Child and Adolescent Mental Health Performance Standards

State of Hawaii

Department of Health
Child & Adolescent Mental Health Division

Effective July 1, 2012

Amended September 30, 2011, April 23, 2012, and April 30 2012

Clinical Services Office and Performance Manage Office • Child and Adolescent Mental Health Division • Department of Health
State of Hawaii

TABLE OF CONTENTS

INTRODUCTION

The Child and Adolescent Mental Health Performance Standards (CAMHPS) is a manual developed by the Hawai'i State Department of Health (DOH), Child and Adolescent Mental Health Division (CAMHD) for use in the development and provision of behavioral health services for youth. This manual is part of the contractual agreement between CAMHD and it contracted provider agencies for delivering behavioral health services to youth and families in Hawai'i. These standards and guidelines are designed to define service content standards, and to assure the efficiency and effectiveness of services.

The CAMHD through its six (6) Family Guidance Centers and a Family Court Liaison Branch, herein after referred to as Branches, provide case management services to youth and families throughout the state through the assigned Care Coordinator. In addition to the case management services, CAMHD employs licensed clinical staff who provide treatment and clinical oversight for their respective Branch. CAMHD also has the ability to procure needed services from its contracted provider agencies to meet the treatment needs of youth. CAMHD provides services to youth who a) have been certified as qualifying under the Individuals with Disabilities Educational Act (IDEA) for special education services and who are in need of related mental health services to benefit from their free and appropriate public education; and b) youth who meet the eligibility requirements for CAMHD's Support for Emotional and Behavioral Development (SEBD) program.

This current manual is a departure from pervious versions as it is not an interagency manual collaboratively written with the Department of Education (DOE). Since July of 2002, CAMHD and the DOE have collaborated to produce three versions of the Interagency Performance Standards and Practice Guidelines (IPSPG), also know as the blue, green and purple books referring to color of the cover and representing the year it was published. With each revised version of the IPSPG, the manual has become more technical, and it has served as the basis for CAMHD contractual requirements for providers. As a result, this version has been produced without the usual collaboration with the DOE. Despite this departure, CAMHD remains committed to working with the DOE in providing behavioral health services to youth in need.

The CAMHPS is designed to define the required content for each of the array of services CAMHD provides through its contracted provider agencies. Unless granted a written waiver from CAMHD, all contracted providers agencies, their employees and subcontractors are required to comply with their specific contracts which delineate additional requirements for each service.

SECTION I:

GENERAL PERFORMANCE STANDARDS

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OVERVIEW

The General Performance Standards are requirements for all Child and Adolescent Mental Health Division (CAMHD) services, and apply to each of the specific services. They are set forth to guide effective practices in the delivery of behavioral health supports and services for eligible youth in the State of Hawai'i. In Hawai'i's integrated system, supports and services are provided in accordance with all regulations as required by Individuals with Disabilities Educational Improvement Act 2004 (IDEA) and Medicaid with active involvement of families and communities in alignment with the Hawai'i Child and Adolescent Service System Program (CASSP) principles (See Appendix 1).

CAMHD reserves the right to amend this book in the future by adding new services or revising existing services as necessary to meet the needs of the youth of Hawai'i. Any and all changes that may occur in the future will be posted on the CAMHD website: http://hawaii.gov/health/mental-health/camhd/index.html. Additionally, CAMHD will periodically revise its policies and procedures to comply with department policies, changing laws, regulation and rules as required. All contractors will be notified of any policy and procedure change that may affect their operations.

A. CORE COMPONENTS OF CURRENT CAMHD SYSTEM

These core components underlie the values CAMHD strives to operationalize in its practices. The CAMHD expects the same commitment from contractors to support these components in their respective practices.

1. Commitment to the Hawaii CASSP Principles

Nationally, the CASSP principles (Stroul, B.A. and Friedman, R.M., 1986) were developed in accordance with the original work of Jane Knitzer in an effort to provide a framework of principles for newly created systems of care. Early in the 1990s, Hawaii communities and stakeholders made minor language revisions to these CASSP principles to effectively address the relevant cultural issues as they presented in Hawaii. CAMHD is committed to the CASSP Principles (See Appendix 1) and expects the same commitment from contracted providers.

2. Commitment to Interagency Collaboration & Coordination

Most of the youth served by CAMHD attend public schools, and may be involved with the child welfare system, juvenile justice system, or other DOH Divisions, including Alcohol & Drug Abuse ("ADAD"), Developmental Disabilities Division ("DDD"), and Early Intervention Services ("EIS"). A large percentage of the CAMHD population is enrolled in QUEST Healthplan services, which requires linkages to the primary healthcare providers. The CAMHD system is committed to work with all other child-serving agencies to integrate services and programs across agencies in the best interest of youth and their families.

3. Commitment to Evidence-Based Practices

Mental health services provided within the CAMHD system are expected to be evidence-based. Interventions with youth are meant to incorporate elements of those treatments identified as most promising based on credible scientific data. The proposed array of services provides a medium through which evidence-based interventions can be applied at high levels of intensity and in a variety of settings, depending on the needs of the youth. The CAMHD regularly reviews, summarizes, and disseminates relevant research data to support agencies in their selection and implementation of services. All treatment planning for psychosocial and

pharmacological intervention should stem from careful consideration of the most current research. In addition, agencies are encouraged to gather and evaluate their own data on child outcomes and functioning to further inform clinical decisions and the design of appropriate interventions. See the following links for the (a) CAMHD Biennial Report: http://hawaii.gov/health/mental-health/camhd/library/pdf/ebs/ebs013.pdf and (b) the evidence-based child and adolescent psychosocial intervention matrix from the American Academy of Pediatrics http://www.aap.org/commpeds/dochs/mentalhealth/docs/CR%20Psychosocial%20Interventions.F.0503.pdf

a. Definition of Evidence-Based Practice

CAMHD has required contractors to use evidence-based treatment approaches for many years, but there is still a lot of confusion about what this really means. In brief, evidence-based practices include all those treatment strategies and interventions for which observable, objective data exist demonstrating positive effects. Using evidence-based treatment means using interventions that have been shown to work. CAMHD contracted providers are expected to utilize data about an individual youth's progress along with the best available information about "what works" in planning and revising treatment. The data (or evidence-bases) showing the positive effects of mental health treatment practices can take one of four major forms, listed below in order of their relative strength. Information about the evidence base for various practices should be utilized throughout the course of treatment to make clinical decisions. Higher priority should be given to more reliable or stronger forms of evidence in making treatment decisions.

i. General Services Research

General service research is data typically found in peer-reviewed scientific journals (e.g., in the form of randomized clinical trial outcomes), and summarized in reports such as the Blue Menu: http://www.aap.org/commpeds/dochs/mentalhealth/docs/CR%20Psychosocial%20Interventions.F.0503.pdf and Practice Element Profiles in the latest CAMHD Biennial Report: http://hawaii.gov/health/mental-health/camhd/library/pdf/ebs/ebs013.pdf. Defined this way, evidence-based practice can include large brand-named packaged protocols (e.g., Multisystemic Therapy), broad-based therapeutic approaches (e.g., Cognitive-Behavioral Therapy) and discrete clinical techniques or practice elements (e.g., Caregiver Psychoeducation). When there is limited or weak published research evidence about a particular approach, but it appears promising, the strategy is often referred to as a "best practice."

ii. Case-Specific Historical Information

Case-specific historical information is case-specific data from repeated clinical interactions in the form of standardized (e.g., Ohio Scales, CAFAS, BASC, ASEBA) or idiographic (individualized) assessment strategies (e.g., MTPS ratings, mood or SUDS ratings, etc.). The usefulness of such data increases as the number of routine assessment points increases over time, and the data can be displayed graphically to help demonstrate strategies that are helpful to an individual youth on a case-by-case basis.

iii. Local Aggregate Evidence

Local aggregate evidence is case-specific data aggregated across numerous youth into meaningful composite units, such as treatment facilities. Such evidence includes not only positive clinical outcomes (e.g., a specialty facility may have high rates of success with youth with severe substance abuse concerns), but also critical incidents (e.g., a certain facility may have higher than average elopement rates, and care should be taken

before youth at risk for elopement are placed there). These types of data are sometimes referred to as practice-based evidence.

iv. Causal Mechanism Evidence

Memory, judgment, and professional knowledge of team members regarding the various causal mechanisms associated with the developmental psychopathology and treatment trajectory associated with a youth. Many times, such expertise is sought to help construct interventions for youth who have received empirically supported treatments but have not yet met treatment goals. Say for example, that a team has an agreed-upon case conceptualization that a youth's treatment for her trauma is not progressing adequately because the youth has an overall poor sense of control over her environment. Therefore, in addition to exposure-based strategies, the team recommends that extra care should be taken for cognitive restructuring and parenting strategies that help the youth exert personal control over her environment. Given potential information-processing biases and other concerns associated with human memory and judgment, care should be taken when relying on this evidence-base and the other forms of data above should first be strongly considered.

As outlined above, the term "evidence-based practice" extends well beyond brand-name packaged programs such as Multisystemic Therapy, Functional Family Therapy, and Multidimensional Treatment Foster Care. As outlined in this definition, the term "evidence" can and should take on many forms.

4. Commitment to Performance Management

The CAMHD is committed to ongoing evaluation of performance and the use of data to continue the development and management of the system as well as to improve provider development. Its performance management practices involve an extensive system for examining performance and using findings to make informed decisions about services and needed adjustments to program implementation. The CAMHD tracks and analyzes contractor performance data across all aspects of service delivery and care. CAMHD uses this information to determine how well the system is performing for youth, and how well youth are progressing. It is sensitive enough to determine if the system is performing better or worse for certain populations, and comprehensive enough to detect what aspects of care, and in what settings, problems may be occurring. Services are monitored through tracking of trends and patterns found in utilization and satisfaction data, and examinations of practice and quality of services.

The CAMHD maintains an active quality assurance and improvement program and expects to achieve goals of the program through an annual work plan that maintains improvement activities and measures for each quality and assurance program objective. Participants, including Contractors, in the system shall engage in ongoing quality assurance activities to improve their services and integration with the system.

5. Commitment to Access & Continuity of Care

The CAMHD has the belief that every child/youth is capable of recovery and resiliency. CAMHD seeks to promote individualized care which empowers youth and their families to achieve their goals, and maximizes their opportunities to live full lives in their own communities.

The CAMHD is committed to the philosophy of providing treatment at the most appropriate and least restrictive level of care necessary for effective and efficient treatment to meet the youth's bio-psychosocial needs. We see the continuum of care as a fluid treatment pathway, where youth may enter treatment at any level and be transitioned to more or less intensive levels of care as their changing clinical needs dictate. At any level of care, such treatment should be individualized and should take into consideration the youth's stage of readiness to change and participate in treatment.

Medical Necessity criteria will dictate the admission, continuing stay and discharge criteria for each service CAMHD provides. While these criteria are designed to assign the most effective and least restrictive level of care in nearly all instances, an infrequent number of cases may fall beyond their definition and scope. Thorough and careful review of each case, including consultation with Branch Clinical Lead, will identify these exceptions. As in the review of other cases, clinical judgment consistent with the standards of good medical practice will be used in making medical necessity determinations.

Medical necessity decisions about each youth are based on the clinical information provided by the treating practitioner or facility, the application of the medical necessity criteria and available treatment resources. We recognize that a full array of services is not available everywhere. When a medically necessary level of care does not exist or is not available, we will authorize a higher than otherwise necessary level of care so that services are available that will meet the youth's essential needs for effective treatment.

6. Medical Necessity

CAMHD will use this definition to define Medical Necessity to guide the service delivery:

a. The medical goods or services provided or ordered must:
   i. Be necessary to protect life, to prevent significant illness or significant disability;
   ii. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment, and not in excess of the enrollee's needs;
   iii. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
   iv. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide;
   v. Be furnished in a manner not primarily intended for the convenience of the enrollee, the enrollee's caretaker, or the provider.
b. "Medically Necessary" or "Medical Necessity" for hospital services require that those services furnished on an inpatient basis could not, consistent with the provisions of appropriate medical care, be effectively furnished on an outpatient basis.
c. The fact that a provider has prescribed, recommended, or approved medical or allied goods, or services does not, in and of itself, make such care, goods or services medically necessary or a medical necessity.

7. CAMHD Clinical Model

To ensure appropriate, effective and efficient treatment, CAMHD maintains clinical oversight of each youth served. Each youth is assigned a Care Coordinator who will facilitate the planning, coordination of services and monitoring of treatment through consultation with the Branch Clinical Lead.

a. Clinical Lead

Within each Branch, a Clinical Psychologists and Child Psychiatrists provide clinical direction to the treatment provided to youth through their collaboration and consultation with the youth's assigned Care Coordinator. Clinical review by a psychologist or psychiatrist helps to assure that the services authorized are appropriate to address the youth's difficulties and that they meet "Medical Necessity" criteria. Each youth will be assigned a "Clinical Lead" – either a CAMHD psychologist of psychiatrist - who will oversee their care and authorize services. The Clinical Lead's involvement may also include consulting with the service provider to help with planning treatment and designing interventions for the youth in order to assure efficient, effective care.

b. Branch Utilization Review Team

Each CAMHD branch holds a regular Utilization Review (UR) Team meeting. The UR team includes all supervisory clinical staff (Clinical Psychologist, Child Psychiatrist, and Mental Health Supervisors) and the branch Quality Assurance Specialist. Minimally, this group monitors all branch youth receiving Hospital Based Residential services and all youth whose length of stay in any level of care has exceeded the threshold for that service. These thresholds are described in the service reauthorization section of each service standard and are based on CAMHD system data about youth improvement over time in each level of care. The role of the UR team is to assure that there is a clear clinical rationale for continuing the service and that all continuing stay criteria are being met. The UR team provides support to the youth's assigned Clinical Lead and Care Coordinator in generating and considering possible alternative options when a youth/family are making little progress despite lengthy treatment in a given program or level of care.

c. Threshold

The CAMHD analyzed its own local data to determine the appropriate and effective length of stay guidelines for each service in its array. By using local aggregate outcome data as entered by CAMHD and its providers, CAMHD has determined the most appropriate time frames for each level of care as stated in the service reauthorization section for each service specific standard.

CAMHD analyzed the Child and Adolescent Functional Assessment Scale (CAFAS) and Monthly Treatment and Progress Summary (MTPS) data from the past two years to determine the time frame in which the majority of youth showed maximum improvement based on these measures. This time frame serves as the threshold for which a second level of review is needed in order to continue the service, since only a minority of youth showed continued improvement beyond this point in time. The thresholds are used to guide treatment time frames based on available data, but are not meant to be absolute end points in any treatment service. Treatment beyond any given threshold must have a UR team review to ensure the youth will continue to benefit from further treatment.

B. ACCESS & AVAILABILITY

CAMHD is committed to providing timely service planning and access to an array of services. CAMHD services, whether they are delivered by employees or contracted providers. These services are expected to be initiated and provided in a timely and consistent manner, as guided by the standards and practice guidelines defined in this manual.

CAMHD serves two (2) distinct populations as described below and eligibility determination as well as service array varies according to type of eligibility. Youth may be eligible in more than one (1) population category.

1. Educationally Supportive (ES) Services

Access for ES services is done through DOE and the Individualized Education Program (IEP) process for students whose complex needs extend beyond their school-based educational program and whose community and home environments require additional specific support via their IEP. Students who have been identified as requiring intensive mental health services are enrolled with the CAMHD Branch located in the school district of their home school. They are assigned a Care Coordinator (CC) at that time. The student may, and often will, continue to receive School-Based Behavioral Health (SBBH) services and supports in conjunction with the

intensive services provided through the CAMHD Branch. The service array for this population is in Section II, Part B, Educationally Supportive (ES) Intensive Mental Health Services.

2. **Support for Emotional and Behavioral Development (SEBD) Program Services**
Access and determination of eligibility for SEBD services is through the SEBD referral process (See website http://hawaii.gov/health/mental-health/camhd/library/pdf/sebd/a7393.pdf). The SEBD Referral form (See website http://hawaii.gov/health/mental-health/camhd/library/pdf/sebd/f0003.pdf) is submitted to the CAMHD Branch within the youth's home district. A determination of eligibility is then made. CAMHD provides services to youth who meet the eligibility requirements for the SEBD program. These services are based on team input and clinical determinations of what each youth needs in order to improve his/her emotional and/or behavioral functioning, including considerations of medical necessity. The service array for this population is described in Section II, Part B, Educationally Supportive (ES) Services and Section II, Part C, Support for Emotional and Behavioral Development (SEBD) Program services.

C. COORDINATION

All CAMHD youth will have their services coordinated by a care coordinator to ensure timely, appropriate and coordinated service delivery.

The Care Coordinator (CC) is the case management who is responsible for engaging the youth and family and assisting parents with coordinating the youth's education, health care and mental health services. Parent Partners are also available to provide peer support to parents in this regard. CCs are responsible for referring the youth for appropriate CAMHD services, maintaining contact with the youth/family, ensuring the timely and efficient delivery of quality services, and continuous monitoring of the effectiveness of interventions to assure that youth receive medically necessary care.

The youth's CC is responsible for convening an initial Coordinated Service Plan (CSP) meeting within thirty (30) days of eligibility determination or immediately if the youth has immediate needs and assuring service delivery within thirty (30) days of identification for routine services. The CC coordinates regular home visits, school visits, and community contacts as indicated in the CSP. When appropriate, responsibilities also include coordination of care with Family Court, and Department of Human Services and other state and community agencies. Contractors are expected to participate in the CSP development and meetings when they are involved with the youth. The CC is responsible for facilitating the integration, coordination, and monitoring of behavioral health services across programs and domains and for communicating important clinical developments to the Branch Utilization Review Team.

Contractors are responsible for coordination of services that are provided within their agency and regular communication about their services to the CC. Coordination and communication are particularly important in settings where there are multiple staff providing services for a youth. Contractors are also expected to coordinate efforts with the youth's school and community settings. Ongoing engagement, communication and coordination with families are a necessary practice as families are an integral part of the therapeutic process.

D. EVALUATIONS

CAMHD believes that clinical evaluation procedures are selected based on the complexity of the youth's problem, as well as the judgment of those individuals working with the youth during the initial stages of information gathering. Evaluation reports provide integrated clinical formulations of the youth's strengths and difficulties that can provide guidance for treatment planning. Recommendations describe and address the strengths and needs of the youth and detail treatment targets and intervention strategies without specifying a particular service, service provider, and program or eligibility status.

Youth who qualify for CAMHD because of their educational needs receive both their initial and annual Emotional and Behavioral Assessment (EBAs), through the DOE and these are used to plan CAMHD services.

1. Mental Health Evaluations for SEBD Youth

These evaluations are specifically necessary to understand a youth's presenting symptoms, diagnosis, strengths, needs and environment so that the most effective treatment interventions can be applied. Evaluations are part of the set of information that is used in planning strategies for treatment interventions, and are necessary prior to initiation of an individualized treatment intervention. Evaluations are informed by the youth's developmental course, family history, school functioning, social roles, substance use, psychiatric and medical history, degree of success or failure of previous interventions, current Diagnostic Statistical Manual (DSM) version diagnoses on all five (5) axes, prognosis, and recommendations for treatment within the context of an integrated clinical formulation. Measures of the youth's behavior and functioning [e.g. Child and Adolescent Functional Assessment Scale (CAFAS) or Preschool and Early Childhood Functional Assessment Scale (PECFAS), ASEBA Checklist for Parent, Teacher, and Youth Self-Report form are to be included along with other relevant measures so as to inform treatment recommendations. More extensive Psychological Testing may be performed when there is a clear need for additional data to answer referral questions or clarify diagnoses. Psychological Testing is performed only as part of a Mental Health Evaluation and requires a separate authorization.

The Mental Health Evaluation is conducted or contracted if a current evaluation does not already exist for an SEBD youth as part of the eligibility determination process for CAMHD services. Thereafter, SEBD youth must have an annual update of the assessment information. **All** Contractors must do a Summary Annual Assessment as specified in the specific level of care standard for SEBD youth in their care at the time the annual assessment is due. The Contractor is obligated to perform this assessment for SEBD youth who have received at least three (3) months of services from the Contractor. The Summary Annual Assessments address significant changes, current status and consequent recommendations.

CAMHD may also conduct or contract for a Mental Health Assessment when there is a specific clinical question to be addressed or when treatment has been unsuccessful and a clearer formulation of the youth's difficulties is needed. All recommendations incorporate youth/family strengths, are evidence-based, and are based on the identified needs of the youth.

If Contractors choose to use an electronic format for assessments, this electronic format must contain all the elements required by CAMHD in the clinical standard.

2. Psychosexual Assessment for ES and SEBD Youth

CAMHD may provide a **Psychosexual Assessment,** as needed, for any registered CAMHD youth who is arrested, charged or adjudicated for a sexual offense. This assessment is a specialized evaluation service to identify the youth's needs in the specific context of sexually deviant behaviors. The assessment is designed to build on the prior mental health assessment, using specialized psychometric instruments to assess sexual attitudes and interests as well as providing a risk assessment.

E. CAMHD CO-OCCURRING DISORDERS

Many youth receiving services from CAMHD have mental health disorders that co-occur with substance abuse, mild intellectual impairments, secondary diagnoses of developmental disorders, or medical impairments (e.g. blindness, deafness, diabetes, etc.) The presence of co-occurring disorders is assessed with all youth at the point of initial assessment, as well as routinely during the course of ongoing treatment. CAMHD does not provide services that are appropriate for youth with moderate or severe intellectual disabilities or severe autism spectrum disorders. Youth with mild intellectual disabilities and pervasive developmental disorders that are secondary to a diagnosed mental health disorder may be eligible for CAMHD in-home supports and treatment services. It is required that all Contractors will provide integrated treatment for co-occurring substance abuse disorders and mental health treatment with appropriate accommodations for youth with medical impairments.

F. SERVICE PLANNING

Each youth's treatment will be directed by a service plan that supports the use of medically necessary evidence-based interventions in the least restrictive environment. CAMHD service planning is an individualized and ongoing process that is youth guided and family/guardian centered.

Planning for a youth's transition to adulthood should begin early (ages 15-17) and will be documented in the youth's CSP for all youth seventeen (17) years and older. When the goals and needs in the CSP revolve primarily around increasing independence, the Mental Health Treatment Plan (MHTP) will include strategies to address the following six (6) areas:

- Living arrangement/personal management
- Vocational/educational
- Mental health and medical
- Community/social experiences
- Financial support and
- Employment.

