DBT Informational Webinar – Q&A Responses

Webinar Session 1: Wednesday, October 18, 2023 @ 3pm

Webinar Session 2: Tuesday, October 24, 2023 @ 12pm

Webinar Session 3: Thursday, November 2, 2023 @ 10am

1. Question: What should agency leadership plan for and commit to, in terms of the caseload for DBT therapists and the overall capacity of the DBT program?

Answer: OBH's goal is to establish, with this first DBT training cohort, **four (4) solid and sustainable DBT teams** which can each provide a comprehensive DBT program in their communities. To achieve that goal, we ask that applicant teams:

- Include **4-6 LMHP clinicians**, committed to full participation in and completion of the DBT training program to achieve OBH-approved DBT qualification.

- Each of the DBT team clinicians, must commit, and have agency leadership support, to carry an initial caseload of DBT training cases immediately following the initial DBT didactic training. Starting with training cases as soon as possible after the didactic training, is critical to learning the DBT model. An **initial caseload of at least 3 DBT cases** starting after the didactic training, can provide the ability to truly learn and practice the DBT model, while providing some balance with the ability to provide "treatment as usual" services to other agency clients. Delivery of DBT to only 1-2 clients, may not provide sufficient practice to learn the model at the same pace as other training participants. Clinicians and agencies can also consider having clinicians serve more than 3 initial DBT training cases, if the agency determines to support the clinician(s) to devote a higher proportion of clinician time to the DBT program.

- Following year 1 of DBT training, we expect that trained DBT clinicians can and should increase their DBT caseload; additional experience with the DBT model should allow for an increase in the DBT caseload, and agency establishment of the DBT program should allow for sufficient outreach and referral pathways, such that the DBT team should be experiencing an increase in demand and can expand the numbers of clients served in DBT. DBT clinicians and agencies should plan for this increase in DBT program capacity. This may look different ways in different agencies and communities; some DBT clinicians/agencies may commit DBT clinicians to "full time" DBT with caseloads of 14-18 DBT clients per clinician, while other DBT clinicians/agencies may maintain partial caseloads of 4-6 DBT clients per clinician, while those clinicians deliver other services alongside DBT.

2. Question: Does more than one therapist from an agency have to participate or can one therapist participate? What about solo practitioners?

Answer: This training opportunity is designed for teams that will be able to deliver a comprehensive DBT program to fidelity, and delivery of comprehensive DBT to fidelity requires a team. If your agency is not providing a full team, you will need to create a team of other clinicians who agree to commit to the training requirements and the delivery of the DBT. If you are in private practice, you can choose to develop a team of clinicians across agencies or solo practices, who are willing to commit to both the training and the delivery of DBT. It is critical that all parties agree to commit to all components of this initiative— the full training, the delivery of DBT, and the consultation.

3. Question: We have difficulty getting our clients, who are primarily domestic violence survivors, to participate in any type of group, however, these skills would be beneficial to them. Can you provide the skills training portion individually in addition to the weekly therapy?

Answer: A large percentage of clients initially do not want to sign up for group skills, however, we have found that they can be talked into trying it. It is more effective to try to only do this in a group setting, and not only do it on an individual level. You may want to administer the skills training on an individual level initially, but it is best to ultimately transition to a group setting as it is more sustainable for managing DBT within your organization.

A large percentage of clients initially do not want to sign up for skills group, however, DBT offers a lot of commitment strategies to support a client participating in the full treatment model. You may have to administer skills training on an individual level initially (for specific programmatic reasons), but it is best to ultimately transition to a group setting as it is more sustainable for managing DBT within your organization.

4. Question: What are the credential requirements for team members?

Answer: In order to provide the individual therapy component of DBT, you must be a licensed mental health practitioner (LCSW, LPC, LMFT, psychologist, psychiatrist) with an independent/unrestricted license. In addition, of the two clinicians co-leading the DBT skills training group, at least one must be independently licensed. Your entire team does not necessarily need to consist of licensed clinicians, but you may find that it is easier to share responsibilities with other licensed clinicians. For this reason, it is typical for teams to consist of multiple licensed clinicians.

5. Question: What is the fee for the service?

Answer: OBH has requested approval from CMS (the federal Medicaid authority) to use temporary federal funding for incentivized payments to DBT providers for delivery of DBT.

