counseling, solution-focused interventions, emotional and behavioral management, and problem behavior analysis with the individual, with the goal of developing and implementing social, interpersonal, self-care and independent living skills to restore stability, to support functional gains and to adapt to community living. These interventions engage the individual and family/caregiver in ways that support the everyday application of treatment methods as described in the individual service plan.

Counseling, including mental health interventions that address symptoms, behaviors, and thought processes that assist the individual in eliminating barriers to treatment and identifying triggers. Counseling includes assisting the individual with effectively responding to or avoiding identified precursors or triggers that would impact the individual's ability to remain in a natural community location. The use of evidenced-based practices/strategies is encouraged.

Crisis Avoidance, Intervention, and Crisis Plan development

Staff Requirements:

LMHP, LMHP-S, LMHP-R or LMHP-RP, QMHP, QMHP-Trainee (T), Certified Substance Abuse Counselor (CSAC), CSAC-Supervisee

Description:

Assisting the individual with effectively responding to or avoiding identified precursors or triggers that would risk their remaining in a natural community location, including assisting the individual and family members or other collaterals with identifying a potential behavioral health crisis, developing a crisis management plan and/or, as appropriate, seeking other supports to restore stability and functioning. It is an intervention to assist the individual and family in developing the capacity to prevent a crisis episode or the capacity to reduce the severity of a crisis episode should one occur.

Assisting families following a crisis episode experienced by the individual as stated in the crisis management plan. This component is intended to be stability-focused and relationship-based. It is also intended for individuals in need of longer-term crisis management interventions after a crisis intervention such as mobile crisis response or an emergency room intervention. The purpose of this activity is to:

- Stabilize the individual in the home and natural environment.

- Assist with goal setting to focus on the issues identified from mobile crisis or emergency room intervention, and other referral sources.

Rehabilitative Psychoeducation

Staff Requirements:

LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP, QMHP-T, CSAC, CSAC Supervisee

Description:

Educating the individual and family members or other collaterals to identify strategies or treatment options with the goal of restoring optimal functioning the individual's daily living, financial management, housing, academic and/or employment progress, personal recovery or resilience, family and/or interpersonal relationships and community integration by addressing emotional disturbances, substance use, or associated environmental stressors.

Psychoeducation includes using therapeutic interventions to provide information and support to better understand and cope with the illness. The goal is for the provider, the individual, and relevant collateral contacts including family members to work together to support recovery, including assisting the individual and family members or other collaterals with identifying a potential behavioral health crisis. Psychoeducation involves giving the individual accurate information about their diagnosis and treatment options, as well as assist the individual and family members, caregivers, or other collateral contacts to identify appropriate strategies or treatment options for the individual's behavioral health needs, with the goal of minimizing the negative effects of mental illness symptoms or emotional disturbances, substance use, or associated behavioral stressors that interfere with the individual's life. The intervention must be directed towards the Medicaid eligible individual. The individual can use this information to make their own decision about how they will engage with their care. They might not choose the treatment options that the provider thinks are best. Instead of pushing the individual to do what the provider thinks is best, psychoeducation empowers the member to make their own decisions about how to move forward.

Care Coordination

Staff Requirements:

LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP, QMHP-T, CSAC, CSAC Supervisee

Description:

Care Coordination means locating and coordinating services including sharing of information among health care providers, who are involved with an individual's health care, to improve the restorative care and align service plans.

Care Coordination ensures that the individual receives all needed Medicaid services and supports in the most effective and efficient manner. Care Coordination facilitates informed and

congruent individual service planning, enables open communication among all treating providers, and ensures needed resources are integrated and well-coordinated.

Care coordination includes any activity that helps ensure that the individuals needs and preferences for health services and information sharing across people, functions, and sites are met over time. Individuals, their families, and other informal caregivers experience failures in coordination particularly at points of transition. Transitions may occur between health care entities and over time and are characterized by shifts in responsibility and information flow.

The Treatment Planning process will identify needs for referrals to ensure the individual receives medications, psychiatric treatments, restorative and rehabilitative services, and therapies recommended and necessary for the restoration of the individual to previous levels of functioning.

The Care Coordination process will ensure that information is shared among health care providers who are involved with an individual's health care.

Restorative Life Skills Training

Staff Requirements:

LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP, QMHP-T, CSAC, CSAC Supervisee

Description:

Restoration, rehabilitation, and support the individual to achieve optimal daily functioning. This may include improving life safety skills such as ability to access emergency services, basic safety practices and evacuation, and accessing physical and behavioral health care (maintenance, scheduling physician appointments), recognizing when to contact a physician or seek information from the appropriate provider to understand the purpose and possible side effects of medication prescribed for conditions. This service component is designed to teach skills that build connectedness, communication, and community stability.