1. Coordinated Service Plan (CSP)

The CC will convene a Coordinated Service Plan (CSP) meeting within thirty (30) days of youth's eligibility determination. The CSP process builds upon the strengths of the youth and family and requires the full engagement and involvement of youth, family/guardian, and key individuals involved in the youth's life including existing or potential service providers. The CSP will use resources available through the service system and shall include some naturally occurring resources in the youth's family and community. Its purpose is to coordinate efforts across public agencies and other supports and services. CSP planning is guided by a long-term holistic view of the youth's life. The CSP identifies the specific strategies that will achieve broadly defined goals for the youth and family, and integrates strategies across all those

involved. The CC shall convene a CSP meeting at least annually or as clinically indicated in order to assure that the youth's needs are continually addressed and that service planning is modified as necessary.

2. Mental Health Treatment Plan (MHTP)

The contracted service provider is responsible for the development, implementation, review, revision and adjustments to the MHTP. The MHTP should be individualized for each youth and should be developed through a collaborative process driven by the family/guardian and youth that includes the Contractor, family and the CC. In out-of-home care, the MHTP goals should identify realistic, measurable outcomes that are directly related to the youth's ability to move into a more normalized, less restrictive setting. The MHTP will identify evidence-based treatment interventions that are the most promising options for meeting a youth's individual goals and objectives. Progress on plans shall be tracked continuously and treatment revised as necessary with youth, family/guardian and Branch collaboration. The treatment planning process begins with the pre-admission meeting and culminates in a document that includes expected intensity of treatment and treatment timelines, crisis and discharge plans. Initial plans should be developed and submitted to the CC within seven (7) calendar days of intake (except where otherwise specified in the Service-Specific standards) or prior to admission.

Specific treatment strategies and services delivered by Contractors are clearly described in a MHTP. It is the role of the Contractor to regularly monitor and adjust treatment plans, with input from the youth, family/guardian, CC and other members of the youth's team. Treatment strategies shall be reviewed at least monthly and with the entire team at least quarterly (except where otherwise specified in the service-specific standards).

a. Crisis Planning

The crisis plan documents the individual's problematic behaviors, setting events, triggers, the youth's preferred methods of calming and regaining control, and the steps caregivers will take in the event that behaviors begin to escalate out of control. The crisis plan is an expected component of the MHTP that builds on available information about the youth and the youth's personal safety plan. A personal Safety Plan (see form in Appendix 18) should be developed in collaboration with the youth when possible and should detail his/her preferences for handling potential crises. The safety plan form can be attached to the crisis plan. Crisis plan components must focus on early intervention for any problematic behavior to reduce the need to take reactive steps. The use of police or crisis hotline services should be utilized only after all preventive strategies and program policies have been followed.

b. Discharge Planning

Discharge planning begins at the time of the pre-admission meeting to ensure that any potential obstacles to discharge are recognized and addressed before the anticipated discharge date. Contractors, CC, youth/family/guardian and other involved parties are expected to work together in this process. The discharge component of the MHTP should spell out specific, realistic, measurable discharge criteria that are consistent with behaviors/symptoms that resulted in the admission, describe a projected timeline for meeting them, and identify any aftercare resources needed. As treatment progressed, all involved parties are expected regularly to review discharge plans, discharge dates, step-down components, new admission dates, etc., to avoid unnecessary delays.

c. Discharge Summary

The Contractor must submit a written discharge summary to the appropriate CAMHD Branch on all youth within seven (7) calendar days of service termination. A preliminary discharge summary may be necessary in emergency situations if imminent services are needed. The discharge summary shall include at least the following components: More informal discussions between discharging providers and admitting providers about the youth's needs, successful strategies, etc. are also encouraged with proper consents.

i. The duration of service provided by the contractor and the level(s) of care,
ii. The reason(s) for discharge,
iii. History of medication use in the contractor's program and discharge medications;
iv. Information about the status of the youth in relation to the prescribed mental health treatment plan. This should include information about the youth's adjustment to the program/service, significant problems and concerns that arose during the treatment episode and significant youth and family accomplishments in the course of the treatment. This section should highlight interventions and/or coping strategies that were especially effective and areas of strength upon which future providers can build;
v. Description of the transition process, including any work done with the planned new treatment providers and/or caregivers to facilitate the transition; and
vi. Recommended aftercare services and specific recommendations regarding treatment targets and useful interventions.

G. REFERRAL PROCESS FOR CONTRACTED SERVICES

CAMHD provides an array of mental health services through its branches and contracted providers. The CC is a vital link in the referral process and makes referrals to contracted provider agencies based on a full review of the youth's current strengths and needs as indicated by the admission criteria in the service specific standard as described in the CAMHPS. The referral must be made within three (3) business days after the determination of strengths and needs through the youth's CSP and/or IEP and with written consent from the youth/family to release information. The CC will ensure that services are initiated in a timely manner. Routine services must be initiated within thirty (30) days of need identification.

All contracted services require prior authorization from CAMHD before service can be provided. With the exception of Emergency Services that must be provided immediately. Without service authorizations Contractors cannot bill for services rendered. The CC is responsible to initiate prompt authorization of services.

It is expected that all youth will have access to needed services. The role of the CC is to make referrals to agencies based on a full review of the youth's current strengths and needs and to ensure that services are initiated in a timely manner. If CAMHD youth from one (1) island is referred to and accepted by an out of home provider on another island, CAMHD will pay for the travel costs for admission, discharge and for CAMHD Branch approved therapeutic passes.

1. CAMHD Referrals

The Contractor is expected to accept all appropriate service referrals in accordance with contractual requirements. All referrals will include explanation of the purpose of treatment, the goals to be achieved via treatment, anticipated duration of treatment, and the discharge/transition criteria. Within three (3) working days of need identification, the CC will submit complete referral packets as follows:

a. Outpatient Referrals: referral packets to outpatient providers (except for MST) will contain:

i. Outpatient Services Referral Application
ii. Referral-Acceptance form (See Appendix 5)
iii. Current CSP
iv. Current CAFAS
v. IEP (as applicable)
vi. Current mental health/emotional behavioral assessment (within twelve (12) months);
vii. Current Functional Behavioral Assessment (FBA) (if applicable)
viii. Any recent admission/discharge summaries (if applicable)

b. Out of Home Referrals*:* referral packets to appropriate out of home providers will include the following:

i. Out of Home Services Referral Application
ii. Referral-Acceptance form (See Appendix 5)
iii, Current CSP
iv. Current CAFAS
v. IEP (as applicable)
vi. Current mental health/emotional behavioral assessment (within twelve (12) months);
vii. Current FBA (if applicable)
viii. Any recent Admission/Discharge Summaries and mental health evaluations from previous out-of-home placements, as relevant.
ix. Tuberculosis (TB) test results
x. Physical Exam according to Medicaid Early Periodic Screening, Diagnosis, and Treatment (EPSDT) standards and periodicity schedule (See Appendix 3)

2. **Contractor Referral Acceptance Protocol:** The referral acceptance process for out-of-home referrals is described in CAMHD Policy and Procedure (P&P) 80.614 "Referral Acceptance Protocol" (See Appendix 4). The Contractor for out-of-home services will be expected to follow the referral acceptance process as outlined in P&P 80.614. This process includes the following:
   a. Within two (2) business days of receipt of the referral packet from the CC, the Contractor shall complete and return to CAMHD the Referral Acceptance Form (See Appendix 5) found in the referral packet to confirm a date for initiation of services.
   b. If there are no beds available, the Contractor shall indicate an anticipated admission date that must be no later than the earliest projected discharge date of youth currently being served by the agency. The Contractor will put all youth accepted for an out-of-home program but not yet receiving services due to the lack of contracted bed capacity on the Waitlisted Youth Form and the Weekly Census Report on Client Status (See Appendices 13 & 12).
   c. If beds are available, the admission date shall be as soon as possible. Otherwise, CAMHD will view the youth as being rejected by the Contractor.
   d. If, for any reason, a Contractor believes a youth is not appropriate for their level of care, the Contractor must complete and submit a written justification summary from the Contractor's Psychiatrist to the Branch's Clinical Director. Within seventy-two (72) working hours, the Branch Clinical Director will review and discuss the concerns with the Contractor's Psychiatrist in an attempt to resolve the issues. If the Contractor Psychiatrist and Branch Clinical Director come to an agreement that the level of care is appropriate, the Contractor will give the CC an anticipated date for the initiation of services.

e. If the concerns cannot be resolved in this manner, the Contractor has the option to request an independent evaluation. The evaluation needs to be completed within fourteen (14) working days at the Contractor's expense. The independent evaluator must be an American Board of Medical Specialties board certified Child and Adolescent Psychiatrist who has no association with either the Contractor or CAMHD and must be approved, in advance, by the CAMHD's Medical Director. The Contractor must complete the "CAMHD Independent Psychiatrist Consultation From" (See Appendix 6) and submit to it to the Clinical Services Office (CSO). The CSO will fax the Medical Director's approval or disapproval to the Contractor within three business days of receipt of the form.

f. If the independent evaluation determines that the level of care is not appropriate, the Branch and its Clinical Director will accept and review the independent psychiatrist's recommendations. The CSP team will determine the appropriate level of care and send out referral packets to other appropriate providers. CAMHD will reimburse providers the cost of an independent evaluation if the level of care is determined to be inappropriate and CAMHD procedures have been followed for the procurement of the independent evaluation.

g. If the independent evaluation determines that the level of care is appropriate, the Contractor will accept the youth as soon as possible and will be responsible for the cost of the independent evaluation.

h. For Outpatient Service Contractors, there is no waitlist. Services are expected to begin as soon as possible at least within fourteen (14) days of acceptance.

i. CAMHD reserves the right to execute contractual action if the Contractor is unable or unwilling to meet the needs of CAMHD youth.

H. CAMHD AND CONTINUITY OF CARE

Contractors will be expected to provide all youth accepted for contracted services with continuity of care until the youth meets the criteria for appropriate discharge or transition to another level of care indicated in team decisions.

For Out-of Home services, the Contractor may not abruptly terminate services or eject a youth from out of home services. As outlined above and in the CAMHD P&P 80.614 "Referral Acceptance Protocol" (See Appendix 4), if a Contractor seeks to terminate services for a youth already in out of home program:

1. The Contractor is required to complete a full internal review that includes a review documented by the Contractor's psychiatrist.
2. The Contractor is required to report the results of this review to CAMHD and the MHTP team prior to any further action being taken.
3. If a Branch receives notification that a Contractor wants to eject a youth, the Branch Clinical Director will contact the Contractor's Clinical Director to review and discuss the issue. If the Contractor's Clinical Director and the Branch Clinical Director come to an agreement that the level of care continues to be appropriate, the Contractor is expected to maintain the youth in its program.
4. If the Branch Clinical Director and the Contractor's Clinical Director are not in agreement, the Contractor's Clinical Director has the option to request an independent assessment, at the Contractor's cost, from a Hawai'i licensed, American Board of Medicine Specialties board certified Child and Adolescent Psychiatrist, who is independent of the Contractor and CAMHD. The Contractor must complete the "CAMHD Independent Psychiatric Consultation Form" (See

Appendix 6) for the CAMHD Medical Director's approval of the independent consultant. The Contractor is expected to keep the youth until the result of the independent evaluation.
5. If the independent evaluation determines that the current level of care is no longer appropriate, the Branch will accept the determination and initiate appropriate and timely transition services for the youth. The Contractor will be requested to maintain the youth for at least ten (10) days per requirements of the consumer appeal process and to allow for transition preparation.
6. CAMHD will reimburse providers the cost of an independent evaluation if the level of care is determined to be inappropriate and CAMHD procedures have been followed for the procurement of the independent evaluation.
7. If the independent evaluation determines that the level of care continues to be appropriate, the Contractor is expected to maintain the youth in its program.

CAMHD reserves the right to execute contractual action if the Contractor is unable or unwilling to meet the needs of CAMHD youth.

I. STAFFING

To ensure quality of services provided, all contracted providers must adhere to their respective professional standards as set forth in professional practice guidelines and standards, ethical principles, and codes of conduct in addition to the following requirements.

1. Orientation and Training Requirements for CAMHD Contractors:

a. Contractors are responsible for providing appropriate training for their staff/contracted consultants on the use of evidence-based treatments and services for the CAMHD youth populations they serve.
b. Periodically, CAMHD will offer training on select evidence-based treatments and services for provider agency staff/contracted consultants with an emphasis on training for provider staff who can train others within their agencies.
c. Contractors must designate a staff person responsible for staff and/or sub-contracted provider training in all aspects of the delivery of services. The Contractor's trainer(s) is/are responsible for providing and/or arranging for the provision of training and documentation of all staff training, to include an outline of the following discussion points:
    i. The topic, name and credentials of trainer;
    ii. Names and titles of trainees that attended the training;
    iii. The date, time, place and duration of the training; and
    iv. An evaluation of the quality and effectiveness of the training.

d. The Contractor must have a specific training plan detailing how and when staff will be trained.
e. At least thirty (30) hours of training are required every year for all full time direct service staff. Those working fifteen (15) hours or less may reduce to fifteen (15) hours annually.
f. At a minimum, each Contractor shall provide all new employees, or sub-contracted personnel, twenty-four (24) hours of orientation to the organization within their first thirty (30) days of employment and/or contract. The orientation process must be completed prior to serving youth. These twenty-four (24) hours can be applied towards the thirty (30) hours of ongoing professional development required for the year. The orientation must include:
    i. An understanding of the agency's mission and goals;
    ii. A review of agency policies and procedures;
    iii. Orientation to the population served by the program and the model of care of the program

iv. An understanding of all laws and regulations regarding confidentiality including Health Insurance Portability and Accountability Act (HIPAA) requirements;
v. An introduction to psychiatric medications used with youth.
vi. A review of agency structure, lines of accountability, and authority;
vii. An understanding of the employee's job description;
viii. A review of State laws regarding child abuse and neglect reporting, reporting criminal behavior, and threats regarding suicide and homicide;
ix. Non-coercive behavior management approaches including positive behavioral support techniques;
x. Evidence-based treatment approaches
xi. Crisis intervention procedures, including suicide precautions;
xii. An overview of IDEA;
xiii. A review of Hawai'i CASSP principles;
xiv. Clinical Record Documentation requirements;
xv. CAMHD reporting requirements;
xvi. CAMHD policies and procedures that are included in the Request for Proposal and the
xvii. CAMHD Performance Standards
xviii. Client's rights and responsibilities;
xix. CAMHD sentinel events documentation and reporting requirements; and
xx. Safety of clients and staff
xxi. Overview of CAMHD Performance Monitoring;
xxii. Sentinel Event Reporting.

g. All staff providing direct services to youth must annually attend, successfully complete, and document in their personnel file at least thirty (30) hours of training, in service, and/or approved continuing education professional development seminars and/or conferences with curricula tailored to the mental health treatment focus of children / adolescents and/or their families. First Aid and Cardiac Pulmonary Resuscitation (CPR) training/recertification also qualify. Annual training must include HIPAA refresher training.

   i. The documentation for in-service training must include:
      1. Name, date, place, and duration of the training;
      2. The topic of the training and an outline of the discussion points;
      3. Name/credentials of the instructor and of the organization sponsoring the training; and
      4. Names and titles of trainees who attended the training.
   ii. The documentation for outside training attended must include:
      1. The name, date, place, and duration of the training;
      2. A brochure, conference agenda, or webinar announcement;
      3. Information about the professional organization that approved the training for continuing education;
      4. Name(s) and title(s) of the staff member(s) who attended the training; and
      5. Certificates of continuing education credits or certificates of attendance when available.

h. Treatment team meetings and individual supervision, although expected, do not apply towards the required (thirty) hours. Training may be provided as part of regular staff meetings or during group supervision sessions.

i. These training requirements apply to all personnel providing direct services to youth including sub-contractors and consulting staff (e.g. psychiatrists, psychologists, etc.)

j. Qualified Mental Health Professionals (QMHP) whose licensure requires continuing education for license renewal may submit evidence of license renewal for documentation of ongoing professional development.

2. Orientation and Training Requirements for CAMHD Direct Service Employees

CAMHD clinical staff (Branch Chiefs, Clinical Directors, Clinical Psychologists, Mental Health Supervisors and Mental Health Care Coordinators) working in CAMHD Branches will receive training in the following topics as part of orientation/shadowing process within ninety (90) days of hire:

a. Engagement Skills (Clinical Directors and Clinical Psychologists are exempted from this training):

   i. Review and practice of interviewing/listening skills;
   ii. Review and practice of solution focused questions;
   iii. Meeting facilitation; and
   iv. Interagency Collaboration.

b. Case Management (Clinical Directors and Clinical Psychologists are exempted from this training):

   i. System of Care including CAMHD mission, and strategic plan;
   ii. Review of Hawaii's CASSP;
   iii. Orientation to the population served and CAMHD service delivery model;
   iv. Understanding of all laws and regulations regarding confidentiality;
   v. Review of State laws regarding child abuse and neglect reporting;
   vi. Overview of IDEA; and
   vii. Evidenced based treatment.

c. Coordinated Service Planning:

   i. Strengths assessment;
   ii. Strengths-based planning;
   iii. Transition planning; and
   iv. Creating a crisis plan.

d. Child and Adolescent Functional Assessment Scale (CAFAS) certification;

e. CAFAS Re-certification once every two (2) years for all CAMHD clinical staff;

f. Use of Clinical Standards;

g. CAMHD Orientation:

   i. An understanding of agency's mission and goals;
   ii. A review of agency structure, line of accountability and authority;
   iii. Overview of Clinical Services Office and Performance Monitoring; and
   iv. Understanding of all laws and regulations regarding confidentiality including Health Insurance Portability and Accountability Act (HIPAA) requirements.

J. SUPERVISION

CAMHD is committed to quality service through regular, ongoing, strength-based, skill building supervision of all staff that provide direct services to youth. CAMHD and each Contractor shall have clear lines of accountability and a clearly described supervision structure for all employees and independent contractors.

Contractors must have policies and procedures and the mechanism to ensure supervision of all direct services and professionals by a QMHP and paraprofessional staff by a QMHP or a MHP who is supervised by a QMHP. The Contractor is responsible for maintaining and tracking supervision records.

All personnel (employees or subcontractors) must have an individualized supervision plan based on a needs assessment completed annually by their respective supervisor. Documentation of individual supervision session must include dates and duration, name and credentials of supervisor, goals and interventions, and summary of the sessions. Documentation must be included in the individual's supervision file and must include documentation of follow- up and consistency from previous supervision sessions.

Case reviews must be a part of each supervision hour. The mental health treatment plan goals and interventions must be reviewed. Outcomes from interventions utilized must be assessed for information to process for continued or revised course of treatment, depending on the outcomes. Supervision is also expected to include the development of and evaluating the effects of evidence-based services and plans for staff development and professional growth.

Supervision does not include training or administrative discussions. Supervision does include utilizing a combination of methods such as case reviews, direct observation, coaching, and role modeling to improve the level of staff skill.

A QMHP shall participate in peer reviews at least two (2) hours per month as evidenced by documentation in their supervision file. Two (2) hours for each one hundred sixty (160) hours of work may be adjusted for part-time professionals. QMHP's may credit regular participation in CAMHD's Evidence-Based Services Committee (EBS) or appointment to and regular participation in the CAMHD Professional Activities Review Committee (PARC) towards the QMHP supervision requirement. Documentation of attendance shall be maintained by the QMHP and submitted to Contractor for inclusion in the credentialing file.

A QMHP shall supervise the equivalent of no more than seven (7) full-time MHP's or paraprofessionals. An MHP shall receive at least three (3) hours of supervision a month from a QMHP. At least one (1) hour must be individual, clinical, youth-specific supervision and two (2) hours may be group supervision.

An MHP shall supervise the equivalent of no more than seven (7) full time paraprofessionals. Paraprofessionals must receive at least four (4) hours of supervision a month from a QMHP or a MHP who is supervised by a QMHP. At least one (1) hour must be individual, clinical, youth-specific supervision and three (3) hours may be group supervision.

Paraprofessional employees, who work fifteen (15) hours or less a week at an agency, are required to receive at least two (2) hours of supervision a month. At least one (1) hour must be individual, clinical, youth-specific supervision and one (1) hour may be group supervision.

K. EVALUATION OF STAFF PERFORMANCE

All CAMHD employees and Contractor shall have a process for evaluation of staff performance that includes a review of qualifications (i.e., an assessment of the employee's capabilities, experience, and satisfactory performance), reports of complaints received including resolutions, corrective actions taken, and supports provided to improve practice and to continue to monitor the staff evaluation process.

L. CREDENTIALING REQUIREMENTS

CAMHD is committed to ensuring that staff is competent and qualified to provide the intervention/services to students/youth as evidenced by meet the following departmental credentialing requirements.

Credentialing requirements apply to all individuals providing direct services including sub-contractors of a Contractor. All Contractors shall have written policies and procedures that reflect their responsibility to credential and re-credential their direct care staff, sub-contracted individuals, and clinical supervisory staff prior to provision of services. Contractors shall be guided by CAMHD's credentialing policies and procedures in developing their policies and procedures. Primary sources of information shall be verified by Contractors as a function delegated by CAMHD.

1. All professionals contracted or employed by Contractors to provide direct services to youth and families must be fully credentialed prior to provision of services to youths. They must have completely met initial credentialing requirements through submittal of required documents and satisfactory verification of primary sources including, but not limited to, employment history, reference verification, criminal background checks and child abuse and neglect checks.

2. Re-credentialing shall occur at least every two (2) years to ensure continued compliance with credentialing requirements including but not limited to internal provider and CAMHD reporting on performance, grievances, and involvement in sentinel events, licensing requirements, malpractice coverage and claims history, as well as child abuse and neglect clearances. Refer to CAMHD P&P 80.308 "Initial and Re-credentialing of Licensed Qualified Mental Health Professionals" (See Appendix 16) for items that need re-verification as well as CAMHD P&P 80.308.1 "Initial and Re-credentialing of Mental Health Professionals and Paraprofessionals" (See Appendix 19).

3. Contractors shall establish and maintain an electronic tracking system, in the format prescribed by CAMHD, to ensure prompt and accurate reporting of current staff and contractors as well as terminations. Evidence of Contractors' accountability is exhibited through the submission of the CAMHD Credentialing Report that is due to CAMHD's Credentialing Office by the 10th business day following the end of each quarter or immediately for terminations of an employee. Contracted agencies' compliance with this requirement is used in the yearly delegation of credentialing agency oversight evaluation.

4. Individual credentialing files for each direct care and supervisory employee and subcontractors shall be established separately from general personnel files.

5. Physician continuing education requirements are outlined by the State Professional and Vocational Licensing requirements for continuing education and will not be individually monitored by CAMHD. The renewal of a physician's licensure by the Board of Medical Examiners shall constitute completion of all required continuing education requirements.

a. CAMHD Individual Practitioner Credentialing Information

i. Qualified Mental Health Professional (QMHP):

1. Must be a current Hawai'i-licensed psychiatrist; board certified by the American Board of Psychiatry and Neurology (ABPN); or board eligible in Child/Adolescent Psychiatry. QMHP Psychiatrists in hospital-based settings must be ABPN board certified in Child/Adolescent Psychiatry.