Pending CMS approval, OBH will direct the Medicaid MCOs to reimburse for DBT services using the psychotherapy reimbursement rates in combination with an "add-on" payment, which will bring the total rates to the following:

- **$200.00** for 60 minutes of DBT individual therapy, with an expected 60-minute session of DBT individual therapy per client per week, and;
- **$177.68** per client for DBT group psychotherapy, for an expected 120-150 minute DBT skills training group session per client per week.

Additional billing guidance can be found here:
https://ldh.la.gov/assets/docs/BehavioralHealth/DBT_ARPA_Provider_Incentives_11_06_2023.pdf

6. Question: In reference to the agency leadership development meeting, does the whole team register, or just the team leadership?

Answer: The Leadership Meeting is designed for clinical supervisors, program managers, or clinical directors, and the identified DBT team leader to help them make informed decisions regarding how to situate and support a comprehensive DBT program within their organization. At a minimum, we encourage each agency to send the person they intend to have as the DBT team leader as well as the supervisor clinically responsible for the program.

7. Question: Have you ever had agencies work together to provide comprehensive DBT services?

Answer: Agencies can combine resources to create a solid team of DBT practitioners, though it requires concerted ongoing leadership coordination in addition to clinical coordination. The agencies and clinical team need to work out referrals, assessments, caseload, how out-of-session crises are managed, who manages out-of-session crises/coaching, and who has clinical responsibility for shared clients. Agencies also need to work through EMHR systems, billing, and communication with MCO's.

8. Question: Has this ever worked with a team in a school district?

Answer: Logistically here in Louisiana, school-based Medicaid providers who are employed by an LEA and reimbursed through the School-Based Medicaid Program would not be eligible for this training opportunity. OBH is seeking provider agencies who are contracted, credentialed, and accept referrals through the Managed Care Organizations. If your agency does contract with MCOs, and if you are interested in your agency integrating within a school district as one (but not the exclusive) location of service delivery, please reach out and we'd be happy to discuss these details.

9. Question: Can someone who works in community-based services providing Community Psychiatric Supportive Treatment (CPST)/Psychosocial Rehabilitation (PSR) do the DBT training?

Answer: Agencies that provide CPST and PSR are typically licensed to provide a menu of services including LMHP therapy and medication management. An agency providing a wide menu of services such as these may be well-situated to provide DBT. It is important to note that the actual DBT team at the agency must be comprised primarily of LMHPs. Please consult the LA Medicaid Specialized Behavioral Health Services Manual description of DBT for detailed requirements for the DBT teams, or see Question four (4) for a brief summary on licensing requirements for team members.

10. Question: Does the Nurse Practitioner (NP) at an agency have to be involved in DBT?

Answer: Prescribers such as nurse practitioners or psychiatrists do not need to be part of the identified DBT team at your agency, though it is very helpful. If your agency does employ prescribers, it is in keeping with best practices for them to be informed of the purpose and benefits of the DBT that the agency commits to deliver and to have a basic understanding of the modules that are being taught.

11. Question: Can the DBT services be implemented through both Telehealth and face-to-face?

Answer: Yes, you can deliver DBT interventions both in-person and via telehealth.

12. Question: Has DBT been found to be effective with clients with higher-functioning Autism?

Answer: Yes, studies do show that DBT can be effective with clients who have autism, especially the skills component of DBT which focuses on teaching new behavior. However, it is important to note that this training will focus on building comprehensive DBT programs and not focus on building a skill-only model. Additionally, other interventions that are autism-specific should still be considered, as they can offer additional assistance to such clients.

13. Question: With submitting tapes of sessions, will releases be provided for recordings, or should those be developed on an agency level?

Answer: The agencies will have to develop their own release of information forms according to agency protocols., but LSU will provide the location for sessions to be uploaded and reviewed in a HIPAA-compliant environment. LSU will delete sessions once the training protocol is complete.

14. Question: When is the DBT RFA period and for how long?

Answer: The DBT RFA period will open on **Monday, November 27th, 2023** and close on **Friday, January 5th, 2023.** Only complete applications will be considered. Complete applications should include one **Agency Agreement** per DBT team and **Individual Applications** for each member of the DBT team.