Restorative life skills training is a goal-directed support and solution-focused intervention, which focuses on optimizing individual functioning, restoring functional skills of daily living, building natural supports, and achieving identified person-centered goals or objectives as set forth in the individualized service plan. Activities address the individualized mental health needs of the member. Interventions will vary with respect to hours, type and intensity of activities, depending on the changing needs of each individual. The purpose/intent of the Restorative Life Skills Training component is to provide specific, measurable, and individualized interventions to each person served in a predictable, secure, trusting climate that establishes a sense of safety and well-being. Restorative Life Skills Training is not intended to be an indefinite, ongoing intervention. Restorative Life Skills Training is designed to provide services to individuals who can benefit from off-site rehabilitation, or who have not been previously engaged in interventions, including those who had only partially benefited from traditional treatment. Restorative Life Skills Training should be focused on the individual's ability to succeed in the community; to identify and access needed activities; and to show improvement in school, work and home functioning.

Restorative Life Skills training is a face-to-face intervention with the individual present; however, family or other collaterals may also be involved. Restorative Life Skills training also provides individual restoration, rehabilitation, and support to the individual and family members, caregivers, or other collateral contacts to develop aggression management skills necessary to meet the individual's goals and to sustain the identified community goals. Most contacts occur in community locations where the person lives, works, attends school and/or socializes. Components must be provided in locations that meet the needs of the persons served.

Workplace or Instructional Setting Assistance *(subcomponent of Restorative Life Skills Training)*

Staff Requirements:

LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP, QMHP-T, CSAC, CSAC Supervisee

Description:

All CPST providers are encouraged to work with individuals at the worksite or instructional setting to assess the need and implement appropriate interventions to support an individual's employment goals within the context of community psychiatric support and treatment (CPST) as appropriate for the individuals they serve. CPST could be utilized to prepare for or in a workplace environment with a focus on helping an individual overcome/address psychiatric symptoms or to develop and/or build a skill set to address symptoms that interfere with seeking, obtaining, or maintaining employment. Medicaid reimbursement for CPST includes employment supports if the activities being provided are focused on illness management and recovery regardless of setting.

The licensed mental health professional (LMHP) shall assess the perceived and/or actual barriers that are impeding an individual's employment success and individual service plans shall address an individual's interest/desire to work or pursue a career. Documentation shall refer to the individual's diagnoses, employment goals, and why assistance is needed due to psychiatric symptoms interfering with achieving employment goals.

1. Recognizing personal signs/symptomology, identifying stressors, and establishing skills set/coping skills for a variety of settings including in a work environment to address these issues.
2. Teaching the individual illness management and emotional regulation skills in the context of employment, both on and off the job.
3. Teaching the individual how to focus on reframing and ordering tasks when symptoms present barriers to working.
4. Role playing with the individual when they are planning interviews with potential employers to use illness management and emotional regulation skills.

5. Post-employment learning to cope with balancing work/home life.
6. Building communications skills to learn to interact with employers/co-workers. Teaching assertiveness training and other interpersonal communication skills in the employment setting. Advocating for self in the workplace (asking for a raise, time off, etc.).
7. Teaching the individual to improve sleep hygiene and daily living activities to enhance their effectiveness in job seeking and keeping.
8. Building skills related to personal hygiene and dress and presenting oneself for job interviews/work.
9. Develop/improve time management skills to include areas specific to work schedules arriving to work when scheduled and timely.
10. Learning appropriate work habits-appropriate topics and behavior when in a work environment.

NOT COVERED:

The following employment supports are not allowable in the CPST Program:

1. Skills training related to a specific job (how to operate equipment, use computer programs. fill customer orders, etc.).
2. Staff presence in the workplace to assist with supervision or teaching of routine work duties.
3. Approaching potential employers to "job develop" without the individual present.
4. Presentations to the business community to seek partnerships in hiring.