OR

2. A Clinical or Educational Psychologist with a current Hawai'i license/certification in Psychology.

OR

3. A licensed Advanced Practice Registered Nurse (APRN) certified as a Psychiatric Clinical Nurse Specialist with a current Hawai'i license/certification.

OR

4. A Hawai'i licensed Clinical Social Worker (LCSW).

OR

5. A Hawai'i licensed Marriage and Family Therapist (LMFT).

OR

6. A Hawai'i licensed Mental Health Counselor (LMHC) at such time inclusion is incorporated into the Medicaid State Plan Amendment and Contractors are officially notified by CAMHD.

ii. Mental Health Professional (MHP):

1. A physician in training in an ACGME (Accreditation Council on Graduate Medical Education) accredited residency program in Child and Adolescent Psychiatry under program faculty supervision,

OR

2. A Ph.D. or Psy.D. in Clinical, Counseling or School Psychology from a nationally accredited university who is not currently licensed in the State of Hawaii,

OR

3. A Hawai'i licensed Social Worker (LSW),

OR

4. Must have a Master's degree from a nationally accredited university as a national board-certified behavioral analyst, marriage and family therapist, mental health counselor, psychologist, social worker, school psychologist, or psychiatric nurse,

OR

5. A Ph.D. or Psy.D. student in clinical psychology studying in an accredited program under program faculty supervision,

AND

   a. Must have at least one (1) year of full-time, clinically supervised progressive work experience inclusive of residency, internship, or practicum in the care or treatment of youth in a mental health or educational setting (experience may be substituted with certificates in a specialty such as Certified Substance Abuse Counselors (CSAC).

AND

   b. Must be supervised by a QMHP.

iii. Teachers in Community-based Residential Programs

The need for specialized educational services for CAMHD youth residing in CBR's require qualified, agency employed/contracted teachers who are:

1. Licensed in Special Education with training in educating students who exhibit a combination of severe social, emotional and behavioral deficits,

OR

2. Licensed in related service areas to include (but not limited to) Speech language Pathologist, Occupational Therapists and others as identified in the IEP,

AND

3. To ensure appropriate family involvement, the Contractor is responsible for providing interpreters for families whose limited English proficiency or mode of communication would inhibit their ability to meaningfully participate in the student's education.
4. CAMHD expects the Contractor to ensure the educational components of the program, including its teaching staff, meet all CAMHD CAMHPS requirements, even if this component is under a separate contract with the DOE.

iv. Paraprofessional

1. Personnel with a Bachelor's degree from a nationally accredited university in Psychology, Social Work, Nursing, Counseling, Education, or Special Education.

OR

2. Personnel with a degree less than a Bachelor's level from a nationally accredited university in either Psychology, Social Work, Nursing, Counseling, Education, or Special Education with at least one (1) year of full-time, clinically supervised work experience in the care or treatment of children or adolescents in a mental health or educational setting.

OR

3. Personnel with a high school diploma who have completed or complete within three (3) months of hire a childcare worker training course that includes at least 50 hours of instruction. The University of Oklahoma model that Maui Community College uses is an example. This course should utilize experimental learning methods (e.g. role-playing situations) in addition to traditional educational methods such as lecture and group discussion. It should stress CASSP principles and strength-based approaches to helping children and youth. Topics covered should include: understanding basic concepts in child development, skills for building positive relationships with youth, skills for providing discipline and skills for creating a positive environment or milieu. The participants should evaluate the training experience and a well-qualified instructor should teach it. Contractors are encourage to provide this kind of training experience to all new paraprofessional workers, including those with some college background.

M. MEDICATION MONITORING

Youth on psychoactive and other prescription medications require careful coordination and oversight.

For contracted services that include medication monitoring, careful coordination and oversight by the out-of-home service Contractor is required including <u>at least monthly</u> monitoring for:

1. Drug interactions,
2. Side effects,
3. Medical complications,
4. Lab test requirements, and
5. Follow-up requirements.

More frequent monitoring is required during medication titration or with the occurrence of serious side effects. Medication Monitoring services includes communication with Contractor's Registered Nurse, Contractor direct care staff and parent/guardian/foster parent. Every physician face-to-face and phone order contact, related to medication/monitoring must be documented in progress notes.

Overall supervision and oversight by the out-of-home Contractor's Hawai'i Licensed Registered Nurse (RN) is required when psychoactive medications have been prescribed. If non- licensed staff are dispensing medications to youth, they must be trained by the Contractor's RN. The Contractor's Nurse Medication Training Protocol must be approved by the Office of Health Care Assurance (OHCA) prior to delegating youth medication to any direct care staff that do not possess medical licenses. All direct care staff who are delegated this function must be trained and supervised by the Contractor's RN.

In accordance with the Hawai'i Administrative Rules (HAR) Title 16, Chapter 89 Nurses, Subchapter 15, Delegation of Special Tasks of Nursing Care to Unlicensed Assistive Personnel, all direct care staff who do not possess a medical license must be trained by the agency's RN prior to making medication available to the youth and supervised.

All over-the-counter (OTC) medications must be prescribed for specific out of home youth by the attending physician prior to making the medication available to the youth. The Contractor's RN must be notified of the need to administer the youth-specific OTC medication prior to making the medication available.

N. MAINTENANCE OF SERVICE RECORDS

CAMHD personnel, contracted agencies, and contracted individual professionals shall have and implement written policies and procedures to guide the content and protocol of youths' records for adherence to Federal law, State statutes, including HIPAA statutes, national accreditation and Medicaid standards. Service records must be current, well-organized, legible, comprehensive and consisting of all relevant documentation for the optimum treatment of youth served.

The youth's full name and/or other identifier, such as CAMHD youth registration number, must be on each page of the youth's record. Any adverse drug reactions and/or medication or other allergies or absence of allergies must be posted in a prominent area on the youth's file. Each youth's file contains easily identifiable past and current medical history including serious accidents, surgeries and illnesses. Diagnostic information, medication information, and substance use information are also included. Consultations and special referrals require documentation including resultant reports. Records also contain emergency care rendered with physician follow-up as well as hospital discharge summaries.

Contractors and professionals must maintain master youth files, including those on youth served by subcontracted providers, in a central, secure location in locked storage to which access is limited to designated persons in accordance with HIPAA regulations. Files in authorized use must be maintained securely.

1. Progress Notes

a. Progress notes are written for each activity/event by the staff/professional providing the service. Every physician contact including medication prescription, administration and monitoring must also be documented. Every therapy session must be documented. Progress notes shall be entered in the youth's file within twenty-four (24) hours of the

service/event. Daily progress notes are required for all youth receiving out of home services.

b. All progress notes must contain the following minimal documentation requirements and must be contained together in a single, continuous note:

   i. Complete date of service (including month, day and year)
   ii. Start and end time of service or start time and duration of service (for non-day rate services);
   iii. Place of service;
   iv. Type of service (Individual Therapy, Group Therapy);
   v. Either DAP note (Data, Assessment, Plan) or SOAP note (Subjective data, Objective data, Assessment, Plan) format including:
      1. Plan of treatment to including goals/objectives being addressed;
      2. Diagnostic tests conducted;
      3. Treatment interventions implemented and other prescribed regimens;
      4. Interpretation of the effectiveness of the intervention(s);
      5. Follow up notes, including results of referrals and subsequent plan of action;
      6. Specific time interval for next "visit" or session;
      7. Unresolved concerns from previous visit addressed in subsequent visits; and
      8. Other health care visits.
   vi. Full name, title, signature and signature date of service provider; and
   vii. Full name, title, signature and signature date of supervisor (if applicable).

c. Electronic medical records are permitted as long as the following criteria are met:

   i. A printed copy of the full record must be available in the youth's master file;
   ii. The electronic record must meet all Medicaid standards;
   iii. Must contain two (2) youth identifiers;
   iv. Must contain an electronic signature;
   v. Must have the date, time and duration of services;
   vi. Must have description of the service;
   vii. Must have agency or CAMHD Branch letterhead or heading on each page; and
   viii. Must be HIPAA compliant.

d. The focus in the content of notes shall clearly evidence the relationship of the intervention(s) to the youth's IEP/MHTP/CSP plan. Progress notes need to reference the goals and objectives stated in the youth's treatment plan and include data summaries, the interventions provided and the measurable outcomes resulting from them. Additionally, progress notes need to address what may not be working and what will be done differently for better results.

e. Progress notes also describe collateral communications pertinent to the treatment of the youth.

f. Contractors providers shall also electronically submit Monthly Treatment and Progress Summary reports to CAMHD by the 5th business day of the following month specifying youth served, service format, service setting, service dates, targets addressed, progress ratings, intervention strategies, projected end date, medications. Outcome measures may also be reported.

O. SERVICE QUALITY

CAMHD is committed to assuring appropriate and effective services for eligible youth and their families. Services are designed to support youth in their educational program, promote healthy functioning, increase independence, and to build upon the natural strengths of the youth, family/guardian and community. Families/guardians must be active participants in the behavioral support process, given the overwhelming evidence that constructive family participation enhances their youth's progress. Interventions are to be evidence-based and tailored to address the identified needs of the youth/family. Interventions/plans and progress/outcomes are to be regularly reviewed and modified, as needed, to effectively achieve goals.

Contractors/employees shall participate with the integration of services across domains as needed. Contractors/employees shall assist with transition planning (as it relates to greater and lesser levels of support and services) in collaboration with the youth, family/guardian and other team members. CAMHD shall encourage individuals with specific concerns regarding service quality to bring them to the attention of the school, provider agency, CAMHD Branch, CAMHD Central Administrative Office, and/or DOE District Office, as appropriate.

CAMHD Contractors shall assume all responsibility for the quality of services provided by employees or subcontracted providers. All Contractors shall implement a Quality Assurance and Improvement Program and demonstrate commitment to ongoing quality improvement activities. The quality program must meet Medicaid standards. Contractors must submit quarterly reports of quality monitoring to CAMHD.

CAMHD personnel, including CCs, Clinical Directors, Certification Specialists, Grievance Specialists, Credentialing Specialists, and Program Performance Reviewers shall have full access to youth and youth records while in a CAMHD contracted program.

CAMHD operates a co-planning and co-management model (active involvement and shared decision-making between the CAMHD Branch and Contractors) for any youth that is receiving intensive services, and also conducts regular reviews of child status, treatment practices, and Contractor's performance as part of its accountability and oversight functions.

P. MINIMUM REPORTING REQUIREMENTS

CAMHD requires submittal of the following reports as determined by the respective department outlined below.

1. **Monthly Treatment and Progress Summary (MTPS)**
   Contractors must electronically submit youth-specific monthly treatment and progress summary reports to the appropriate CC by the 5th day of each month describing the provided service and progress of the youth and family during the preceding month. The report must specify youth served, service format, service setting, service dates, treatment targets, progress ratings, intervention strategies, medications and dosage. Additional outcome measures may also be reported.

   The report should be completed by the clinician(s) most familiar with the youth and family's treatment and progress and must be verified for accuracy, signed and dated by a qualified provider. If multiple clinicians within an agency have worked with the youth and family during the month, the clinician completing the MTPS should gather relevant information from others to comprehensively complete the form. The form that must be used for this purpose is the "Service Provider Monthly Treatment and Progress Summary" (See website

http://hawaii.gov/health/mental-health/camhd/library/pdf/paf/paf-002.pdf), and the "Instructions and Codebook for Provider Monthly Summaries" (See website http://hawaii.gov/health/mental-health/camhd/library/pdf/paf/paf-001.pdf). Contractors are responsible for ongoing training of their clinicians and supervisors in accurate completion of the MTPS. A videotape of the statewide training on the MTPS is available from the CAMHD Clinical Services Office.

2. QUALITY ASSURANCE (QA) REPORTS

All Contractors must maintain Quality Assurance Programs, document their Quality Assurance Plan, and submit Quality Assurance Reports.

Quarterly QA Reports
Contractors must submit quarterly Quality Assurance Summary reports that are based upon the agency's quality assurance and improvement program that define measurable indicators for identified clinical and non-clinical process and outcome objectives. These reports state the findings and analyses conducted as well as actions that have been or will be taken by the agency following its quarterly review.

Contractors must report the following components, to the CAMHD Performance Management Section every quarter, no later than forty-five (45) calendar days following the end of each quarter. Forty-five days are allowed to give Contractors the time to complete the quarter's data collection and to analyze the data in their quality assurance committee(s). The quarterly Quality Assurance Summary report is to include the following information:

a. Sentinel Events:
- An analysis, including numbers, types and identified trends and patterns including issues/problems that accounted for the sentinel events
- A discussion of significant findings with opportunities for improvement identified
- Specific actions taken to impact youth care

b. Clinical Supervision:
- Adherence to supervision requirements, as indicated by the CAMHD supervision standards
- Analysis of performance of supervision program practices
- Description of any barriers to implementing supervision according to CAMHD supervision standards
- Opportunities for improvement identified with actions taken to impact effectiveness of supervision

c. Clinical Documentation:
- Completeness, quality and timeliness of clinical records and progress notes based on chart review conducted through a tool that reflects CAMHD requirements.
- Findings of internal chart reviews
- Opportunities for improvement identified
- Actions taken to impact quality of charts and documentation

d. Facility (if applicable):

- Brief analysis of facility condition: Status of facility maintenance including cleanliness, needed repairs and safety based upon routine, procedural inspections
- Opportunities for improvement identified and actions taken
- Steps taken to create and sustain a home-like engaging, family-friendly atmosphere
- Facility or administration office relocation plans.

e. Highlights of Other Significant Quality Assurance Finding and Accomplishments:

- List Quality Assurance Findings and other key accomplishment during the quarter

f. Status of Corrective Action/Improvement Plans:

- A copy of the current Corrective Action/Improvement Plan must be attached to the report with updates to completion date and outcome of developed activities/strategies

g. Contractor Quality Assurance Meeting Agenda and Minutes

- Submit agendas and minutes for meetings held regarding quality issues conducted during the quarter including summary of any focused reviews and/or special studies planned or conducted. Minutes should include only those activities related to CAMHD contracts/programs.

3. FACILITIES INFORMATION REQUIREMENTS:

Applicable Contractors are required to meet all facilities certification requirements as requested by the CAMHD's Facility Certification Specialist including:

- Staff schedules
- List of key facility personnel/consultants with location/phone numbers
- Copy of written information regarding residents/client rights
- Abuse Prohibition Review
- Medication pass time
- List of CAMHD clients' admissions during the past three (3) months
- Copy of facility's physical layout
- Tracking system for incidents/accidents/sentinel events
- List of new employees for the past six (6) months
- List of paraprofessionals; date of hire, list of paraprofessionals hired in the last six (6) months
- Credential of licensed/registered/certified personnel
- Contract for arrangement of services not provided by facility
- Policy and Procedure Manuals
- Program/Plans and Committee minutes for the past year
- Prevention Maintenance Records
- Pre-employment and annual health evaluation/TB clearance of employees
- In-service education records
- Other documents as requested

4. CAMHD SUMMARY OF LICENSING CORRECTIVE ACTIONS AND ANY REQUIRED DELIVERABLES:

Applicable contractors must provide a summary of corrective actions and required deliverables that result from desk or site reviews conducted by CAMHD's Facilities Certification Specialist to Department of Health CAMHD and Office of Health Care Assurance (OHCA).

5. **CAMHD SENTINEL EVENTS:**
   All sentinel events, as defined in the CAMHD Sentinel Event Policy and Procedure 80.805 (See Appendix 9), shall notify the youth's parent/legal guardian and CC within twenty-four (24) hours of occurrence by fax or phone and submit a written hard copy report on the CAMHD 72-Hour Sentinel Event Report Form (See Appendix10) submitted to CAMHD Sentinel Events Specialist and the CAMHD Branch within three (3) business days of the event.

6. **CAMHD ACCREDITATION:**
   Current Joint Commission on Accreditation of Healthcare Organizations (JCAHO), Council on Accreditation of Rehabilitation Facilities (CARF), or Council on Accreditation (COA) is required. All Contractors shall submit evidence of current accreditation to CAMHD Performance Management Section.

7. **CAMHD WEEKLY CENSUS REPORT ON CLIENT STATUS AND WAITLISTED YOUTH**
   All out-of home levels of care including Transitional Family Homes, Multidimensional Treatment Foster Care, Therapeutic Respite Home, Community-Based Residential Programs, and Hospital-Based Residential treatment service are required to submit a CAMHD Weekly Census Report on Client Status Form. (See Appendices B-12 & 13) in standard format to CAMHD's Clinical Services Office, Utilization Management section no later than Tuesday noon of each week either by fax or electronically.

8. **CAMHD ATTENDANCE AND ENCOUNTER RECORDS:**
   Attendance records and encounter records must be maintained at each facility for prescribed program activities. Residential facilities must maintain a log of whole day and/or night absences from both program and residence whether authorized or not. Such records are filed in the youth's file and made available to CAMHD upon request.

9. **CAMHD TITLE IV-E ADMINISTRATIVE REPORTS:**
   In accordance with CAMHD's efforts to maximize federal reimbursement, quarterly submission of Title IV-E training activity and cost will be submitted via the Contracted Agency Quarterly Training Report (See Appendix 14) by applicable Contractors to the CAMHD Fiscal Section is required, using standard training reporting forms.

10. **Other specified reports/documents periodically requested by the CAMHD**.
    CAMHD may periodically request specific information or documents to address specific issues or system needs. In making these requests CAMHD will be sensitive to the anticipated resources required of Contractors to respond to such requests. Nevertheless, Contractors are expected to provide such information upon request by CAMHD.

Q. RISK MANAGEMENT

All CAMHD Contractors must have policies and procedures that address critical risk management activities that include the following:

1. **Criminal, Child Abuse, and Background Screening**
   CAMHD requires a background check on each employee that has direct contact with children and youth receiving contracted services. This includes a Criminal History Record Check through the Hawai'i Criminal Justice Data Center and Hawai'i Child Protective Services System, a Child Abuse and Neglect screening in accordance with CAMHD P&P 80.406 "Child Abuse and Neglect Check: (See Appendix 15), a driver's license screening, and references from all employers for the previous three (3) years of employment. Annually a Child Abuse and Neglect

screening must be conducted. Every two (2) years a local criminal records check must be conducted. This is documented in the employee's personnel file. The Contracting agency is responsible for reviewing the documentation and taking actions as needed.

2. Safety

CAMHD requires Contractors to have procedures to ensure the safety and well-being of youth at all times. Safety is relative to known risks, and no procedure can provide an absolute protection from all possible risks.

Contractors shall manage, control, or alter potentially harmful conditions, situations, or operations including those leading to abuse, neglect and sexual exploitation, or induced by youth's high-risk behaviors to prevent or reduce the probability of physical or psychological injuries to youth. Safety from harm extends to freedom from unreasonable intimidation and fears that may be induced by other children, line staff, treatment professionals, or others. Safety procedures shall apply to settings in the natural community as well as to any special care or treatment setting.

3. Restraints and Seclusion

The State of Hawai'i is committed to fostering violence-free and coercion-free treatment environments for children and adolescents. As part of this commitment, CAMHD advocates that Contractors seek to minimize the use of restraint and seclusion, and work to increase the effective use of positive behavioral support strategies. Restraint and seclusion are emergency interventions that are used only to assure safety in situations where there is imminent risk of physical harm. Each youth has a right to be free from restraint or seclusion in any form that is used as a means of coercion, discipline, convenience, or retaliation.

Historically, seclusion and restraint have been seen as a necessary and even therapeutic part of treatment for those with emotional and behavioral difficulties. Over the past several decades, however, there has been an increasing recognition nationally that: 1) restraint and seclusion can lead to youth injury and even death, 2) youth usually experience significant psychological trauma in the course of seclusion or restraint interventions, and 3) treatment environments that minimize use of these methods are safer for both youth and staff members.

Because incidents of restraint and seclusion represent a significant risk to youth and staff members, CAMHD and all Contractors shall have internal policies and procedures regarding restraints and seclusion. The policies and procedures must include, but are not limited to, the following:

- The training that staff must receive prior to using restraint or seclusion with an emphasis on the serious potential for restraint or seclusion to cause injury or death;
- Reviewing and updating restraint and seclusion policies and procedures regularly, based on clinical outcomes;
- Agency-wide priority to use restraint or seclusion only when there is no safe alternative to prevent harm to self or others, safely and in accordance the agency's restraint and seclusion policies and procedures;
- Adequate allocation of resources to prevent the frequent use of restraint or seclusion; and
- Appropriate decision-making guidelines for when the use of restraint or seclusion is necessary.

The current Centers for Medicare and Medicaid Services accreditation standards set the minimal requirements with regards to the use of restraints and seclusion, but CAMHD goes beyond these minimum requirements in keeping with its commitment to violence-free and coercion-free treatment environments that ensures the safe treatment of youth. CAMHD requirements are outlined in this section and defined in its policies and procedures. CAMHD reserves the right to revise its policies and procedures periodically or as new requirements are established by the Center for Medicare and Medicaid Services. All Contractors will be notified of any policy or procedural change.

Non-aversive interventions and positive behavioral supports shall be the *absolute first course of action* to ensure the safety of the youth and others. These strategies must be part of a programmatic youth-specific plan to anticipate and manage a high-risk situations and unsafe behavior, and it must be clearly documented that such non-aversive strategies were the first course of action.

Restraint or seclusion are safety interventions *of last resort* and are to be used only in situations where risk of danger to the youth or others is reasonably imminent. Any use of seclusion or restraint must be documented and tracked following the use of the most recent and current Centers for Medicare and Medicaid Services accreditation standards.

Seclusion involves maintaining a youth in a locked and/or secure room to ensure the safety of the youth or others. Any such isolation in a secure environment from which the youth is not potentially free to leave is considered seclusion (e.g., having a staff member block the exit from an unlocked seclusion room). The use of seclusion as a safety intervention is different from the use of the discipline technique called a "time out". Time out from reinforcement is the removal of a youth from potentially rewarding people or situations. A "time-out" is not used primarily to confine the youth, but to limit accessibility of reinforcement. Such a time-out requires constant monitoring by staff. In a time-out, the individual is not physically prevented from leaving the designated time-out area.

Mechanical restraint involves restricting a youth's movement through the use of a restraining device (e.g., four point bed restraints, restraint chair) to ensure the safety of the youth or others.

Physical restraint involves any use of physical force to restrict a youth's freedom of movement. Physical escorts in which the youth is willfully cooperating with the guide are not considered restraint until such time as the youth no longer intends to follow or be escorted (e.g., youth struggles with staff). All physical restraints must follow CPI Protocol. Prone physical restraints are prohibited.

Drug used as a restraint involves administering a drug or medication when it is used as a restriction to manage that youth's behavior or restrict the youth's freedom of movement and is not a standard treatment or dosage for the youth' condition. Adjusting the dose of a prescribed medication or prescribing a new medication to achieve better symptom control is not considered chemical restraint.

All forms of restraints and seclusions are treated as potentially dangerous emergency procedures. Restraint and seclusion:

a. Are not to be used as treatment interventions.
b. All forms of restraints and seclusion require:
    i. Written orders for each procedure,
    ii. Ongoing monitoring during the intervention,

iii. Assessment of the youth when the intervention is concluded,
iv. Debriefing of staff and youth involved, and
v. Notification of the youth's guardians and CAMHD.

c. Must terminate when the emergency safety situation has ended and the risk of imminent harm has passed, even if the order has not expired. Any additional restraint/seclusion, even if the original order has not expired, requires a new order.
d. Shall not be used simultaneously.
e. May not exceed four (4) hours for 18-21 year olds, two (2) hours for 9-17 year olds, and one (1) hour for children less than nine (9) years of age
f. Must not involve the use of mouth coverings.
g. Must not result in harm or injury to the youth.
h. Standing orders and as-needed (PRN) orders are prohibited.

Orders:
Drugs used as a restraint must be preceded by a written order by a qualified physician. That physician must be available to staff for consultation, at least by telephone, throughout the entire period of the emergency safety intervention. The attending physician must be consulted as soon as possible if restraint or seclusion is not ordered by the patient's attending physician.

Other forms of restraint and seclusion may be ordered only by: a) a board-certified psychiatrist, b) a licensed psychologist, c) a physician licensed to practice medicine, or d) APRN with specialized training and experience in the diagnosis and treatment of mental diseases as well as the application of seclusion and restrains.

Such orders utilize the least restrictive emergency safety intervention that is most likely to be effective in resolving the emergency safety situation based on consultation with staff. Standing orders and as needed (PRN) orders are prohibited. Safety interventions must not involve the use of mouth coverings nor result in harm or injury to the youth.

Each order must include:

- The name and signature of the staff issuing the order;
- The date and time the order was issued; and
- The type of emergency safety intervention ordered, including the length of time authorized.
- Written orders must be in the chart within twenty-four (24) hours

The qualified person issuing the order must be available to staff for consultation, at least by telephone, throughout the period of the emergency safety intervention.

If the emergency safety situation continues beyond the time limit of the order for the use of restraint or seclusion, a registered nurse or other licensed professional, such as a licensed practical nurse, must immediately contact the person who issued the order to receive further instructions.

Monitoring
Clinical staff, trained in the use of emergency safety interventions, must be physically present, continually assessing and monitoring the physical and psychological well-being of the youth and the safe use of restraint throughout the entire duration of the emergency safety intervention.

Clinical staff, trained in the use of emergency safety interventions, must be physically present in or immediately outside of the seclusion room, continually assessing, monitoring, and evaluating the physical and psychological well being of the youth in seclusion. Video monitoring does not meet this requirement. The seclusion room must:

- Allow staff full view of the youth in all areas of the room; and
- Be free of potentially hazardous conditions such as unprotected light fixtures and electrical outlets.

Assessment after the initial intervention

For Hospital-Based Facilities: A board-certified psychiatrist, licensed psychologist, physician licensed to practice medicine, APRN or RN with specialized training and experience in the diagnosis and treatment of mental health disorders must conduct a *face-to-face assessment* of the youth's well-being *within one (1) hour of the initiation of the emergency safety intervention*. If the one (1) hour face-to-face assessment is conducted by someone other than the attending physician responsible for the care of the youth, that individual must be consulted as soon as possible after the completion of the evaluation.

For Non-Hospital-Based Programs: If the authorized individual who issued the order is not available, Centers for Medicare and Medicaid Services (CMS) regulations require a clinically qualified registered nurse trained in the use of emergency safety interventions to conduct a *face-to-face assessment* of the youth's well-being *within one (1) hour of the initiation of the emergency safety intervention*.

All assessments will include, but are not limited to:

- The youth's physical and psychological status;
- The youth's behavior;
- The appropriateness of the intervention measures as a last resort, safely applied, monitored, released ASAP and return to preventative milieu; and
- Any complications resulting from the intervention (e.g. trauma or injury).

Notification

The program must notify the parent(s) or legal guardian(s) that the youth has been restrained or placed in seclusion as soon as possible after the initiation of each emergency safety intervention. Documentation of this notification, including the date and time of notification and the name of the staff person providing the notification will be placed in the youth's master file. The program must document attempts to establish contact within twenty-four (24) hours of initiation of the restraint or seclusion.

Each Contractor must record, maintain, and track, any use of seclusion and restraint adhering to the most recent and current Centers for Medicare and Medicaid Services accreditation standards that include, at a minimum, the following:

- The type of restraint or seclusion used;
- Staff involved;
- Documentation of the verbal and/or written order;
- Witnesses to the restraint/seclusion;
- The time frame and duration of use;
- The rationale for restraint or seclusion;
- The types of less restrictive alternatives that were tried or considered; and
- An assessment of the youth's adjustment during the episode and reintegration to the daily program.

The Contractor must make a sentinel event telephone call to CAMHD within twenty-four (24) hours of the occurrence of the restraint or seclusion. Complete written documentation of the episode must follow to the CAMHD within seventy-two (72) hours (three business days) of the sentinel event via a the Sentinel Event Report form (See Appendix 10), including (1) a review of the less restrictive alternatives that were considered, and (2) a reference to the debriefing with the youth and all staff and residents who were involved in or witnessed the event. The notification must include the duration of the seclusion or restraint and type of restraint. For a chemical restraint, the medication and dosage must be reported.

Debriefing

As soon as possible, but at least within twenty-four (24) hours after the use of restraint or seclusion:

- The youth and staff (except when the presence of a particular staff person may jeopardize the well-being of the youth) involved in the emergency safety intervention must have a face-to-face discussion.
- Other staff and the parents or legal guardians may participate when it is deemed appropriate by the facility. If this occurs the program must conduct such a discussion in a language that is understood by the parents or legal guardians.

The discussion must provide both the youth and staff the opportunity to discuss the circumstances leading to the use of restraint or seclusion and strategies to be used by the staff, the youth, or others that could prevent the future use of restraint or seclusion.

Within twenty-four (24) hours after the use of restraint or seclusion, all staff involved in the emergency safety intervention, and appropriate supervisory and administrative staff, must conduct a debriefing session. A senior manager not involved in the event should lead the debriefing session. This formal debriefing must include, at a minimum, a review and discussion of:

1. The emergency safety situation that required the intervention, including a discussion of the setting events and *precipitating factors* (e.g. identification of the behavior being controlled) that led up to the intervention;
2. Alternative techniques and youth de-escalation preferences that were implemented or might have prevented the use of the restraint or seclusion;
3. The procedures, if any, that staff are to implement to prevent any recurrence of the use of restraint or seclusion;
4. The outcome of the intervention, including any injuries that may have resulted from the use of restraint or seclusion;
5. Determination of whether imminent danger was present and whether the early signs of risk were detected;
6. The procedures for notification, documentation, and return to the therapeutic environment.
7. The agency must document in the youth's record that *both* debriefing sessions took place and must include the names of staff who were present for the debriefing, names of staff who were excused, and any changes to the youth's crisis/safety/treatment plan that resulted from the debriefings.

4. Sentinel Events and Incidents

All CAMHD Contractors must have internal policies and procedures regarding sentinel events and incidents in accordance with CAMHD's P&P 80.805 "Sentinel Events" attachment "Sentinel Event Code Definitions" (See Appendices 9 & 11). At a minimum these policies must address:

- How the Contractor notifies CAMHD (CAMHD Branch and Sentinel Events Specialist) within twenty-four (24) hours by fax or telephone and in writing within seventy-two (72) hours (excluding week ends and state holidays) of any serious sentinel event as defined in CAMHD's P&P 80.805";
- How the Contractor tracks the occurrence of all incidents and sentinel events to identify trends and patterns in order to implement improvements; and
- A complete analysis of the event as well as actions taken to address the event. Both the initial notification and the subsequent written report must be forwarded to the CAMHD Performance Management-Section and the CC,

The Contractor's QMHP's or clinical designee shall review all events reported by staff as evidenced by their signature to the Sentinel Events Report form, in discerning whether the events are reportable incidents in accordance with CAMHD's definitions.

5. Police

Requests for police assistance should be limited to situations where the youth's behavior is deemed to be critically out of control and can no longer be safely contained by staff. CAMHD's out of home providers are to follow their internal crisis management procedures including consultation with their QMHP prior to during or after requesting police assistance. The QMHP must follow-up to ensure the crisis has stabilized, debrief the incident and provide triage for youth needing more intensive interventions and document their efforts in the youth's chart.

R. YOUTH RIGHTS AND CONFIDENTIALITY

CAMHD recognizes the rights of all youth and families accessing behavioral health services.

Consumer Rights

All Contractors and their employees or subcontracted professionals are required to recognize CAMHD Consumer Rights and Responsibilities (See website: http://hawaii.gov/health/mental-health/camhd/library/pdf/a6218.pdf) that states:

- You have the right to be treated with respect. You also have the right to your privacy.
- You have the right to treatment no matter what your situation is. You have this right regardless of your age, race, sex, religion, culture, ability to communicate, or disability.
- You have the right to know about the CAMHD services you can receive and who will provide the services. You also have the right to know what your treatment and service choices are.
- You have the right to know all of your rights and responsibilities.
- You have the right to get help from CAMHD in understanding your services.
- You are free to use your rights. Your services will not be changed or you will not be treated differently if you use your rights.
- You have the right to receive information and services in a timely way.
- You have the right to be a part of all choices about your treatment. You have the right to have your treatment plan in writing.
- You have the right to disagree with your treatment or to ask for changes in your treatment plan.
- You also have the right to ask for a different provider. If you want a different provider, we will work with you to find another provider in our network.
- You have the right to refuse treatment.
- You have the right to get services in a way that respects your culture and what you believe in.

- You have the right to look at your records and add your opinion when you disagree. You can ask for and get a copy of your records. You have the right to expect that your information will be kept private within the law.
- You have the right to complain about your services and to expect that no one will try to get back at you. If you complain, your services will not stop unless you want them to.
- You have the right to be free from being restrained or secluded unless an allowed doctor or psychologist approves, and then only to protect you or others from harm. Seclusions and restraints can never be used to punish you or to keep you quiet. They can never be used to make you do something you don't want to do. They can never be used to get back at you for something you have done.

All CAMHD employees and Contractors must adhere to these rights in the provision of behavioral health services to eligible youth. Each Contractor is to identify a Behavioral Health Rights Advisor within their organization who will ensure that all youth and families are made aware of their rights, and that the provider respects and upholds these rights.

Each Contractor shall have in place, its own administrative process through which youth and their families can have their concerns and/or complaints addressed in a thorough and efficient manner. The CC is required to review the CAMHD Consumer Handbook with parents and youth (as appropriate) who sign a form acknowledging receipt of this information as well as the Notice of Privacy Practices. The Acknowledgement Form is filed in the youth's chart.

S. COMMUNITY FOCUS

CAMHD shall participate in local community organizations, including service areas boards, neighborhood boards and/or Community Children's Councils (CCC). CAMHD shall work collaboratively with the community organizations to address issues and concerns about the services and the continuum of care provided to Hawai'i's eligible youth. Contractors are required to participate in local community organizations to ensure healthy, ongoing communication between the providers and the community organizations and to provide opportunities for collaboration in the development of behavior health services/resources to complement existing services and to meet local needs.

T. TEAM-BASED DECISIONS

All behavioral health services with the exception of emergent services are the result of clinically informed team-based decisions regarding medically necessary care and made in collaboration with the youth and family/guardian. The IEP/CSP team utilizes assessment information evidenced-based service information, practice guidelines and performance standards to make decisions. Services emanate from an IEP, or CSP with a MHTP to elaborate the program and setting specific actions.

U. GRIEVANCES/APPEALS

The CAMHD respects the right of any youth or family to disagree with aspects of planning or service delivery and will make every effort to resolve these disagreements directly with the family. If resolution is not possible in direct exchange, families and providers have additional recourse through the CAMHD's Grievances and Appeals Process (See Appendix 17 Grievances and Grievance Appeals P&P 80.603). Youth and/or families are informed of these processes upon registration at a CAMHD Branch. If a service is going to be denied, terminated or reduced, CAMHD provides at least ten (10) days notice to the youth/family and Contractor (if applicable). This notice includes appeal rights and appeal process information.

V. ACCOUNTABILITY/SERVICE STANDARDS

All Contractors will remain obligated to (a) aspects of the contract as agreed upon by CAMHD, and the provider; (b) to general professional practice and ethical standards as dictated by the various State professional and vocational licensing standards; (d) and to service standards as delineated in this manual.

The CAMHD shall be responsible for monitoring each contract at least annually and more frequently as needed.

W. CAMHD BED HOLDS AND THERAPEUTIC PASSES

1. Bed Holds

Bed holds are used by CAMHD to hold a bed space for a youth not currently in an out-of-home program for at least twenty-four (24) hours. The Branch where the youth is registered may authorize a bed hold which is reimbursed at fifty percent (50%) of the unit rate. Bed holds may be authorized under the following conditions:

- Youth who elope from a program may have a bed hold authorization for a maximum of three (3) consecutive days per elopement.
- Youth who require an acute admission or short-term detainment in the Detention Home or Hawai'i Youth Correctional Facility may have a bed hold authorization for a maximum of seven (7) consecutive days per incident.

The Contractor must accept the youth back into the program at anytime during the authorized bed hold period, unless it has been determines, at the cost of the Contractor, through an evaluation by a CAMHD approved independent psychiatrist that an alternate service is necessary. The results of this evaluation must be provided to CAMHD in writing prior to any action being taken. If the youth returns after the bed hold days have been utilized, the Contractor is obligated to accept the return of the youth if there are vacant beds. If there are no vacant beds, the Contractor is obligated to put the youth on the waitlist with an anticipated admission date. CAMHD reserves the right to execute contractual action if the Contractor is unable or unwilling to meet the needs of the youth.

2. Therapeutic Passes

Therapeutic passes are used by CAMHD to hold a bed space for a youth not currently in an out-of-home program for at least twenty-four (24) hours. Therapeutic passes will be authorized whenever a youth has a planned pass of at least twenty-four (24) hours or more which is reimbursed at one hundred percent (100%) of the unit rate for the number of days specified in the service-specific standard. Any authorization of therapeutic pass beyond the threshold requires Branch Utilization Review team review and approval for authorization. Any pass of less than twenty-four (24) hours does not require authorization and are not considered "therapeutic passes."

A therapeutic pass is defined as a pass of twenty-four (24) hours or more to assist the youth in achieving their MHTP goals. Therapeutic passes are used to assist youth in maintaining/improving family relationships, generalizing skills to the home/community and transitioning to home/community living. The therapeutic pass must be a planned therapeutically structured passes to the youth's home or post-treatment environment and requires prior authorization by the CC. Each therapeutic pass must be scheduled and planned with the youth and parent/guardian prior to the pass. The out-of-home program must have contact with the youth and parent/guardian during the pass to ensure compliance with the plan for the therapeutic pass and must debrief each therapeutic pass with the youth and parent/guardian either direct after the therapeutic pass or during the next scheduled family therapy session.

SECTION II:

SERVICE SPECIFIC PERFORMANCE STANDARDS

SECTION II – PART A:

EMERGENCY MENTAL HEALTH PERFORMANCE STANDARDS

SECTION II – PART A: EMERGENCY MENTAL HEALTH PERFORMANCE STANDARDS

A. 24-HOUR CRISIS TELEPHONE STABILIZATION

Definition	24-Hour Crisis Telephone Stabilization serves all youth whose immediate health and safety may be in jeopardy due to a mental health issue. After receiving consultation, referral and the necessary support to dissipate the crisis situation, the youth may be permitted to stay in his or her natural environment, if safety can be assured. The absence of this capacity would indicate need for mobile outreach services to assess situation and arrange appropriate course of actions.
Services Offered	1. Crisis Telephone Stabilization service is staffed twenty-four (24) hours/seven (7) days a week. 2. Initial assessment is made over the phone regarding the nature of the mental health crisis. 3. Support, consultation and referral services are provided based on the initial assessment. 4. The crisis worker provides the caller with sufficient information or guidance to dissipate crisis. 5. The agency must provide at least quarterly advertisements of the 24-Hour Crisis Telephone Stabilization service via public service announcements, flyers, posters, mailing list, etc.
Admission Criteria	All youth, families or community members in need of help during a mental health crisis.
Initial Authorizations	No authorization needed.
Discharge Criteria	Crisis situation diffused and natural supports sufficient for youth to remain safe in the community or dispatch of Crisis Mobile Outreach team.
Service Exclusions	No exclusions.
Clinical Exclusions	No exclusions.

Staffing Requirements:

In addition to the staffing requirement listed in the general standards, the following staff requirements must be followed. If the standards referenced here differ from those in the general standards, these staffing requirements will supersede the general standards.

1. A QMHP is on call twenty-four (24) hours a day, seven (7) days a week, in the event of clinically complex or psychiatric related situations in need of consultation and is available for on-call service, consultation, direction, and case debriefings.
2. The agency staff must be under the supervision of a QMHP. A MHP with crisis experience must be on the premises at a minimum of eight (8) hours/day and must be on call at all other times.
3. The agency must have adequate numbers of crisis workers available, particularly during peak call hours to minimize call waiting and call hold instances.
4. At a minimum, crisis workers must meet paraprofessional credentialing requirements.

Clinical Operations

1. Services are available twenty-four (24) hours a day, seven (7) days a week.
2. Trained crisis workers must be available at all times to assess the nature and severity of the mental health crisis, to provide needed support and consultation, and to refer for appropriate treatment or other needed service.
3. The crisis telephone stabilization service must be a toll free number for all callers in the covered geographic area.
4. Crisis telephone stabilization service must have Telephone Device for the Deaf (TTY) or Text Telephone Display (TTD) capacity.
5. All calls must be answered by trained crisis workers within three (3) rings or ten (10) seconds.
6. All calls must not be on hold for more than fifteen (15) seconds.
7. The agency must have a process for dispatching crisis telephone stabilization calls for on-site visits by the crisis mobile outreach team when situations warrant face-to-face lethality assessments and consultation.
8. The agency must have written policies and procedures to ensure that crisis workers have timely access to the agency's QMHP for assistance with complex situations. Protocols must specify the role of the QMHP in providing additional guidance until the crisis dissipates or diminishes, or until the mobile outreach team arrives and initiates services.
9. Prior to performing hotline services, hotline workers receive at least twenty-four (24) hours of orientation training including: crisis assessment and intervention, suicidal assessment, homicidal assessment, clinical protocol, proper documentation, and knowledge of community resources.
10. Hotline workers must be familiar with CAMHD service array and other community resources and services to provide guidance and referrals to callers.
11. The program must have documented training on a quarterly basis, to expand knowledge base and skills relative to crisis intervention treatment protocols as guided by the agency's training curriculum, and youth-specific situations experienced by crisis telephone stabilization workers. Training should promote Evidence-Based Services and Best Practice procedures for urgent and emergent care situations.
12. Please see Section I General Standards for additional clinical operation requirements:
    - I. Staffing
      - Orientation and Training and Training Requirements for CAMHD Contactors;
    - J. Supervision
    - K. Evaluation of Staff Performance;
    - L. Credentialing Requirements;
    - Q. Risk Management

Documentation

1. An emergency service note must be completed and entered in the service log immediately, that includes, to the extent provided by the caller:
   a. Identifying demographic information.
   b. The date and actual time and duration of the services rendered.
   c. The worker who took the call.
   d. The nature of the crisis.
   e. Description of the nature of interventions made, including natural community resources utilized in diminishing the crisis and ensuring the safety of the youth.
   f. The involvement of additional staff in the provision of service, particularly the on-call QMHP or MHP.

g. The youth's status, referrals for continued services and disposition at the end of the call.

h. If the youth's name is not given, a note describing any relevant general information (e.g. male teenager) is obtained. Anonymous caller notes are placed in a separate file.
i. Contact with any current providers or reference to current treatment or crisis plans in place for the youth.

2. If the youth is registered with a CAMHD Branch, this documentation must be forwarded to the CC by close of the next business day.
3. The crisis telephone stabilization agency must have the necessary systems in place to monitor calls, length of calls, call wait times and aborted calls. These reports must be provided to CAMHD every quarter.

B. CRISIS MOBILE OUTREACH

Definition	This service provides mobile outreach assessment and stabilization services face-to-face for youth in an active state of psychiatric crisis. Services are provided twenty-four (24) hours per day, seven (7) days per week and can occur in a variety of settings including the youth's home, local emergency facilities, and other related settings. Immediate response is provided to conduct a thorough assessment of risk, mental status, immediate crisis resolution/stabilization and de-escalation if necessary.
Services Offered	1. Twenty-four (24) hour-seven (7) day a week response. 2. Immediate response is required, with a maximum arrival time within forty-five (45) minutes of notification. 3. Pre-hospitalization screening and assessment. 4. Crisis intervention and counseling. 5. Intensive in-home services to stabilize the youth/family. 6. Arrangement of and assist with transportation to a Therapeutic Crisis Home or Emergency Room (when needed). 7. Care coordination, including obtaining information regarding any providers/agencies involved with youth and notifying the involved parties about the crisis the next business day. 8. Care coordination also includes arranging appropriate referrals to community resources or at a minimum providing family with community resource cards for youth not currently receiving behavioral health services.
Admission Criteria	<u>At least **one** (1) of the following criteria is met:</u> 1. The youth demonstrates suicidal/assaultive/destructive ideas, threats, plans or attempts which represent a risk to self or others as evidenced by the degree of intent, lethality of plan, means, hopelessness or impulsivity; 2. The youth may be displaying acute psychotic symptoms such as delusions, hallucinations, and thought disorganization that are unmanageable; or 3. The youth evidences lack of judgment, impulse control, or cognitive/perceptual abilities.
Initial Authorizations	Prior authorization is not required for this level of care. Usual time frame is one (1) to four (4) hours. Unit = fifteen (15) minutes
Discharge Criteria	<u>At least **one** (1) of the following criteria is met:</u> 1. Appropriate community or natural resources are planned and/or engaged to reduce stress factors and to stabilize the current living environment and the youth's symptoms/behaviors abated to a level no longer requiring outreach services; 2. The youth is admitted to Therapeutic Crisis Home service because the situation could not be stabilized in the home; or

	3. The youth is escorted to a hospital-based emergency unit for medical disposition.
Service Exclusions	None
Clinical Exclusions	None

Staffing Requirements:
In addition to the staffing requirement listed in the general standards, these staff requirements must be followed. If the standards referenced here differ from those in the general standards, these staffing requirements will supersede the general standards.