Rehabilitation Skill Practice and Repetition:

Staff Requirements:

Behavioral Health Technician (BHT), QMHP, QMHP-T, CSAC, CSAC Supervisee

Description:

For Level 2 CPST, Behavioral Health Technicians provide repetition and practice of skills under a Collaborative Behavioral Health Rehabilitative agency and assist with the implementation of an LMHP developed ISP. Activities will include rehabilitation interventions and individualized, collaborative, hands-on training to build developmentally appropriate skills. The intent is to promote personal independence, autonomy, and mutual supports with the individual's support network by developing and strengthening the individual's independent community living skills and support community integration in the domains of employment, housing, and education in both personal and community life. This includes:

Social and Interpersonal Skills, with the goal to restore, rehabilitate and support:

CardinalCare
Virginia's Medicaid Program

- Increasing community awareness and tenure, and avoiding more restrictive treatment settings.
- Building and enhancing personal relationships.
- Establishing support networks including support to establish and maintain friendship/supportive social networks, improve interpersonal skills such as social etiquette and anger management.
- Increasing community awareness. Developing coping strategies and effective functioning in the individual's social environment, including home, work, and school locations.
- Learning to manage stress, unexpected daily events, and disruptions, and behavioral health and physical health symptoms with confidence.

Daily Living Skills, with the goal to restore, rehabilitate and support the effects of the individual's diagnosis and reestablish daily functioning skills:

- Improving self-management of the negative effects of psychiatric, emotional, physical health, developmental, or substance use symptoms that interfere with an individual's daily living.
- Support the individual with the development and implementation of daily routines necessary to remain in the home, school, work and community.
- Personal autonomy skills, such as:
    - Learning self-care.
    - Developing and pursuing personal interests.
    - Developing daily living skills specific to managing their own medications and treatment consistent with the directions of prescribers (e.g., setting an alarm to remind the youth or adult individual when it is time to take a medication, developing reminders to take certain medications with food, writing reminders on a calendar when it is time to refill a medication).
    - Learning about community resources and how to use them.
    - Learning constructive and comfortable interactions with health care professionals.
    - Learning relapse prevention strategies.
    - Re-establishing good health routines and practices.

Practicing crisis prevention techniques with the goal to restore, rehabilitate and support the individual's skills to reduce the effects of the behavioral health diagnosis:

- Reestablish social skills so that the person can remain in a natural community location and re-achieve developmentally appropriate functioning including using collaboration, partnerships and mutual supports to strengthen the individual's community integration in areas of personal interests as well as other domains of community life including home, work and school.
- Assisting the individual with generalizing coping strategies and social and interpersonal skills in community settings.
- Assisting the individual with effectively responding to or avoiding identified precursors or triggers that result in functional impairments.
- Implementing learned skills (that may have been developed through a licensed practitioner providing treatment) in the following areas.

Social skills, such as:

- Developing interpersonal skills when interacting with peers, establishing and maintaining friendships and a supportive social network while engaged in recovery plan.
- Developing conversation skills and a positive sense of self to result in more positive peer interactions.
- Coaching on interpersonal skills and communication.
- Training on social etiquette.
- Developing self-regulation skills including anger management.

Health skills, such as:

- Developing constructive and comfortable interactions with healthcare professionals.
- Relapse prevention planning strategies.
- Managing symptoms and medications.
- Re-establishing good health routines and practices.
- Assisting the individual with effectively responding to or avoiding identified precursors or triggers that result in functional impairments.

Supporting the identification and pursuit of personal interests:

- Identifying resources where interests can be enhanced and shared with others in the community.

Identifying and connecting to natural supports and resources, including family, community networks, and faith-based communities.

CardinalCare
Virginia's Medicaid Program

Summary/Visual of Practitioner Types and Service Components

CPST Additional Criteria-Agency Level Requirements

Possible Agency Level Requirements for Virginia
1. CPST may only be provided by a staff who is under the authority of a DBHDS agency license.
2. All agencies shall be accredited within 24 months of the approval of the State Plan or within 24 months of establishment of a new agency by the Council on Accreditation, The Joint Commission, DNV Healthcare, or the Commission on Accreditation of Rehabilitation Facilities. Certification/accreditation shall be initiated and submitted to DMAS during enrollment or within 24 months if the agency is new. $10,000 for costs for this requirement is typically added to rates.
3. Must have clinical director (licensed, FT) Supervisors may only be independently licensed practitioners according to the practice act and licensing board requirement (e.g., provisionally licensed practitioners). LMHP is defined as: Physician, licensed clinical psychologist, licensed professional counselor, licensed clinical social worker (LCSW), licensed substance abuse treatment practitioner, licensed marriage and family therapist (LMFT), certified psychiatric clinical nurse specialist,

licensed behavior analyst, or licensed psychiatric/behavioral health nurse practitioner. DBHDS - 12VAC35-105-20