1. The program must be under the supervision of a QMHP. This QMHP must be available for service and treatment consultation, direction, facilitation or field visits as necessary.
2. Psychiatric services must be available twenty-four (24) hours/seven (7) days a week.
3. At a minimum, mobile outreach staff must be:
   a. A Paraprofessional with a Bachelor's degree either in Social Work, Psychology, Counseling, or Nursing working under the guidance of a MHP, with two (2) years supervised clinical experience in providing direct crisis response for youth.

   OR

   b. A MHP with one (1) year supervised clinical experience in providing direct crisis response for youth.
4. There are no specific face-to-face ratios; however pairs of staff may be needed where the safety of workers is of concern or where more than one staff is needed to successfully defuse the situation.

Clinical Operations
In addition to the clinical operation requirements listed in the general standards, these requirements must be followed. If the standards referenced here differ from those in the general standards, these clinical operation requirements will supersede the general standards.

1. Services are available twenty-four (24) hours a day, seven (7) days a week.
2. Staff respond and are on site within forty-five (45) minutes of the initial phone call.
3. For more remote or small geographic locations such as Hana or Ka'u, face-to-face assessments by the staff shall occur within the usual transport time to reach that destination if staff is not stationed at the remote site. However, the program must make, with the approval of their QMHP, alternative interim arrangements sufficient to ensure the safety of the youth until the mobile outreach worker arrives. The use of Telehealth or video conferencing may be utilized for assessment and crisis intervention in remote locations.
4. Assessment and therapeutic stabilization/resolution and/or disposition of the youth in crisis are timely, appropriate, and effective. Families/caregiver(s) and other involved providers/agencies, if not already involved, are sought and informed by the next business day.
5. If the youth is registered with a Branch, the crisis worker contacts the CC at the time of the crisis or leaves a telephone message for the CC with a full report of the occurrences, including any requirements for CC follow-up. Information exchanges guides the collaboration process toward stabilization/resolution and disposition and follow through of services.
6. The youth and family are provided information about, and as necessary, linked to appropriate medical, social, mental health or other community resources or at minimum provided with a community resources card with contact information for accessing the resources.

7. The Contractor has policies procedures regarding staff transporting youth to crisis bed or emergency rooms.
8. Prior to arranging for emergency room assessments the staff shall seek consultation of the agency's on-call psychiatrist. The psychiatrist may either make a field visit for a face-to-face evaluation and possible emergency treatment, or contact the emergency unit with significant information in anticipation of the youth's arrival, or conduct a face-to-face evaluation at the emergency unit. The agency's psychiatrist will direct the staff regarding additional actions to make or preparations to take.
9. Staff are expected to remain with the youth at any emergency unit until the youth is either admitted, transported to a crisis bed, or released to his/her home.
10. If the crisis worker believes emergency services are needed, then the worker will contact the programs on call psychiatrist for consultation. If the psychiatrist determines that Therapeutic Crisis Home is needed, the psychiatrist will notify the appropriate service of the forthcoming admission.
11. The Crisis Mobile Outreach Contractor and the Therapeutic Crisis Homes Contractor will have a memorandum of understanding which allows for the efficient admission of youth determined to be in need of crisis placement.
12. The Contractor will have policies and procedures that delineate the admission process into Therapeutic Crisis Homes.
13. The agency must make a follow-up call to the family within twenty-four (24) hours of the mobile crisis intervention to ensure that the crisis has stabilized and referral sources (if needed) were contacted and document the results.
14. Staff must have at least twenty-four (24) hours of orientation training including: crisis field assessment and intervention, self-harm and suicide assessment, clinical protocols, documentation, knowledge of community resources as well as the court processes and legal documents relative to emergency procedures, and specific legal issues governing informed consents that must be completed prior to performing crisis outreach services. Training should promote evidenced-based services and best practice procedures for urgent and emergent situations.
15. The program must have documented ongoing training on a quarterly scheduled basis, to expand the knowledge base and skills relative to crisis intervention and treatment protocols as guided by the agency's training curriculum, and youth-specific situations experienced by emergency workers.
16. Please see Section I General Standards for specific clinical operation requirements regarding:
    - H. CAMHD Continuity of Care;
    - I. Staffing:
        - Orientation and Training and Training Requirements for CAMHD Contactors;
    - J. Supervision;
    - K. Evaluation of Staff Performance;
    - L. Credentialing Requirements;
    - O. Service Quality;
    - P. Minimum Reporting Requirements;
    - Q. Risk Management:
        - Criminal, Child Abuse, and Background Screening;
        - Safety;
        - Restraints and Seclusion;
        - Police;
        - Sentinel Events and Incidents.

Documentation

In addition to the documentation requirements listed in the general standards, these requirements must be followed. If the standards referenced here differ from those in the general standards, these documentation requirements will supersede the general standards.

1. Clinical documentation must be recorded and include all significant written information available, including, but not limited to: the nature and status of the crisis; demographic information; signed parental consents to transport youth; or ex-parte applications and authorizations. All such documentation must be prepared and arranged in advance of the youth's arrival at any emergency unit.
2. An outreach service note must be documented for each youth. The note must include all of the following:
    a. Identifying information: youth name, date of birth (DOB), address, phone number, legal guardian, school/home-school, and grade;
    b. The place, date and actual time (start and end time) and duration of services rendered;
    c. The outreach service worker rendering the service;
    d. Description of the nature of the crisis;
    e. Description of the nature of interventions made, including natural community resources utilized in diminishing the crisis and ensuring the safety of the youth;
    f. The involvement of additional staff in the provision of service, particularly the on-call QMHP;
    g. The youth's status, referrals for continued services and disposition at closure of the outreach services;
    h. Specific follow-through recommendations, including the need for additional services; and
    i. Documentation of follow-up phone call to the family twenty-four (24)-hours later with date and time of call and follow-up results;
3. A brief written summary accompanies the youth to the Therapeutic Crisis Home placement and consists of information that facilitates assessment, communication, continued stabilization and disposition of the youth.
4. A copy of this note is sent to the CC by closure of the next business day if the youth is registered with a Branch.
5. A copy of the note documenting the results of the agency follow-up call to the family is sent to the CC by the closure of the next business day after the follow-up call, if the youth is registered with a Branch.

C. THERAPEUTIC CRISIS HOME

Definition	Therapeutic Crisis Home provides short-term crisis stabilization interventions in a safe, structured setting for youth with urgent/emergent mental health needs. This service includes observation and supervision for youth who do not require intensive clinical treatment in a psychiatric setting and can benefit from a short-term, structured stabilizing setting. Youth who are experiencing a period of acute stress that significantly impairs their capacity to cope with normal life circumstances and who cannot be safely managed in his/her natural setting are appropriate for Therapeutic Crisis Home. The primary objective of this service is to provide crisis intervention services necessary to stabilize and restore the youth's functioning and return them to their natural setting.
Services Offered	1. Services are available twenty-four (24) hours, seven (7) days a week. 2. Services are provided in a Transitional Family Home setting. 3. Assessment of each youth that leads to the development of a treatment plan to stabilize the crisis and transition to him/her back to the natural setting. 4. Safety planning and discharge planning are part of the treatment plan. Concrete and specific discharge criteria are established as part of the initial planning along with timeframe for discharge and any aftercare resources needed. 5. Crisis intervention stabilization and counseling for youth and family. 6. Family based interventions. 7. Skills development directed at improving the youth's ability to cope with daily stressors; manage emotions and behaviors; improve communication and strengthen interpersonal relationships. 8. Services are provided to assist youth and families to find and secure necessary community supports and to communicate and collaborate with relevant community members, or with the IEP/CSP team as applicable.
Admission Criteria	<u>At least **one** (1) of the following criteria is met:</u> 1. The youth may pose a danger to self or others, is expressing some suicidal ideation or is engaging in some self-destructive or self-injurious behaviors without high level of imminent risk; or 2. The youth evidences lack of judgment, impulse control, or cognitive/perceptual abilities.
Initial Authorizations	One (1) to three (3) units maximum no prior authorization required. Youth may be admitted via Mobile Crisis Outreach or via CAMHD Clinical Lead with parental consent.

	Unit = one (1) day Level of Care = 4102
Reauthorization	Reauthorization may be up to four (4) units with review and approval of the CAMHD Clinical Lead at CAMHD Branch in the youth's home district. Unit = one (1) day Level of Care = 4102 Any authorization beyond seven (7) units must be reviewed and approved by the Branch Utilization Review Team.
Continuing Stay Criteria	At least **one** (1) of the following criteria is met: 1. The youth continues to pose a danger to self or others; or 2. The youth continues to lack judgment, impulse control, or cognitive/perceptual abilities.
Discharge Criteria	At least **one** (1) of the following criteria is met: 1. The youth's targeted symptoms and/or behaviors have abated and can be managed in his/her natural environment with the necessary support services; 2. The youth's psychological, social and/or physiological levels of functioning have returned to a level that allows the youth's safe return to his/her natural environment with the necessary support services; or 3. Appropriate natural community resources have been mobilized or are planned to reduce stress factors and to stabilize the current living environment.
Exclusions	Therapeutic Crisis Home is **not** considered medically necessary and will not be authorized in the following circumstances: 1. No admissions for youth who meet criteria for an acute admission. 2. Not offered at the same time as Hospital-Based Residential, Community-Based Residential programs. 3. No admissions and/or continued stays which are solely for parent/guardian convenience and not related to the care and treatment of the youth. 4. No admissions that are being sought solely for convenience of child protective services housing, as an alternative to incarceration within juvenile justice, as an alternative to specialized schooling, or simply as respite.

Staffing Requirements:
In addition to the staffing requirement listed in the general standards, these staff requirements must be followed. If the standards referenced here differ from those in the general standards, these staffing requirements will supersede the general standards.

1. Transitional family parents must be licensed with the Department of Human Services prior to service initiation.

2. The program has a QMHP who is experienced in providing crisis service to youth/families, is knowledgeable of evidenced-based and best practice treatments, is responsible for the Crisis Transitional Family program and for those in care and provides on-call coverage twenty-four (24) hours per day/seven (7) days a week.
3. Transitional families are required to receive at least two (2) hours a month of supervision from a Contractor's QMHP or a QMHP supervised MHP. One (1) hour of the required supervision may be multi-family or group supervision.
4. The Contractor ensures the provision of necessary additional personnel, to meet the needs of the youth receiving services for emergencies including escorts and remaining with the youth at an emergency unit.

Clinical Operations

In addition to the clinical operation requirements listed in the general standards, these requirements must be followed. If the standards referenced here differ from those in the general standards, these clinical operation requirements will supersede the general standards.

1. Services are available twenty-four (24) hours a day, seven (7) days a week.
2. The Therapeutic Crisis Homes Contractor and the Crisis Mobile Outreach Contractor will have a memorandum of understanding which allows for the efficient admission of youth determined to be in need of crisis placement.
3. The Contractor will have policies and procedures that delineate the admission process into Therapeutic Crisis Homes from Crisis Mobile Outreach.
4. The program provides transitional parents with a written plan for providing emergency and psychiatric care prior to youth being treated in the transitional family home.
5. In addition to all requirements for licensure of transitional families, Contractors will ensure that all transitional family parents receive at least twenty (20) hours of initial orientation to include: orientation to the Contractor agency; orientation to the Hawaii Child-Serving System and the role of Transitional Family Care; understanding children and youth with emotional disturbances; providing positive behavioral support to children and adolescents; how to work as part of a treatment team; how to relate to the transitional youth's parents and family members; a review of State laws regarding child abuse and neglect reporting, reporting criminal behavior, and threats regarding suicide and homicide; how to access Contractor's respite homes and be trained in CPR and First Aid.
6. On an on-going basis, transitional family parents shall receive at least twenty (20) hours of training annually on topics related to mental health special needs youth. Documentation of all transitional family training is the responsibility of the Contractor.
7. The transitional family home will have no more than two (2) minor youth in the home and no more than two (2) youth in placement with them, unless a waiver is requested and approved by CAMHD. There shall be a minimum of one (1) adult at home whenever the youth is present. The agency shall ensure additional staff support as necessary to meet this requirement.
8. Youth must be in line of site supervision of transitional family parent at all times during awake hours
9. The physical structure of living premises shall, to the extent possible, prevent the youth's elopement during sleep hours.
10. In conjunction with the anticipated short duration of stay, youths' education is not considered a primary focus. However, transition planning shall consider youths' educational needs such that loss of academic credits is minimized.
11. All efforts are made to ensure the assessment, stabilization, and treatment efforts continue to be family centered in accordance with CASSP. Family members and naturalistic supports are included in all aspects of planning.

12. Assessment and therapeutic resolution and/or disposition of the youth in crisis are timely, appropriate, and effective. Parent(s)/caregiver(s), involved agencies/providers, if not already involved, are immediately sought and informed when located.
13. There is daily communication between the crisis transitional agency, the IEP/CSP team, and the family, through the CC if the youth is registered with CAMHD, to keep everyone apprised of the youth's status and progress.
14. Contact with the MHCC should occur at the time of admission to the crisis transitional home and daily contact with the CC is maintained, if the youth is registered with CAMHD.
15. If indicated, referrals of non-IDEA youth are initiated for DOE identification and eligibility procedures or referred to CAMHD for SEBD eligibility.
16. Follow-up services for non-IDEA or non-SEBD youth are arranged through the families' medical insurance or community resources.
17. Upon contract execution, all Contractors of Transitional Family Homes Services shall submit a list of families with all of the following information required on the TFH Profile Form (See Appendix 8). The Contractor will provide updates to this list as they occur to the CAMHD Utilization Management Section of the Clinical Services Office that shall maintain the information in accordance with all confidentiality requirements.
18. The Contractor must have written policies and procedures and train staff on securing and storing medications; labeling and administering medications as ordered by a physician; recording medication administration, youth request for adjustment or change, and any side effects and notifying physician or advanced practice registered nurse immediately of possible side effects; and disposing of medications.
19. The Contractor has established policies and procedures in place for managing crises effectively and efficiently through the direct interventions of its professional clinical staff and transitional parents. Included in these procedures are descriptions of methods for handling emergency and crisis situations and triaging youth who require more intensive interventions. Request for police assistance is limited to situations of imminent risk of harm to self or others and requires consult with the program QMHP prior to, during, or after the call for assistance. The QMHP must follow-up to ensure the crisis situation has stabilized, debrief the incident and provide triage for youth needing more intensive interventions and document their effort in the youth's chart.

Documentation

In addition to the documentation requirements listed in the general standards, these requirements must be followed. If the standards referenced here differ from those in the general standards, these documentation requirements will supersede the general standards.

1. If a crisis plan does not exist, the crisis transitional home's QMHP shall formulate the crisis plan and discharge plan as part of the treatment plan for the program.
2. The transitional family parents shall actively participate in treatment planning processes and communicate daily with the family and involved agencies.
3. A documented treatment plan that identifies targets of treatment connected to realistic goals, objectives, and discharge criteria will be developed as part of the initial assessment process.
4. The crisis plan component of the treatment plan includes a safety plan that identifies the youth's problematic behaviors, triggers and preferred means of calming or regaining control. The safety plan is an essential component of the larger crisis plan. The safety plan is part of the treatment plan that articulates the youth's self-calming interventions consistent with treatment targets, goals and objectives. The purpose of the safety plan is to help the youth regain control and avoid escalation into crisis.
5. Clinical documentation must be recorded and include all significant information available, including, but not limited to: the nature and status of the crisis; psychiatric and other

medications the youth is taking if any, demographic information; signed parental consents to transport, evaluation and treatment at emergency units, and hospitalization as applicable; and ex-parte applications as applicable, all of which must be prepared and arranged in advance of any youth's arrival at any emergency unit.

6. A brief written discharge summary shall accompany the youth to another level of care and/or school consisting of information that facilitates assessment, communication, ongoing intervention and disposition of the youth with appropriate consent for release of information.
7. Provide parents with information about how to refer to DOE as applicable for a comprehensive evaluation to determine IDEA eligibility.
8. Provide parents with information about how to refer to CAMHD as applicable for Support for Emotional and Behavioral Development (SEBD) program eligibility.
9. Individual and Family Therapy progress notes must document the course of treatment including a description of the interventions implemented, youth's response, and interpretation of the effectiveness of the intervention in addressing treatment plan goals/objectives. The note must include the date of treatment, length of the session, type of therapy provided, and specific treatment goals addressed. The notes shall be fully signed by the writer and supervisor if needed. The original note must be maintained in the agency's master youth file within 24 hours of service.
10. Transitional family parents shall maintain progress notes that provide a) daily attendance log indicating the youth's presence or absence from the home including absences of twenty-four (24) hours or more and b) provide daily progress notes as documentation of treatment progress, events or activities youth engaged in and developmental milestones achieved. These notes shall be fully dated and signed by the transitional parent, originals of which shall be placed in the agency's master youth file within seven (7) calendar days. These transitional home progress notes may be in the form of a checklist or written note.
11. Please see Section I General Standards for additional documentation requirements:
    - F. Service Planning
        - Mental Health Treatment Plan including transition, crisis and discharge planning;
        - Discharge Summary;
    - N. Maintenance of Service Record

SECTION II – PART B:

EDUCATIONALLY SUPPORTIVE INTENSIVE MENTAL HEALTH SERVICES PERFORMANCE STANDARDS

A. ANCILLARY SERVICES

Definition	Ancillary services are services that are not available through existing contracted mental health services for youth. The funding for such services is limited and closely monitored to assure that disbursement is completed in the most clinically appropriate and fiscally responsible manner.
Services Offered	Supportive services that facilitate mental health treatment delivery as outlined in the CSP for time-limited interventions that are not available through existing contracted services. Examples include: transportation services, interpretive services, specific clinical services that are not available through contracted providers and special community programs or classes. The ancillary service must clearly support the youths improved functioning in their home/community and/or prevent the likelihood of movement to a higher level of care.
Admission Criteria	**All** of the following criteria must be met: 1. The identified youth meets at least one (1) of the Service Eligibility criteria for CAMHD (as described in General Standards, Section B, Access & Availability), is registered with a Branch and has an assigned CC; and 2. The clinically appropriate requested services/items are required to allow the youth to meet the goals identified in the CSP and improve his/her functioning in the home/community or likely prevent the movement to a higher level of care. The services are procured by the CC after all other resources are exhausted.
Initial Authorizations	The need for clinically appropriate services/items is identified by the CSP team and documented in the CSP, approved by the Branch Clinical Lead and procured by the CC. Unit = One (1) Dollar
Re-Authorization	The approval of the amounts greater than 5000 units requires the Division Chief's approval. Unit = One (1) Dollar
Continuing Stay Criteria	**All** of the following criteria are met as determined by clinical review at least quarterly: 1. All admission criteria continue to be met; 2. Services/items are being provided as indicated in the CSP and documented in progress notes and in plan reviews; 3. There are regular and timely assessments and documentation of youth/family response(s) to services. Timely and appropriate modifications are made to services and plans as needed; 4. Goals, objectives, and discharge planning as related to ancillary funded services/items are reviewed at least quarterly; 5. The youth/family continues to be actively involved in treatment interventions and treatment planning; and 6. The youth/family continues to be in need of ancillary funded

	services/items.
Discharge Criteria	Ancillary funded services/items are terminated when **one** (1) of the following criteria are met: 1. The youth is no longer eligible for CAMHD services. As part of discharge, the CC will help coordinate transfer to appropriate treatment services in the least disruptive manner possible; 2. The youth is no longer eligible for services/items - (i.e., does not meet admission criteria); 3. The clinical review determines that services/items are no longer needed; or 4. Services/items are obtained through alternative sources.
Service Exclusions	3. No educational or basic health services are to be provided through ancillary services. 4. Ancillary services are not stand-alone services. Ancillary services must augment and compliment other intensive mental health treatment services.

Staffing Requirements

1. If the ancillary service is a direct mental health service, then only a professional practitioner credentialed by CAMHD shall be allowed to perform this service.
2. All professionals providing direct services to youth and families shall have minimally met initial credentialing requirements for provisional appointments through submittal of required documents and satisfactory verbal verification of primary sources prior to date of hire.

INDIVIDUAL PRACTITIONER CREDENTIALING INFORMATION:

Qualified Mental Health Professional (QMHP):

Must be a current Hawaii-licensed psychiatrist; board certified by the American Board of Psychiatry and Neurology (ABPN); and board certified or board eligible in Child and Adolescent Psychiatry. QMHP Psychiatrists in hospital-based settings must be ABPN board certified in Child and Adolescent Psychiatry;

OR

A Clinical or School Psychologist with a current Hawaii license/certification in psychology;

OR

A certified Advanced Practice Registered Nurse (APRN) as a Psychiatric Clinical Nurse Specialist with a current Hawaii license/certification;

OR

A Hawaii licensed Clinical Social Worker (LCSW);

OR

A Hawaii licensed Marriage and Family Therapist (LMFT);

OR

A Hawaii licensed Mental Health Counselor (LMHC) at such time inclusion is incorporated into the State Plan Amendment and Contractors are notified by CAMHD.

Clinical Operations
If providing direct mental health services, then the professional is bound by all professional licensing requirements, professional ethics as well as CAMHD practice guidelines.

Documentation
1. Provider must submit Ancillary Provider Registration Form to the CC prior to the initiation of services if providing mental health treatment services.
2. Original receipts for services/item must be provided as appropriate.
3. Providers of direct mental health services, please see Section I General Standards for additional documentation requirements:
    - F. Service Planning:
        - Mental Health Treatment Plan including transition, crisis and discharge planning;
        - Discharge Summary;
    - N. Maintenance of Service Records:
        - Progress Notes;
    - P. Minimum Reporting Requirements:
        - Monthly Treatment and Progress Summary.

B. RESPITE SUPPORTS

Definition	Respite supports involve the provision of funds to families of eligible youth with serious emotional and/or behavioral challenges for the purpose of providing temporary short-term planned or emergency relief.
Services Offered	Respite is the provision of care, arranged by the parent(s) of an identified youth(s) to provide relief to the parent(s)/primary caregiver(s) to help maintain the youth(s) in the home. Respite is integrated with other mental health services, as needed to promote coordinated, effective service delivery to the youth(s) and family. Respite will be reviewed at least quarterly and adjusted as needed for a specific period of time.
Admission Criteria	**All** of the following criteria must be met: 1. The identified youth meets at least one (1) of the service eligibility criteria for CAMHD (as described in General Standards, Section B, Access & Availability) is registered with a Branch and has an assigned CC; 2. The clinically appropriate respite is deemed necessary to prevent out-of-home placement, prevent abuse/neglect, or preserve family unity and is related to specific goals and objectives and is documented in the CSP, as this is not an IEP service; 3. The youth/family are actively involved in treatment implementation and treatment planning; and 4. The need for respite services is identified by the CSP team and procured by the CC using the Quarterly Service Procurement Form.
Initial Authorizations	DOH Respite Authorization Form (Respite I) is completed by the family and CC and submitted to CAMHD Fiscal Office. The DOH Respite Service Record (Respite 2) is completed by the parent and provider and submitted monthly to the CAMHD Branch. The family selects and negotiates payment with their respite provider(s). Respite provider rates are provided in accordance with the guidelines as written in the CAMHD Respite policy and procedure. Respite funds are not available to a non-custodial parent/caregiver. These services are time-limited with services reduced and then discontinued as family needs decrease. 1 Unit = 1 Dollar
Continuing Stay Criteria	**All** of the following criteria are met as determined by clinical review at least quarterly: 1. Services are being provided as indicated in the CSP and as documented on respite forms. This is documented in progress notes and in plan reviews; and

	2. The family continues to be in need of respite services and there is a reasonable expectation that the youth will continue to make progress in reaching the goals identified within the CSP.
Discharge Criteria	<u>The youth is no longer in need of or eligible for Respite due to **one** (1) of the following criteria</u>: 1. The youth is no longer eligible for CAMHD services. As part of discharge, the CC will help coordinate transfer to appropriate treatment services in the least disruptive manner possible; or 2. The CSP team determines that services/items are no longer needed.
Service Exclusions	Respite services may not be used during school hours and is not an IEP service.

Staffing Requirement

1. CAMHD is not involved in the credentialing of respite providers when the parent selects their own provider.
2. CAMHD does not train, monitor, or assume any liability for the services provided. Parents/families are responsible to arrange the delivery of respite services. Respite funds are not available to non-custodial parents/caregivers.

Clinical Operations

1. Parents/families are responsible to arrange the delivery and payment of respite services.
2. CAMHD shall pay the parent or primary caregiver directly for services rendered.
3. CAMHD shall inform the parent or caregiver that:
   a. If the parent or primary caregiver is reimbursed more than $600 per year their reimbursement may be seen as a taxable income; and
   b. If the parent or primary caregiver pays a private provider (someone who is not an employee of an agency) more than $1000 in one (1) year, the family may be considered as an employer by the Internal Revenue Service and be liable for payroll taxes.

Documentation

Documentation of Respite will be provided in accordance with the guidelines as written in the CAMHD Respite policy and procedures.

C. PSYCHOSEXUAL ASSESSMENTS

Definition	Specialized diagnostic and evaluation services involving a strengths-based approach to identify youths' needs in the specific context of sexually abusive behaviors that have led to the youth being arrested, charged, or adjudicated for a sexual offense. Service components include conducting a comprehensive risk assessment and providing a written assessment report. Psychosexual assessments are preceded by information gathering from existing sources and should not occur unless a Mental Health Evaluation, Emotional Behavioral assessment, or Psychiatric Assessment has been completed within the last year. The psychosexual assessment is designed to build on the prior mental health assessments, using specialized psychometric instruments designed to assess sexual attitudes and interests.
Services Offered	1. Make appointment with the youth and family within one (1) week of referral and authorization. 2. Review and incorporate any relevant data including developmental, psychosocial, medical, educational, clinical, behavioral, psychiatric and legal histories as provided by the CC or Juvenile Probation Officer. 3. Conduct face-to-face or phone interviews with individuals who have first hand knowledge of the behavior, functioning and alleged offense of the youth. This must include obtaining the victim's statement about the offense and reports from the victim's mental health service provider whenever possible. 4. Interview family/significant others and the youth face-to-face. 5. Administer developmentally and clinically appropriate psychometric instruments that are evidence-based or are considered best practice among sexual offense treatment specialists to assess sexual attitudes and behaviors (e.g., Multiphasic Sex Inventory, Child Sexual Behavior Inventory, Adolescent Cognition Scale). 6. Summarize and synthesize the available information in a clinical formulation and describe the youth's risk to the community. 7. Provide current multi-axial diagnostic impression. 8. Offer treatment recommendations, including suggestions regarding treatment modality, priority problems to be targeted, ways to utilize strengths, etc. Recommendations need to specify clinical interventions and techniques that should be used to target the needs of the youth based on the clinical formulation. 9. Recommendations should describe the intensity of the interventions and restrictiveness of the treatment setting, but MAY NOT name specific levels of care, programs or organizations. (e.g. you may specify that a youth needs 24/7 line of sight supervision in a secure self-contained setting, etc., but do not specify "a locked residential program").

	10. Assessors are to provide recommendations on how the youth's progress in treatment should be measured over time. 11. Assessors are to provide recommendations on how the family will be included in the treatment to ensure family involvement and maximum treatment benefit. 12. Recommendations shall include treatment interventions that are provided in the least restrictive manner that will address the needs of the youth and family. 13. Submit the signed typed report to the CC within thirty (30) days from the date of referral. If more time is needed, the provider must contact the CC with his/her reason for time extension requested. 14. The report must be approved by the Branch Clinical Lead *before* results/recommendations are shared with the parents or other team members. If the report does not meet these standards, it will be returned to the evaluator for amendment. 15. Upon approval of the report, a feedback session will be authorized and must be conducted with the youth and family/guardian. If, after extensive efforts are made (i.e. three attempts), the provider is not able to schedule a face-to-face feedback session, a phone feedback session is the alternative. Inability to contact the family within the specified time must be documented in the progress notes.
Admission Criteria	**All** of the following criteria must be met: 1. The identified youth meets at least one (1) of the service eligibility criteria for CAMHD (as described in General Standards, Section B, Access & Availability) is registered with a Branch and has an assigned CC; 2. The youth has been arrested, charged, or adjudicated for a sexual offense[1]; and 3. The CSP team has determined that the youth is in need of a specialized psychosexual evaluation because of a need to understand the youth's sexual behavior or attitudes in order to provide appropriate treatment for the youth's emotional or behavioral problems.
Initial Authorizations	Initial authorization may be up to sixteen (16) units [four (4) hours] with approval of the Branch Clinical Lead. Unit = fifteen (15) minutes Level of Care = 5201 If there is no Mental Health Assessment current within one year, the Branch Clinical Lead may authorize the provider to complete a Mental Health Evaluation along with the Psychosexual Assessment if the youth is SEBD eligible. If the youth is not SEBD eligible, then the IEP team must authorize an Emotional Behavioral Assessment prior to the Psychosexual Assessment.

[1] When there are treatment-related concerns about the sexual behavior or attitudes of a youth in the SEBD program, and the youth has NOT been arrested or charged with a sexual offense, the youth may be referred for a Mental Health Evaluation and Psychological Testing to address the specific clinical questions.

	Procurement units reflect the time required for completing the review of data and assessment process. The units do not include report-writing time, as it is incorporated in the unit cost. There is no payment for travel time, wait time, no shows, or cancellations.
Reauthorization	Once the completed report is approved by the Branch Clinical Lead, an additional four (4) units may be authorized for a feedback session with the youth/family. Unit = fifteen (15) minutes Level of Care = 5201
Discharge Criteria	<u>At least **one** (1) of the following criteria are met:</u> 1. The assessment sessions are completed, the written report has been submitted to the CC, the report has been approved by the Branch Clinical Lead, and the feedback session has been held; OR 2. The youth/family no longer wants to participate in this service and revokes consent in writing prior to the completion of the report[2].
Clinical Exclusions	<u>Psychosexual Assessment will not be authorized under the following conditions:</u> 1. Youth in need of immediate crisis stabilization because of active suicidal, homicidal, or psychotic behavior. Once stable, youth who otherwise meet the eligibility criteria may be referred. 2. Youth eleven (11) years or younger. 3. Youth who have not been arrested, or charged with a sexual offense. When there are treatment-related concerns about the sexual behavior or attitudes and the youth has NOT been arrested or charged with a sexual offense, an SEBD youth may be referred for a Mental Health Evaluation (page 157) and Psychological Testing (page 162) to address the specific clinical questions.

Staffing Requirements

1. The following practitioners may provide Psychosexual Assessment Services:
   a. Credentialed QMHP with a minimum of three (3) years experience conducting psychosexual assessments. Specifically, providers must have special training and demonstration of competency in specific testing measures for offenders and documentation of training in child abuse laws and procedures for evaluating and investigating psychosexual disorders. Providers must comply with any state certification or license requirements for performing specific assessments for offenders;

   OR

   b. QMHPs who do not meet these requirements for relevant experience and demonstrated competency or MHPs may perform Psychosexual Assessments under the direct supervision of a QMHP who is qualified under these standards. The supervising QMHP must co-sign the report acknowledging supervisory responsibility for the assessment.

[2] The youth/family may revoke consent to be evaluated anytime during the evaluation process, but once the assessment is complete they may only revoke consent for further release of the report beyond CAMHD. CAMHD as the owner of the report will keep a copy on file.

Clinical Operations

1. Direct service provider must coordinate with family/significant others and with other systems of care partners such as education, juvenile justice system, child welfare as needed to complete the assessment.
2. Direct service provider must obtain consent to be evaluated and consent to release information to CAMHD. In keeping with informed consent, providers are required to inform the guardian (or the youth if over age 18) that they may revoke the consent to be evaluated anytime during the evaluation process, but once the report is complete they can only revoke the consent to further release beyond CAMHD. CAMHD as the owner of the report will still maintain a copy in the file but will not release further. However, this may impact service delivery.

Documentation

1. Progress notes are written to document all assessment activities.
2. Complete typed Psychosexual Assessment report is due within thirty (30) days from date of referral and authorization. Written report includes all of the following:
   a. Date(s) of assessment and date of report;
   b. Identifying information: youth name, Date of Birth, legal guardian, home school, grade level, IDEA status;
   c. Reason for referral, including specific referral question(s);
   d. Sources of information: including review of records, interviews, and assessment tools;
   e. The youth's offense history, including information from the youth's Juvenile Justice records;
   f. Description and history of presenting problems and concerns about behavior of a sexual nature;
   g. Assessment results and interpretation; must include specific scores from psychometric instruments, plotted profiles when appropriate, and clear interpretations;
   h. The report is signed by the assessor (and his/her supervisor when applicable) acknowledging responsibility for the assessment);
   i. The report is typed; and
   j. The written report includes all of the clinical information outlined in the aforementioned standard.
5. Professionally recognized standards of ethical practices are followed in all assessments.

D. FUNCTIONAL FAMILY THERAPY (FFT)

Definition	This is an evidenced-base family treatment system provided in a home or clinic setting for youth experiencing one of a wide range of externalizing behavior disorders (e.g., conduct, violence, drug abuse) along with family problems (e.g., family conflict, communication) and often with additional co-morbid internalizing behavioral or emotional problems (e.g., anxiety, depression). The goals of FFT are: 1. Phase I: Engagement of all family members and motivation of the youth and family to develop a shared family focus to the presenting problems; 2. Phase II: Behavior change – target and change specific risk behaviors of individuals and families; and 3. Phase III: Generalize or extend the application of these behavior changes to other areas of family relationships. FFT services range from eight to twelve (8 to 12) one-hour sessions for mild challenges, up to 30 hours of direct service (i.e., clinical sessions, telephone calls, and meetings involving community resources) for more difficult situations, and are usually spread over a three to six (3 to 6) month period. FFT can be conducted in a clinic setting, as a home based model or as a combination of clinic and home visits.
Services Offered	1. One (1)-to-two (2) hour therapy sessions with the clinician and the youth/family scheduled one (1) or two (2) times per week. 2. Phase Task Analysis – a systemic and multiphasic intervention map used to identify treatment strategies. 3. Ongoing assessment of family functioning to understand the ways in which behavioral problems function within the family. 4. The use of formal and clinical tools for model, adherence, and outcome assessment. 5. Clinical Services System (CSS) – an implementation tool that allows therapists to track the activities such as process goals, essential to successful outcomes. 6. FFT therapist maintains collateral contacts with the CC. 7. FFT therapist develops a mental health treatment plan in collaboration with the youth and family that includes a crisis plan and a discharge plan. 8. Active, on-going treatment is based on measurable goals and objectives that are part of the youth's CSP and MHTP.
Admission Criteria	**All** of the following criteria are met: 1. The identified youth meets at one (1) Eligibility criteria for CAMHD (as described in General Standards, Section B, Access & Availability), is registered with a Branch and has an assigned CC; 2. Youth is age ten (10) to through seventeen (17).

	3. There must be a reasonable expectation that the youth and family can benefit from FFT services within three to six (3 to 6) months; 4. The youth must have an adult/parental figure able to assume the long term parenting role and to actively participate with FFT service providers for the duration of treatment; and 5. The CSP identifies this service and measurable objectives for outcomes of this service prior to admission.
Initial Authorizations	Initial authorization may be up to ninety-six (96) units per day for one (1) month at a time for three (3) months with review and approval of the Branch Clinical Lead. Unit = fifteen (15) minutes Level of Care = 7104
Reauthorization	Reauthorization may be up to ninety-six (96) units per day for one (1) month at a time for three (3) months with review and approval of the Branch Clinical Lead. Request for continued stay reviews must be submitted no more than twenty one (21) calendar days and no less than seven (7) calendar days before the end date of the initial authorization or any reauthorizations. Unit = fifteen (15) minutes Level of Care -=7104 Any request for reauthorization beyond six (6) months must be reviewed and by the Branch Utilization Management.
Continuing Stay Criteria	**All** of the following criteria are met as determined by clinical review: 1. All admission criteria continue to be met; 2. Progress in relation to specific targeted symptoms or impairments is clearly evident and can be described in objective terms, but goal of treatment have not yet been achieved; 3. The documented treatment plan is individualized and appropriate to the individual's changing condition with realistic, measurable and achievable goals, objectives and discharge criteria directed toward stabilization to allow treatment to continue in a less restrictive environment. The treatment plan has been shared with relevant team members; 4. There is documented evidence of active family involvement in treatment as required by the treatment plan or there is active documented efforts being made to involve them unless it is documented as contraindicated; and 5. There is reasonable expectation that continued treatment will remediate the symptoms and/or improve behaviors or there is reasonable evidence that the youth will decompensate or experience relapse if services are discontinued.

Discharge Criteria	<u>Youth is no longer in need of or eligible for services due to **one** (1) of the following</u>: 1. The youth no longer eligible for CAMHD services. As part of discharge, the CC will help coordinate transfer to appropriate treatment services in the least disruptive manner possible; 2. The youth's documented treatment plan goals and objectives have been substantially met and can be transitioned to a less intensive level of treatment; 3. The youth/family no longer wants to participate in this service and revokes consent with no danger to self or others; 4. The youth or parent/guardian is not participating in treatment or in following program rules and regulations. The non-participation is of such a degree that treatment at this level of care is rendered ineffective, despite multiple (at least 3) documented attempts to address non-participation issues. 5. Youth has demonstrated minimal or no progress toward treatment goals for a two (2) month period and appropriate modifications of the MHTP have been made and implemented with no significant success, suggesting the youth in not benefiting from Functional Family Therapy at this time.; or 6. Youth exhibits new symptoms and/or maladaptive behaviors which cannot be safely and effectively addressed through this service.
Service Exclusions	<u>Functional Family Therapy is not considered medically necessary and will not be authorized under the following circumstances</u>: 1. Not offered at the same time as any out-of-home service, except in cases where the youth has a planned discharge from out-of-home care within thirty (30) days. FFT can work with the youth and family for up to thirty (30) days when the transition plan calls for FFT to aid in family reunification following out-of-home care. 2. Not provided at the same time as any Intensive Outpatient services (IIH, IILS, MST). 3. No acceptance of youth for whom a primary long-term caregiver cannot be identified despite extensive efforts to locate all extended family, adult friends, and other potential surrogate caregivers.
Clinical Exclusions	Youth in need of immediate crisis stabilization because of active suicidal, homicidal, or psychotic behavior. Once stable, youth who otherwise meet the eligibility criteria may be referred for FFT services.

Staffing Requirements

In addition to the staffing requirement listed in the general standards, these staff requirements must be followed. If the standards referenced here differ from those in the general standards, these staffing requirements will supersede the general standards.

1. Contractor must have a QMHP that oversees all program staff is and responsible for all clinical decisions made.
2. FFT services must be provided by therapists who are MHPs.
3. Staff must complete the required FFT training program from a licensed trainer of FFT services prior to assignment of families/clients. In addition, staff must attend quarterly booster training sessions.
4. Therapists must be supervised by a QMHP. Supervisors must have training and experience in providing family therapy.
5. Staff shall receive at a minimum one (1) hour of group supervision and one (1) hour of FFT services telephone consultation per week.

Clinical Operations

In addition to the clinical operation requirements listed in the general standards, these requirements must be followed. If the standards referenced here differ from those in the general standards, these clinical operation requirements will supersede the general standards,

1. Service delivery must be preceded by a thorough assessment of the youth and their family so that an appropriate and effective treatment plan can be developed.
2. Contractors must have the ability to deliver services in a home setting; they may deliver some of the services for each youth and family in a clinic setting.
3. The Contractor has policies that govern the provision of services in natural settings and documents the Contractor respects the youths' and families' right to privacy and confidentiality when services are provided in these settings.
4. The Contractor has established written policies and procedures in place for managing crises effectively and efficiently through the direct interventions of its professional clinical and medical staff. Included in these procedures is the handling of emergency and crisis situations that describe methods for triaging youth who require more intensive interventions. Request for police/crisis hotline assistance are limited to situations of imminent risk or harm to self or others.
5. Upon receipt of the referral packet from the CC the Contractor will assign a therapist who must make face-to-face contact with the youth/family within seventy-two (72) hours or notify CC of reasons why contact could not be made.
6. Each Contractor has policies and procedures governing the provision of outreach services, including methods for protecting the safety of staff who engage in outreach activities.
7. These outreach activities include consultation with the youth, parents or other caregivers regarding behavior management skills, dealing with treatment responses of the individual and other caregivers and family members, and coordinating with other treatment providers.
8. Services are individually designed for each family, in full partnership with the family, to minimize intrusion and maximize independence. Services are normally more intensive at the beginning of treatment and decrease over time as the individual and/or family's strengths and coping skills develop.
9. FFT services must be flexible with the capacity to address concrete therapeutic and environmental issues in order to stabilize a crisis situation as soon as possible. Services are evidence-based, family-focused, active and rehabilitative, and delivered primarily in the individual's home or in a clinic. Services are initiated when there is a reasonable likelihood that such services will lead to specific, observable improvements in the youth and family's functioning.

10. The majority of services, sixty percent (60%) or more, are provided face-to-face with the youth and their families and eighty percent (80%) of all face-to-face services are delivered in non-clinic settings over the authorization period.
11. The Contractor must have an FFT organizational plan that addresses the following:
    a. Description of the particular family preservation, coordination, crisis intervention and wraparound services models utilized, types of intervention practiced, and typical daily schedule for staff;
    b. Description of the staffing pattern and how staff are deployed to ensure that the required staff-to-youth ratios are maintained, including how unplanned staff absences, illnesses, etc. are accommodated;
    c. Description of the hours of operation, the staff assigned and types of services provided to youth, families, parents, and/or guardians; and
    d. Description as to how the plan for services is modified or adjusted to meet the needs specified in each youth's individual plan.
12. The Contractor must perform a Summary Annual Evaluation for SEBD eligible youth in their care at the time the annual evaluation is due for youth who have received at least three (3) months of services from the Contractor. See Summary Annual Evaluation performance standard in Section II, Part C.
13. Please see Section I General Standards for additional clinical operation requirements:
    - E. Co-Occurring Disorders;
    - G. Referral Process for Services:
        - Referral Acceptance;
    - H. CAMHD Continuity of Care;
    - I. Staffing;
    - J. Supervision;
    - K. Evaluation of Staff Performance;
    - L. Credentialing Requirements;
    - O. Service Quality;
    - P. Minimum Reporting Requirements;
    - Q. Risk Management:
        - Criminal, Child Abuse, and Background Screening;
        - Safety;
        - Restraints and Seclusion;
        - Sentinel Events and Incidents;
        - Police.

Documentation

In addition to the documentation requirements listed in the general standards, these requirements must be followed. If the standards referenced here differ from those in the general standards, these documentation requirements will supersede the general standards.

1. Progress notes must document the course of treatment including a description of the interventions implemented, youth's response, and interpretation of the effectiveness of the intervention in addressing treatment plan goals/objectives. The note must include the date of service, the length of session, type of therapy provided and specific treatment goals addressed. The notes shall be fully dated and signed by the writer and supervisor if needed. The original note must be maintained in the Contractor's master youth file within 24 hours of service.
2. FFT therapists must complete an intake and assessment form upon assignment of youth/family to FFT services.

3. FFT therapists must complete “Case Consultation summary forms” weekly for case review during group supervision and FFT case consultation sessions.
4. FFT therapists must provide CC with a thirty (30) day written notice of intent to discontinue services.
5. FFT therapists must provide the CC with a copy of MHTP goals or overarching goals so the Branch has in the youth’s record what the Contractor goals are.
6. Contractor must complete all documentation requirements specific to FFT.
7. Please see Section I General Standards for additional documentation requirements:
    - F. Service Planning:
        - Mental Health Treatment Plan including safety, crisis and discharge planning. If any major changes occur in the course of treatment, the all components of the MHTP should be updated;
        - Discharge Summary;
    - N. Maintenance of Service Records:
        - Progress Notes;
    - P. Minimum Reporting Requirements:
        - Monthly Treatment and Progress Summary.

E MULTISYSTEMIC THERAPY

Definition	Multisystemic Therapy (MST) is a time-limited intensive family and community-based treatment that addresses the multiple determinants of serious anti-social behavior (including crimes against others and property, aggression and other disruptive behaviors, substance use, and status offenses such as truancy, and curfew violations). Treatment averages 60 hours, over the course of 3-to-5 months. MST treats the youth's entire ecology – home and family, school, peers community. MST works to improve the following targets: • Keep youth in their homes, reducing out-of-home placements; • Keep youth in school; • Keep youth out of trouble, reducing re-arrest rates; • Improve family relations and functioning; • Decrease adolescent psychiatric symptoms; and • Decrease adolescent drug and alcohol use.
Services Offered	1. Intensive family-centered treatment delivered in-home and other community settings. 2. 24/7 availability to families for treatment, crisis response and management. 3. Ongoing assessment of youth behavior and patterns of interactions within the family, and between the family and others in the community. 4. Evidence-based interventions to address unique factors contributing to negative youth outcomes and problematic family interactions, including addressing safety risks, youth school attendance and behavior, negative peer alliance, aggression, substance use, and other status offenses. 5. Evidence-based interventions to address barriers to caregiver effectiveness (e.g., depression, anxiety, substance abuse), as well as supports to seek and utilize psychiatric care when indicated. 6. Evidenced-based interventions to address individual youth risk factors (e.g., aggression, impulsivity, social skills deficits) including specific disorders common among youth receiving MST (e.g., ADHD, trauma-related symptoms) as well as support to seek and utilize psychiatric care when indicated. 7. MST therapist maintains collateral contact with FGC CC and other key participants in the school and community. 8. MST therapist assists family to access needed supports, through internal and external linkages. 9. MST therapist work with families to create and implement behavior support plans. 10. Provide parent skills training to help the caregiver cope with youth behavior. 11. Create MHTP in collaboration with family that includes crisis, safety and discharge planning.