4. Agencies can offer Level 1 or both Level 1 and 2 rehabilitative services. Can be youth, adult, or both. Can be center/school-based, community based, or both.
5. Supervision requirements will include hours of supervision and other requirements for license-eligible, licensed, and non-licensed (e.g., QMHP) staff.
6. Caseload limits for each staff level, including across agencies (i.e., licensed individual's caseload is counted across all agencies where employed)
7. Evidence-based practices and principles integrated into service definition where possible; proposing each agency must embed at least one evidence-based protocol in their care model.
8. Required trainings for all direct care staff types such as:
    a. Introductory Motivational Interviewing
    b. Permanent Supportive Housing Training
    c. Basics of Psychiatric Rehabilitation and Functional Assessments
    d. Trauma Informed Care
    e. Designated therapies, practices or models below specific to the population(s) to be served. Practices or models must be treatment focused models, not prevention, such as Cognitive Behavior Therapy: Trauma-Focused Therapy or Illness Management and Recovery.
9. Minimum field experience of at least two years for cases involving individuals with Severe Mental Illness or Serious Emotional Disturbance.

Incorporation of Evidence-Based Practices and Protocols

Since Rehabilitative Services are not in themselves a specific research-based model, each provider must instead incorporate research-based models developed for a broader array of settings that respond to the specific presenting problems of the clients served. Each Rehabilitative agency shall incorporate appropriate research-based programming for both treatment planning and service delivery.

For treatment planning, the agency shall use a standardized assessment and treatment planning tool such as the CANS or the ANSA. The assessment protocol must differentiate across life domains, as well as risk and protective factors, sufficiently so that an individual service plan can be tailored to the areas related to the presenting problems of each youth and their family or adult and family in order to ensure targeted treatment. The tool shall also allow tracking of progress over time. The specific tools and approaches used by each program shall be specified in the program description and are subject to approval by the State. In addition, the program shall ensure that requirements for pretreatment assessment are met prior to treatment commencing.

Use of evidence-based principles, practices, and protocols will also be required for all agencies providing Level 1 and Level 2 Community Psychiatric Supports and Treatment. Principles and practices are written into the service definitions and agency requirements when possible, and the

accompanying rates will be designed to allow agencies to seek training, certification, and consultation to embed specific evidence-based model protocols in their practices based on the population served and focus of the agency services. Different protocols have different training, consultation, supervision, and certification requirements, all of which have different costs.

We are proposing to require rehabilitative agencies embed **at least one** evidence-based protocol within one year of implementation. Rehabilitative agencies will be required to include assessments and measurement-based care and modular treatment approaches.

CAVEAT: The lists of protocols below are non-exhaustive, under development, still being researched, and primarily for illustrative purposes. It is not determined whether multiple evidence-based protocol will be required for single agencies servicing youth *and* adults or providing youth services in homes *and* schools.

For service delivery, the agency shall incorporate research-based approaches pertinent to the sub-populations of individuals to be served by the specific agency. Examples of specific research-based approaches that could be used for various sub-populations of individuals include the following.

School *or* Community Principle Based Youth Protocols:

a. Modular Approach to Therapy for Children with Anxiety, Depression, Trauma or Conduct Problems (MATCH-ADTC)
b. Managing and Adapting Practice

Community Based Youth Rehabilitative Protocols:

a. Brief Strategic Family Therapy
b. Family Centered Treatment

School Based Youth Rehabilitative Protocols:

a. Cognitive Behavioral Intervention for Trauma in Schools (CBITS)
b. Support for Students Exposed to Trauma, Blues Program, Bounce Back, Coping Cat

Community Based Adult Rehabilitative Protocols for Consideration:

a. Illness Management and Recovery
b. Integrated Treatment for Co-Occurring Disorders
b. Example outpatient protocols that can be integrated into rehabilitative services:
    - Cognitive Behavioral Therapy for Psychosis
    - Metacognitive/Cognitive Remediation Training
    - Cognitive Processing Therapy
    - Prolonged Exposure
    - Solution Focused Brief Therapy

All agencies shall also incorporate some form of research-based, trauma-informed programming and training, if the primary research-based treatment model used by the agency does not. Annually, facilities must submit documentation demonstrating compliance with evidence-based practice fidelity standards which vary by Evidence-Based Practice (EBP).

In addition, agencies may propose other models, citing the research base that supports use of that model with the target population (e.g., gender-specific approaches). They may also work with the purveyors of research-based models. The specific research-based models to be used shall be incorporated into the agency description and submitted to the State for approval. All research-based programming in Rehabilitative settings must be approved by the State.