	12. Significant Quality Assurance training and support to MST teams, including research-validated adherence measurement and feedback to ensure model-fidelity. 13. Ongoing treatment planning, based on measurable behavioral goals, reflected in youth CSP and MHTP.
Admission Criteria	**All** of the following criteria must be met: 1. The identified youth meets at least one (1) of the service eligibility criteria for CAMHD (as described in General Standards, Section B, Access & Availability) is registered with a Branch, and has an assigned CC; 2. Youth is age twelve (12) through seventeen (17); 3. The youth displays willful misconduct behaviors (e.g., theft, property destruction, assault, truancy; as well as substance use/abuse or juvenile sex offense, when in conjunction with other delinquent behaviors); 4. The youth is at imminent risk of out-of-home placement or is currently in out-of-home placement and reunification is imminent within thirty (30) days of referral; 5. MST services are required to allow the youth to meet the goals identified in the CSP and improve his/her functioning in the home/community preventing movement to a higher level of care; and 6. The youth has an adult/parental figure that is willing to assume a long term parenting role (e.g., must be willing to participate with service providers for the duration of treatment).
Initial Authorizations	Initial authorization may be up to ninety-six (96) units per day, one (1) month at a time for three (3) months with review and approval of the Branch Clinical Lead. Unit = fifteen (15) minutes Level of Care = 13201
Re-Authorization	Reauthorization may be up to ninety-six (96) units per day, one (1) month at a time for a maximum of two (2) months with review and approval of the Branch Clinical Lead. Unit = fifteen (15) minutes Level of Care = 13201 Not to exceed five (5) months from date that consents to treatment are signed by caregiver unless approved by the CAMHD Medical Director via the MST System Supervisor.
Continuing Stay Criteria	**All** of the following criteria are met as determined by clinical review: 1. Youth is actively involved in treatment and all admission criteria continue to be met; 2. Youth does not require a more or less intensive level of care;

	3. The treatment plan has been developed, implemented and updated, based on the youth's clinical condition and response to treatment, as well as the strengths of the family, with realistic goals and objectives clearly stated 4. Progress is clearly evident in objective terms, but the goals of treatment have not yet been achieved, or adjustments have been made in the treatment plan to address the lack of progress are evident; and 5. Family/guardians are actively involved in treatment, or there are active, persistent efforts being made that are expected to lead to engagement in treatment.
Discharge Criteria	Youth is no longer in need of or eligible for service due to **one** (1) of the following: 1. The youth is no longer eligible for CAMHD services. As part of discharge, the CC will help coordinate transfer to appropriate treatment services in the least disruptive manner possible; 2. Youth no longer meets admission criteria, or meets criteria for a less or more intensive level of care; 3. Youths documented treatment plan goals have been substantially met, including discharge plan; 4. The youth/family requests discharge and is not imminently dangerous to self/others; 5. Youth and/or family has not benefited from MST despite documented efforts to engage and there is no reasonable expectation of progress at this level of care.; or 6. Youth's CSP team determines that out of home placement is more appropriate for youth and/or the CC is seeking such placement (in this case, MST services will be terminated within seven (7) days).
Service Exclusions	Multisystemic services is not considered medically necessary and will not be authorized under the following circumstances: 1. Not provided at the same time any out-of-home service, except in cases where the youth has a planned discharge from out-of-home service within thirty (30) days. MST can work with the youth and family for up to thirty (30) days prior to discharge when the transition plan calls for MST to aid in family reunification. 2. Not provided at the same time as any Intensive Outpatient services (IIH, IILS, FFT).
Clinical Exclusions	1. Youth in need of immediate crisis stabilization because of active suicidal, homicidal, or psychotic behavior. Once stable, youth who otherwise meet the eligibility criteria may be referred to MST. 2. Youth with an active thought disorder or severe mental illness, or Pervasive Developmental Disorder. 3. The youth with relatively mild behavioral problems that can effectively and safely be treated at a less intensive level of care. 4. Youth living independently or for whom no primary caregiver

	can be identified. 5. Juvenile Sex Offenders where the sex offense occurs in the absence of any other delinquent behavior. 6. Youth who have previously received MST services, regardless of outcome, unless specific conditions have been identified that have changed in the youth's ecology compared to the first course of MST, which would suggest that more favorable or generalizable outcomes could be obtained with a second course of MST. Such conditions are assessed by the MST supervisor with review by the System Supervisor.

Staffing Requirements

In addition to the staffing requirements listed in the general standards, these staff requirements must be followed. If the standards referenced here differ from those in the general standards, these staffing requirements will supersede the general standards.

1. MST services are provided by a team of QMHP supervised clinicians, who must meet the requirements for MHP or Paraprofessional as specified in CAMHD credentialing requirements with the exception that paraprofessionals must have a minimum of five (5) years of appropriate supervised experience. LSWs, MFT or APRNs are preferred.
2. MST Clinical Supervisors must meet CAMHD requirements for QMHP as well as the CAMHD requirements based upon NCQA standards. Licensed Ph.D.'s are preferred for the Clinical Supervisor position.
3. MST therapist to family ratio shall not exceed four to six (4-6) families per therapist at any given time with the consideration that one to two (1-2) families will be stepping down to a less intensive level of care. Staff to family ratio takes into consideration evening and weekend hours, needs of special populations, and geographical areas to be covered.
4. Staff must complete a five (5)-day training program designed by MST services prior to assignment of families/youth. In addition, staff must attend quarterly booster training sessions.
5. Staff shall receive at a minimum one (1) hour of group supervision and one (1) hour of MST services telephone consultation per week. Individual supervision occurs on an as needed basis.
6. MST therapists must be assigned on a full-time basis to MST services. MST supervisors must be assigned on at least a half-time basis to MST services, except where by provider contract they are committed as full-time (100% FTE) to MST services.

Clinical Operations

In addition to the clinical operation requirements listed in the general standards, these requirements must be followed. If the standards referenced here differ from those in the general standards, these clinical operation requirements will supersede the general standards.

1. Services must be available twenty-four (24) hours a day, seven (7) days a week.
2. These services include consultation with the youth, parents or other caregivers regarding behavior management skills, dealing with treatment responses of the individual and other caregivers and family members, and coordinating with other treatment providers.
3. Services are individually designed for each family, in full partnership with the family, to minimize intrusion and maximize independence. Services are normally more intensive at the beginning of treatment and decrease over time as the individual and/or family's strengths and coping skills develop.
4. MST services must be flexible with the capacity to address concrete therapeutic and environmental issues in order to stabilize a crisis situation as soon as possible. Services are evidence-based, family-focused, active and rehabilitative, and delivered primarily in the individual's home or other

locations in the community. Services are initiated when there is a reasonable likelihood that such services will lead to specific, observable improvements in the youth and family's functioning.

5. The majority of services, sixty percent (60%) or more, are provided face-to-face with the youth and their families and eighty percent (80%) of all face-to-face services are delivered in non-clinic settings over the authorization period. Service delivery must be preceded by a thorough assessment of the youth and their family so that an appropriate and effective treatment plan can be developed.
6. Services provided to youth must include coordination with family and significant others and with other systems of care such as education, juvenile justice, and youth welfare, when appropriate to treatment and educational needs.
7. Contractors must have the ability to deliver services in various environments, such as homes (birth, kin, and adoptive/foster), schools, jails, homeless shelters, juvenile detention centers, street locations, etc.
8. The Contractor has policies, which govern the provision of services in natural settings and which document that it respects youths' and/or families' right to privacy and confidentiality when services are provided in these settings.
9. The Contractor has established policies and procedures for handling emergency and crisis situations that describe methods for triaging youth who require psychiatric hospitalization.
10. Upon approval/acceptance of referral, the MST team will assign a therapist who must attempt to make face-to-face contact within twenty-four (24) hours (immediately if an emergency). If unable to make face-to-face contact within seventy-two (72) hours, the referring CC will be notified immediately regarding reasons for lack of contact. Each Contractor has policies and procedures governing the provision of outreach services, including methods for protecting the safety of staff who engage in outreach activities.
11. The Contractor must perform a Summary Annual Evaluation for SEBD eligible youth in their care at the time the annual evaluation is due for youth who have received at least three (3) months of services from the Contractor. See Summary Annual Evaluation performance standard in Section II, Part C.
12. The Contractor must have a MST organizational plan that addresses the following:
    a. Description of the particular family preservation, coordination, crisis intervention and wraparound services models utilized, types of intervention practiced, and typical daily schedule for staff;
    b. Description of the staffing pattern and how staff are deployed to ensure that the required staff-to-youth ratios are maintained, including how unplanned staff absences, illnesses, etc. are accommodated;
    c. Description of the hours of operation, the staff assigned and types of services provided to youth, families, parents, and/or guardians; and
    d. Description as to how the plan for services is modified or adjusted to meet the needs specified in each youth's individual plan.
13. The Contractor must perform a Summary Annual Evaluation for SEBD eligible youth in their care at the time the annual evaluation is due for youth who have received at least three (3) months of services from the Contractor. See Summary Annual Evaluation performance standard in Section II, Part C.
14. Please see Section I General Standards for additional clinical operation requirements:
    - E. CAMHD Co-Occurring Disorders;
    - H. CAMHD Continuity of Care;
    - I. Staffing;
    - J. Supervision;
    - K. Evaluation of Staff Performance;
    - L. Credentialing Requirements;

- O. Service Quality;
- P. Minimum Reporting Requirements;
- Q. Risk Management:
  - Criminal, Child Abuse, and Background Screening;
  - Safety;
  - Restraints and Seclusion;
  - Sentinel Events and Incidents;
  - Police.

Documentation

1. MST therapist must complete MST Clinical Intake Assessment**:** list of reasons for referral, genogram, desired outcomes of key stakeholders, ecological strengths and challenges, "fit" assessment of referral behaviors.
2. The MST therapist must submit to the CC the Service Plan within five (5) days of intake. The MST Service Plan includes the MST Clinical Intake Assessment (see above), the MST Overarching Treatment Goals, the anticipated discharge date and the anticipated individualized transition/discharge criteria.
3. Therapists must complete "Case Consultation summary forms" weekly for case review during group supervision and MST case consultation sessions.
4. Progress notes must document the course of treatment including a description of the interventions implemented, youth's response, and interpretation of the effectiveness of the intervention in addressing treatment plan goals/objectives. The note must include the date of service, the length of session, type of therapy provided and specific treatment goals addressed. The notes shall be fully dated and signed by the writer and supervisor if needed. The original note must be maintained in the agency's master youth file within 24 hours of service.
5. Please see Section I General Standards for additional documentation requirements:
   - F. Service Planning:
     - Mental Health Treatment Plan including safety, crisis and discharge planning. If any major changes occur in the course of treatment, the all components of the MHTP should be updated;
     - Discharge Summary;
   - N.. Maintenance of Service Records:
     - Progress Notes;
   - P. Minimum Reporting Requirements:
     - Monthly Treatment and Progress Summary.

F. INTENSIVE IN-HOME THERAPY (IIH)

Definition	This service is used to stabilize and preserve the family's capacity to improve the youth's functioning in the current living environment and to prevent the need for placement outside the home or a DHS resource family home. It also may be used to re-unify the family after the youth has been placed outside the home, or to support the transition to a new DHS resource family for youth with behavioral challenges. This service is a time- limited focused approach that incorporates family-and youth-centered evidence-based interventions and adheres to CASSP principles. This service may be delivered in the family's home or community. This service also assists families in incorporating their own strengths and their informal support systems to help improve and maintain the youth's functioning. When a high level of support is needed in the home or community, Intensive In-Home Paraprofessional Support service should be authorized to augment this level of care (see page 79).
Services Offered	1. Youth-and family-centered interventions that target identified treatment outcomes. Services are provided in the home or community at a level that is more intensive than outpatient services. Interventions include: a. Work with families to set up and maintain consistent, strength-based interactions in the household, including training parents in behavior management skills, other parenting skills and working with parents on implementing home based behavioral support plans; b. Individual work with youth who have internalizing problems (depression, anxiety, post-traumatic stress disorder) utilizing evidence-based therapy approaches; c. Intensive Family Therapy interventions; d. Crisis management interventions; e. Linkages to other needed supports through coordination activities and referral, including utilizing, ensuring, and facilitating access to formal and informal supports in the community and school; and f. If the youth is involved in treatment with another behavioral health provider(s) then, with proper consent, the therapist will notify any other behavioral health provider(s) of the youth's current status to ensure care is coordinated. 2. Development of a treatment plan that identifies targets of treatment connected to realistic goals, objectives, and discharge criteria will be developed as part of the initial assessment process and includes information from the pre-admission meeting. The treatment plan will be evaluated and revised as necessary as treatment proceeds and the planning process will include the youth, family/guardian and other relevant treatment team members. a. The crisis plan component of the treatment plan includes a safety plan that identifies the youth's problematic behaviors, triggers and preferred means of calming or regaining control. The safety plan is an essential

	component of the larger crisis plan. The safety plan is part of the treatment plan that articulates the youth's self-calming interventions consistent with treatment targets, goals and objectives. The purpose of the safety plan is to help the youth regain control and avoid escalation into crisis; and b. The discharge component of the treatment plan will be developed that specifies discharge criteria directly linked to behaviors/symptoms that resulted in the admission, time frame for discharge and any aftercare resources needed to transition the youth to a lower level of care or out of CAMHD services. 3. Monitoring of the youth/family's progress on a regular basis using reliable and valid data gathering strategies. The monitoring strategy shall be noted on the Treatment Plan and shall take one or both of these forms: a. Frequent and repeated assessment (at least monthly) of individually determined and behaviorally observable treatment targets (e.g. monitoring the frequency and intensity of temper outbursts); and/or b. Regularly scheduled administration of reliable and valid measures that are meaningful to the youth's presenting concerns (e.g. giving the Child Depression Inventory to a youth whose depressed mood is a major concern). 4. If the services of a paraprofessional support worker (PSW) for skills training is needed and recommended by the treatment team, then the IIH therapist will provide clinical direction to the PSW as follows: (see service standard for Intensive In-Home Paraprofessional Support p. 79): a. Develop a clear plan for use of the PSW's services in collaboration with the family. This should include the estimated length of the service and how the support provided by the PSW will be transitioned to family members and/or natural community supports; b. Maintain regular and frequent direct contact with the youth and family, particularly during the initial stages of intervention. This should include scheduled meetings every week; and c. Work concurrently with the PSW and the youth or family for limited amounts of time (up to 2 hours/week) in order to plan the use of the PSW's time and to model for or coach the PSW in how to work with the youth or family members.
Admission Criteria	**All** of the following criteria must be met: 1. The identified youth meets at least one (1) of the service eligibility criteria for CAMHD (as described in General Standards, Section B, Access & Availability) is registered with a Branch, and has an assigned CC; 2. The youth must be age three (3) through twenty (20) years; 3. The youth is displaying behavioral or emotional challenges in the home/community and there is a reasonable likelihood that

	IIH services will lead to specific observable improvements in the youth and family's functioning; 4. Pre-admission meeting is held with the youth, family/guardian, CC and other relevant treatment members to identify treatment targets to be addressed in the treatment and safety plan and reflected in the realistic discharge criteria along with expectations of family/guardian involvement in the treatment process. If clear goals cannot be identified at the preadmission meeting (e.g. the family is too distressed or uncomfortable with the process), developing a workable plan shall become the primary target within the first month of service; 5. If the youth's primary problem is a disruptive behavioral disorder, and the youth is age 12 or over, there must be documentation of the use of one of the available evidenced-based treatments for disruptive behavior disorders (i.e. Multisystemic Therapy or Functional Family Therapy) unless there is documentation of clear and compelling clinical evidence that the youth is inappropriate for one of these approaches at this time; 6. If the youth is stepping down from Multisystemic Therapy or Functional Family Therapy, Intensive In-Home Therapy can be a step down only if recommended as part of the discharge plan or there are specific non-disruptive symptoms that are identified for treatment by this service; and 7. The family/guardian(s) agree to active involvement in treatment and planning meetings, and the youth is willing to participate.
Initial Authorizations	<u>Pre-admission meeting authorization</u>: Maximum of eight (8) units [two (2) hours] may be authorized by the Branch Clinical Lead for an IIH therapist to attend a pre-admission meeting with the youth/family present. Initial authorization may be up to ninety-six (96) units [twenty-four (24) hours] per month for up to three (3) months with review and approval of the Branch Clinical Lead. Daily billing must not exceed sixteen (16) units [four (4) hours] per day. Unit = fifteen (15) minutes Level of Care = 13101 If extensive support services are needed to help the youth/family, these should be provided through the use of Intensive In-Home Paraprofessional Support (p. 79) which can be authorized concurrently. When a PSW is added to this service, additional units up to two hundred twenty four (224) [fifty-six (56) hours] may be authorized. The combined total for both the Therapist and the PSW must not exceed three hundred twenty (320) units [eighty (80) hours] per month. Daily billing must not exceed sixteen (16) units [four (4)

	hours] per day for the Therapist and PSW combined. When the Therapist and the PSW work conjointly with the youth/family, only the therapist's time will be counted toward the daily and monthly maximums. Conjoint work is limited to eight (8) units [two (2) hours] per week.
Reauthorization	Reauthorization may be up to ninety-six (96) units [twenty-four (24) hours] per month for up to two (2) months with review and approval of the Branch Clinical Lead. Daily billing must not exceed sixteen (16) units [four (4) hours] per day. Request for continued stay reviews must be submitted no more than twenty one (21) calendar days and no less than seven (7) calendar days before the end date of the initial authorization or any reauthorizations. Unit = fifteen (15) minutes Level of Care = 13101 The number of hours authorized each month should be determined by the needs of the youth and family, should meet medical necessity criteria, and should decrease as progress is made. Any reauthorization request beyond five (5) months of service must be reviewed and approved by the Branch Utilization Review Team.
Continuing Stay Criteria	**All** of the following criteria are met as determined by clinical review: 1. All admission criteria continue to be met; 2. Progress in relation to specific targeted symptoms or impairments is clearly evident and can be described in objective terms, but the goals of treatment have not yet been achieved. Data on progress have been presented in a visual or tabular format showing changes over time, and reviewed with the family and treatment team; 3. The documented treatment and safety plan is individualized and appropriate to the individual's changing condition with realistic, measurable and achievable goals, objectives and discharge criteria directed toward stabilization to allow treatment to continue in a less restrictive environment. The treatment plan has been shared with relevant team members; 4. The treatment plan includes a formulated discharge plan that is directly linked to the behaviors and/or symptoms that resulted in admission, and begins to identify appropriate post Intensive In-Home resources; 5. There is documented evidence of active family involvement in the treatment as required by the treatment plan or there is active documented efforts being made to involve them unless it is documented as contraindicated; 6. There is reasonable expectation that continued treatment will remediate the symptoms and/or improve behavior or there is reasonable evidence that the youth will decompensate or

	experience relapse if services are discontinued; and 7. There are documented active attempts at coordination of care with other relevant behavioral health providers when appropriate. If coordination is not successful, the reason(s) are documented.
Discharge Criteria	<u>Youth is no longer in need of or eligible for this service due to **one** (1) of the following criteria:</u> 1. The youth is no longer eligible for CAMHD services. As part of discharge, the CC will help coordinate transfer to appropriate treatment services in the least disruptive manner possible; 2. Targeted symptoms and/or maladaptive behaviors have lessened to a level of severity which no longer requires this level of care as documented by substantial attainment of goals in the treatment plan; 3. Youth exhibits new symptoms and/or maladaptive behaviors that cannot be addressed safely and effectively through this service as determined by clinical review; 4. Youth/family has demonstrated minimal or no progress toward treatment goals for at least a two (2) month period, and clinical review has determined that the youth is not benefiting from this service at this time; 5. The youth or parent/guardian is not participating in treatment or is not following program rules and regulations. Non-participation is of such a degree that treatment at this level of care is rendered ineffective or unsafe, despite multiple (at least 3), documented attempts to address the non-participation issues; and 6. The youth/family no longer wants to participate in this service and revokes consent with no imminent danger to self or others.
Service Exclusions	<u>Intensive In-Home service is not considered medically necessary and will not be authorized under the following circumstances:</u> 1. Not offered at the same time as any out-of-home services except in cases where the youth has a planned discharge from out-of home care within thirty (30) days. Intensive In-home therapy can begin to work with the youth and family for up to thirty (30) days to aid in family reunification following out-of-home care. 2. Not offered at the same time as Intensive Independent Living Skills, Multisystemic Therapy or Functional Family Therapy. 3. No admissions and/or continued stays which are solely for parent/guardian convenience and not related to the care and treatment of a youth. 4. No admission that is being sought solely for child protective services, as an alternative to incarceration within juvenile justice, as an alternative to specialized schooling, or simply as respite.
Clinical Exclusions	Youth in need of immediate crisis stabilization because of active

	suicidal, homicidal, or psychotic behavior. Once stable, youth who otherwise meet the eligibility criteria may be referred into the program. IIH may be provided to hospitalized youth who are still stabilizing as part of a transition back to the home.

Staffing Requirements:
In addition to the staffing requirements listed in the general standards, these staff requirements must be followed. If the standards referenced here differ from those in the general standards, these staffing requirements will supersede the general standards.

1. A QMHP experienced in evidence-based treatment and family based interventions has oversight and supervision responsibilities for all staff decisions made regarding youth/family treatment;
2. IIH Therapist must minimally be credentialed as an MHP with experience working with youth who have serious behavioral or emotional challenges. In many instances the IIH Therapist will be sufficient to deliver the appropriate services, however;
3. The IIH Therapist working directly with the family may partner with a PSW or team of PSWs as needed with the recommendation of the treatment team and authorization by the Branch Clinical Lead. The PSW will work under the direct guidance of the IIH Therapist to meet the specific identified needs (see also standards for Intensive In-home Paraprofessional Support page 79).
4. The Contractor is required to have a QMHP who provides twenty-four (24) hour on-call coverage seven (7) days a week.
5. The ratio shall not exceed twelve (12), families per primary IIH therapist (team leader) at any time with the consideration that at least two (2) of the twelve (12) families will be stepping down to a less intensive level of care. This staff to family ratio takes into consideration evening and weekend hours, needs of special populations, and geographical areas to be covered.

Clinical Operations
In addition to the clinical operation requirements listed in the general standards, these requirements must be followed. If the standards referenced here differ from those in the general standards, these clinical operation requirements will supersede the general standards.

1. Services must be available twenty-four (24) hours a day, seven (7) days a week, through on-call arrangements with practitioners skilled in crisis and family based interventions.
2. A preadmission meeting is required to obtain youth, family, CC, and other relevant team members' input into symptoms/behavior that are the targets of treatment and reflected in the goals and objectives in the MHTP. A safety plan will be developed that identifies effective youth self-calming interventions that will be incorporated into the youth's MHTP/crisis plan. The preadmission meeting also facilitates the development of the youth's discharge plan, including the development of concrete, realistic, measurable discharge criteria and projected timeframe for discharge
3. The Contractor has an intake process that includes integration of information available on youth/family in the treatment planning to ensure appropriate and effective treatment. Contractor also has an established protocol for orienting the youth and family to the service.
4. Service delivery must be preceded by a thorough assessment of the youth and their family so that an appropriate and effective treatment plan can be developed.
5. A treatment plan that identifies targets of treatment that are reflective of the youth's admission behaviors/symptom and the development of realistic goals, objectives, and discharge criteria will be developed within ten (10) days of admission as part of the initial assessment process. The treatment plan and safety plan component will be evaluated and revised as necessary as treatment proceeds and will include the youth, family/guardian and other relevant treatment team members.
6. As part the of the treatment planning, a discharge plan will be developed with the family that specifies realistic discharge criteria directly linked to behaviors/symptoms that resulted in the

admission, time frame for discharge and any aftercare resources needed to transition the youth to a less restrictive level of treatment.

7. Intensive In-Home Therapy services are individually designed for each youth, in full partnership with the family, to minimize intrusion and maximize strengths and independence. Services are normally more intensive at the beginning of treatment and decrease over time as the individual and/or family's strengths and coping skills develop.
8. Intensive In-Home Therapy must be flexible with the capacity to address concrete therapeutic and environmental issues in order to stabilize the crisis situation as soon as possible. Services are evidence-based, family-centered, strengths based, culturally competent, active and rehabilitative, and delivered primarily in the individual's home or other locations in the community.
9. The majority of services [eighty percent (80%) or more] are provided face-to-face with youth and their families.
10. The Contractor must have the ability to deliver services in various environments, such as homes (birth, kin, adoptive and foster), schools, jails, homeless shelters, juvenile detention centers, street locations, etc.
11. The Contractor has policies, which govern the provision of services in natural settings and which document that it respects youths' and/or families' right to privacy and confidentiality when services are provided in these settings.
12. The Contractor has established policies and procedures for handling emergency and crisis situations that describe methods for triaging youth who require psychiatric consultation or hospitalization. Request for police/crisis hotline assistance are limited to situations of imminent risk or harm to self or others and requires consult with the program AMHP prior to, during or after the call for assistance. The QMHP must follow-up to ensure the crisis situation has stabilized, debrief the incident and provide triage for youth needing more intensive interventions and document their efforts in the youth's chart.
13. The Contractor has policies and procedures governing the provision of outreach services, including methods for protecting the safety of staff who engage in outreach activities.
14. The Contractor has policies and procedures around the use of personal vehicles for outreach services and for transporting clients when necessary.
15. The Contractor must have an Intensive In-Home Intervention organizational plan that addresses the following:
    a. Description of the particular family centered interventions, coordination, crisis intervention and wraparound service models utilized, types of intervention practiced, and typical daily schedule for staff;
    b. Description of the staffing pattern and how staff are deployed to ensure that the required staff-to-youth/family ratios are maintained, including how unplanned staff absences, illnesses, etc. are accommodated;
    c. Description of the hours of operation, the staff assigned and types of services provided to youth/families;
    d. Description as to how the plan for services is modified or adjusted to meet the needs specified in each youth's individual plan.
16. The Contractor must perform a Summary Annual Evaluation for SEBD eligible youth in their care at the time the annual evaluation is due for youth who have received at least three (3) months of services from the Contractor. See Summary Annual Evaluation performance standard in Section II, Part C.
17. Please see Section I General Standards for additional clinical operation requirements:
    - E. CAMHD Co-Occurring Disorders;
    - G. Referral Process for Services:
        - Referral Acceptance;
    - H. CAMHD Continuity of Care;

- I. Staffing:
  - Supervision;
- K. Evaluation of Staff Performance;
- L. Credentialing Requirements;
- O. Service Quality:
- P. Minimum Reporting Requirements;
- Q. Risk Management:
  - Criminal, Child Abuse, and Background Screening;
  - Safety;
  - Restraints and Seclusion;
  - Sentinel Events and Incidents;
  - Police.

Documentation

In addition to the documentation requirements listed in the general standards, these requirements must be followed. If the standards referenced here differ from those in the general standards, these documentation requirements will supersede the general standards.

1. A written treatment plan and current safety plan identifying targets of treatment with realistic goals, objectives and discharge criteria linked to the admission behavior/symptoms will be submitted to the CAMHD Branch with ten (10) calendar days of admission. This documentation is required for any reauthorization of Intensive In-Home services.
2. IIH Therapists must provide a written progress note for each face-to-face contact with the youth and/or family, and for indirect service activities (e.g. team meeting attendance, phone calls with team members) that are billed. Progress notes must document the course of treatment including a description of the interventions implemented, youth's response, and interpretation of the effectiveness of the intervention in addressing treatment plan goals/objectives. The note must include the date of service, the length of session, type of therapy provided and specific treatment goals addressed. The notes shall be fully dated and signed by the writer and supervisor if needed. The original note must be maintained in the agency's master youth file within 24 hours of service.
3. When a PSW is involved with a youth/family, their progress notes shall be co-signed by the IHH therapist; the Monthly Treatment and Progress Summary (MTPS) must be completed by the IHH therapist and must include descriptions of the work done by the PSW when applicable.
4. Please see Section I, General Standards for additional documentation requirements:
   - F. Service Planning:
     - Mental Health Treatment Plan including safety, crisis and discharge planning. If any major changes occur in the course of treatment, the all components of the MHTP should be updated;
     - Discharge Summary
   - N. Maintenance of Service Records:
     - Progress Notes;
     - Minimum Reporting Requirements:
     - Monthly Treatment and Progress Summary.

G. INTENSIVE IN-HOME PARAPROFESSIONAL SUPPORT (IIH PS)

Definition	This service augments Intensive In-Home (IIH) Therapy services (see page 71) by supplying trained paraprofessional personnel who provide intensive support to youth and caregivers for the purpose of averting treatment in a more restrictive environment such as a residential or inpatient treatment setting. This service is offered on a short-term basis, and it must include intervention services such as one-to-one skills training, supportive counseling, positive behavioral support, coaching, modeling, and data collection, along with enhanced supervision. These services must be provided in close accordance with specific goals and objectives as delineated in the youth's Mental Health Treatment Plan. The Intensive In-Home Paraprofessional Support Worker (PSW) will work under the close guidance of the youth's assigned IIH therapist. This is not a stand-alone service, and it may not be used in a school setting.
Services Offered	All PSW services are provided in coordination with Intensive In-Home Therapy services and coordinated with the work of the youth's IIH therapist. The activities of the PSW may include: 1. Implementing crisis and safety plans and providing crisis intervention and de-escalation. 2. Working with the identified youth and/or caregiver to support skill-building interventions being offered by the therapist. For example, practicing problem-solving skills with the youth while engaging in a community activity, practicing the use of praise and selective ignoring with the caregiver during the bed-time routine. 3. Collecting detailed information about problematic behavior to help the therapist design effective interventions. For example, recording incidents of non-compliance during the morning routine or recording details about a temper incident to help identify obstacles to utilizing planned coping skills in the heat of the moment. 4. Providing "line of sight" supervision and working with the identified youth to support emotional regulation and acceptable behavior during community-based activities or household routines. 5. Modeling behavior management skills and parenting approaches for parents during daily routines in the home. 6. Working conjointly with the primary therapist to plan interventions and to develop agreements with the family about the paraprofessional's schedule and activities. This can include the therapist's modeling the specific ways the paraprofessional should work with the youth/caregiver, demonstrating skills for them to practice, etc. (Concurrent work must be no more than 2 hours/week) 7. Accompanying the client or caregiver in order to support their participation in important appointments or activities may be a part of this service when necessary, with a clear clinical rationale included in the treatment plan.

Admission criteria	**All** of the following criteria must be met: 1. The identified youth meets at least one (1) of the Service Eligibility criteria for CAMHD (as described in General Standards, Section B, Access & Availability), is registered with a Branch and has an assigned CC; 2. The youth must be age three (3) through twenty (20) years; 3. The youth has been admitted into a CAMHD-contracted Intensive In-Home Therapy service; 4. The identified youth has a DSM-IV psychiatric disorder which significantly interferes with his/her ability to function effectively at home, and/or in the community such that one-to-one support, skills training or enhanced supervision is a necessary adjunctive service; 5. There must be a reasonable expectation that including this service as part of the treatment will remediate symptoms and/or improve behaviors or there is reasonable evidence that the youth will decompensate if this service is not initiated: 6. The Intensive In-Home therapy MHTP identifies this service and measurable objectives for outcomes of this service prior to initiation of the service; AND 7. The youth and caregiver(s) agree to participate fully in the service.
Initial Authorization	Authorization for this service is the same authorization as the Intensive In-home therapy. Initial authorization of the PSW may be up to an additional two hundred twenty four (224) units [fifty-six (56) hours] for one (1) month with review and approval of the Branch Clinical Lead. Unit = fifteen (15) minutes Level of Care = 13101 The combined total for both the Therapist and the PSW must not exceed three hundred twenty (320) units [eighty (80) hours] per month. Daily billing must not exceed sixteen (16) units [four (4) hours] per day for the Therapist and PSW combined. When the Therapist and the PSW work conjointly with the youth/family, only the therapist's time will be counted toward the daily and monthly maximums. Conjoint work is limited to eight (8) units [two (2) hours] per week.
Reauthorization	Reauthorization for this service is the same authorization as the Intensive In-Home therapy. Reauthorization of the PSW may be up to two hundred twenty four (224) units [fifty-six (56) hours] monthly for two (2) months with review and approval of the Branch Clinical Lead. The combined total hours for both the IIH therapist and the PSW must not exceed three hundred twenty (320) units [eighty hours] per month. Daily billing must not exceed sixteen (16) units [four (4) hours] per day. Unit = fifteen (15) minutes Level of Care = 13101

	The number of hours authorized each month for the combined time of the IIH therapist and the PSW should be determined by the needs of the youth and family as spelled out in the treatment plan. The service must meet medical necessity and should decrease as progress is made. Any reauthorization request for paraprofessional services beyond three (3) months must be reviewed by the Branch Utilization Review Team and Clinical Lead.
Continuing Stay Criteria	**All** of the following criteria are met as determined by clinical review: 1. Youth and family are actively involved in treatment and all admission criteria continue to be met; 2. A written MHTP with measurable goals describing the activities of the PSW has been received by the CC; 3. Progress in relation to specific targeted symptoms or impairments is clearly evident and can be described in objective terms, but the goals of treatment have not yet been achieved. Data on progress have been presented in a visual or tabular format showing changes over time, and reviewed with the family and treatment team; 4. The documented treatment and safety plan is individualized and appropriate to the individual's changing condition with realistic, measurable and achievable goals, objectives and discharge criteria directed toward stabilization to allow treatment to continue in a less restrictive environment. The treatment plan has been shared with relevant team members; 5. The treatment plan includes a formulated discharge plan that is directly linked to the behaviors and/or symptoms that resulted in admission, and begins to identify appropriate post Intensive In-Home resources; 6. There is a reasonable expectation that the youth and family will make progress toward reaching the goals and objectives identified in the youth's Treatment Plan during the next four (4) weeks; AND 7. The youth's progress in not sufficient to allow termination of the paraprofessional support services.
Discharge Criteria	Youth is no longer in need of or eligible for this service due to **one** (1) of the following criteria: 1. The youth is no longer eligible for CAMHD services. As part of discharge, the CC will help coordinate transfer to appropriate treatment services in the least disruptive manner possible; 2. The youth/family no longer wants to participate in this service and revokes consent without imminent danger to self or others; 3. Targeted symptoms and/or maladaptive behaviors have abated to a level of severity which no longer requires paraprofessional services as documented by substantial attainment of goals related to the work of the PSW in the MHTP; 4. Youth/family has demonstrated minimal or no progress toward treatment goals for at least a two (2) month period (this may

	include documented non-participation in services), and appropriate modifications of the MHTP have been made and implemented with no significant success, and the Branch Clinical Lead has determined that the youth is not benefiting from this service at this time; or 5. Youth exhibits new symptoms and/or maladaptive behaviors that cannot be addressed safely and effectively through this service as determined by the Branch Clinical Lead.
Service Exclusions	<u>Intensive In-Home Paraprofessional Support is not considered medically necessary and will not be authorized under the following circumstances:</u> 1. Not offered at the same time as any out-of-home service except in cases where the youth has a planned discharge from out-of home care within thirty (30) days. Intensive In-home can begin to work with the youth and family for up to thirty (30) days to aid in family reunification following out-of-home care. Paraprofessional services can be used as part of the transition services. 2. This service is not utilized as a substitute for Personal Assistant (PA) services (such as those provided by the Developmental Disabilities Division) or as a substitute for Skills Trainer Services or tutoring (such as those provided by the Dept. of Education). Paraprofessional Support is not used to supervise visits with birth parents or to transport for family visits in place of services provided by Child Protective Services.
Clinical Exclusions	Youth in need of immediate crisis stabilization because of active suicidal, homicidal, or psychotic behavior are excluded. Once stable, youth who otherwise meet the eligibility criteria may be referred into the program. IIH may be provided to hospitalized youth who are still stabilizing as part of a transition back to the home.

Staffing Requirements:
In addition to the staffing requirements listed in the general standards, these staffing requirements must be followed. If the standards referenced here differ from those in the general standards, these staffing requirements will supersede the general standards.

1. Intensive In-Home Paraprofessional Support is provided by a Contract Agency that also provides Intensive In-Home therapy. The Contract Agency ensures that the program includes:
   a) A QMHP experienced in evidence-based treatment and family based interventions has oversight and supervisory responsibilities for all staff decisions made regarding youth/family treatment;
   b) IIH Therapist must, at minimum, be a credentialed MHP with experience working with youth with serious behavioral or emotional challenges works with the youth/family and provides direct oversight and supervision to the PSW.
   c) The PSW is credentialed as a paraprofessional and works under the direction of an IIH Therapist (See the Standard for Intensive In-Home Therapy, p. 70).
2. The contractor is required to have a QMHP who provides twenty-four (24) hour on-call coverage seven (7) days a week.

3. The ratio shall not exceed twelve (12) families per Paraprofessional Support worker at any time with consideration that at least two (2) of the twelve (12) families will be stepping down to a less intensive level of care. This staff to family ratio takes into consideration evening and weekend hours, needs of special populations, and geographical areas to be covered.

Clinical Operations:
In addition to the clinical operation requirements listed in the general standards, these requirements must be followed. If the standards referenced here differ from those in the general standards, these clinical operation requirements will supersede the general standards. Please see also the Clinical Operations requirements for Intensive In-Home Therapy (p. 70).

1. Services must be available on a flexible schedule to meet the needs of the youth or family.
2. The program must provide emergency coverage, including phone access to a supervisor, twenty-four (24) hours a day, seven (7) days a week, through on-call arrangements with practitioners skilled in crisis and family based interventions.
3. Intensive In-Home Paraprofessional Support must be provided through a cohesive team approach and services must be flexible with the capacity to address concrete therapeutic and environmental issues in order to stabilize the crisis situation as soon as possible. Services are evidence-based, family-centered, strengths based, culturally competent, active and rehabilitative, and delivered primarily in the individual's home or other locations in the community.
    a. Team services are individually designed for each youth, in full partnership with the family, to minimize intrusion and maximize strengths and independence. Services are normally more intensive at the beginning of treatment and decrease over time as the individual and/or family's strengths and coping skills develop.
    b. All (100%) of the services provided by the Paraprofessional Support Worker are provided face-to-face with youth and their families. Indirect services such as attending IEP meetings and discussing the case with the Care Coordinator are provided by the IIH Therapist involved in the case.
4. Service delivery by the Paraprofessional is based on an appropriate and effective treatment plan developed by the youth's IIH therapist.
5. The Contractor must have the ability to deliver services in various environments, such as homes (birth, kin, adoptive and foster), homeless shelters, juvenile detention centers, street locations, etc.
6. The Contractor has policies, which govern the provision of services in natural settings and which document that it respects youths' and/or families' right to privacy and confidentiality when services are provided in these settings.
7. The Contractor has established policies and procedures for handling emergency and crisis situations that describe the responsibilities of the Paraprofessional Support Worker.
8. Each Contractor has policies and procedures governing the provision of outreach services, including methods for protecting the safety of staff who engage in outreach activities.
9. Each Contractor has policies and procedures around the use of personal vehicles for outreach services and for transporting clients when necessary.
10. Approval of supervised staff's case and progress notes must be documented by the supervising QMHP. Progress notes will be made available to the Branch upon request.
11. The Contractor must have an Intensive In-Home Intervention organizational plan that addresses the following:
    a. Description of the particular skill-building interventions, coordination, crisis intervention and wraparound service models utilized, types of intervention practiced, and typical daily schedule for staff;
    b. Description of the staffing pattern and how staff are deployed to ensure that the required staff-to-youth/family ratios are maintained, including how unplanned staff absences, illnesses, etc. are accommodated;

c. Description of the hours of operation, the staff assigned and types of services provided to youth/families;
d. Description as to how the plan for services is modified or adjusted to meet the needs specified in each youth's individual plan.
e. Description of the qualifications of the QMHP experienced in evidenced-based treatment who supervises the treatment program and assumes clinical responsibility.

12. Please see Section I General Standards for additional clinical operation requirements:
    - E. CAMHD Co-Occurring Disorders;
    - G. Referral Process for Services:
        - Referral Acceptance;
    - H. CAMHD Continuity of Care;
    - I. Staffing;
        - Supervision;
    - K. Evaluation of Staff Performance;
    - L. Credentialing Requirements;
    - O. Service Quality;
        - Minimum Reporting Requirements;
    - Q. Risk Management:
        - Criminal, Child Abuse, and Background Screening;
        - Safety;
        - Restraints and Seclusion;
        - Sentinel Events and Incidents;
        - Police.

Documentation

In addition to the documentation requirements listed in the general standards, these requirements must be followed. If the standards referenced here differ from those in the general standards, these documentation requirements will supersede the general standards.

1. The IIH MHTP must include specific goals and objectives related to the work of the PSW, and these goals must be appropriate and focused on changes necessary to stabilize the youth and transition to more normalized supports. The youth's IIH therapist is responsible for developing the plan prior to the PSW's involvement.
2. PSWs must provide a written progress note for each face-to-face contact with the youth and/or family.
3. Progress notes must document the course of treatment including a description of the interventions implemented, youth's response, and interpretation of the effectiveness of the intervention in addressing treatment plan goals/objectives. The note must include the date of service, the length of session, type of therapy provided and specific treatment goals addressed. The notes shall be fully dated and signed by the writer and supervisor if needed. The original note must be maintained in the agency's master youth file within 24 hours of service.
4. The Monthly Treatment and Progress Summary (MTPS) must be completed by the IHH therapist and must include descriptions of the work done by the PSW.
5. Please see Section I, General Standards for additional documentation requirements:
    - N. Maintenance of Service Records:
        - Progress Notes.

H. INTENSIVE INDEPENDENT LIVING SKILLS (IILS)

Definition	A comprehensive treatment service provided to youth and young adults who need to work intensively on developing a range of skills to prepare for independent living. The youth or young adults live in his/her home setting while participating in the service. This service focuses on developing skills and resources related to life in the community and to increasing the participant's ability to live as independently as possible. Service outcomes focus on maximizing the youth or young adults' ability to manage their illness and their lives with as little professional intervention as possible, and to participate in community opportunities related to functional, social, educational, and vocational opportunities The amount of time any individual spends in these services will vary, depending on the individual needs. When a high level of support is needed, Intensive Paraprofessional Support for Independent Living Skills should be authorized to augment this level of care (see page 94).
Services Offered	The core components of the intensive outpatient service for young adults and youth with emotional and behavioral challenges who need to develop independent living skills include the following; 1. Each youth/young adult in the service is assigned a therapist who meets with him/her regularly and also engages his/her family as appropriate. 2. Each youth/young adult will be give assistance in accessing community resources such as: a. Assistance is provided with accessing needed financial assistance and benefits (e.g. applying for Social Security Disability benefits, obtaining housing subsidies, etc.); b. Assistance is provided with obtaining appropriate services (e.g. vocational rehabilitation services; adult mental health services); and c. Assistance is provided with obtaining support with any legal concerns (e.g. guardianship issues, birth certificate etc.). 3. Skills training interventions will be provided based on the initial and on-going assessment of the individual's needs in at least the following areas: a. Social skills, including communication and problem-solving in personal relationships; b. Emotion regulation skills, including anger control and conflict management; c. Self-care skills (i.e. cooking, laundry, house-cleaning, personal hygiene); d. Basic personal finances (i.e. developing a budget, balancing a checkbook; utilizing credit); e. Developing life goals and planning for the future, including career planning; f. Understanding and taking charge of your own mental health treatment; g. Taking charge of your own physical health including nutrition, healthy lifestyles, smoking cessation, and sexual and reproductive health;

	h. Chemical dependency education; and i. Parenting skills training. 4. Assistance developing vocational skills is provided in a practical, hands-on way: a. Investigating fields and jobs that might be of interest; b. Doing volunteer work in areas consistent with career goals; c. Assessing one's own job-relevant skills and writing a resume; d. Obtaining job applications and interviewing for jobs; e. Finding sources of needed job training, including assistance working with DOE programs, vocation rehab programs, community college programs, GED programs, etc.; and f. Coaching and support to help the young adult/youth stick with challenging training and job experiences. 5. Specific efforts to engage and support parents and other family members with the challenges of parenting a young person through the transition from adolescence to adulthood are part of the service. Specific interventions may include: a. Psychoeducation for parents addressing concerns such as benefits, changes in confidentiality requirements, guardianship options etc. b. Family therapy interventions (biological and/or foster). 6. Individual Therapy focused on mental health challenges utilizing evidenced-based approaches; 7. Each youth/young adult will have his/her services proceeded by an intake assessment focusing on the young person's needs in the areas of housing, employment, education, social, financial and health/mental domain in support of acquiring independent living skills. This intake assessment along with pre-admission meeting and existing documents will result in: a. A documented treatment plan that identifies targets of treatment connected to realistic goals, objectives, and discharge criteria as related to independent living skills will be developed as part of the initial assessment process and includes information from the pre-admission meeting. The treatment plan will be evaluated and revised as necessary as treatment proceeds and the planning process will include the youth/young adult family/guardian and other relevant treatment team members. b. The crisis plan component of the treatment plan includes a safety plan that identifies the youth's problematic behaviors, triggers and preferred means of calming or regaining control. The safety plan is an essential component of the larger crisis plan. The safety plan is part of the treatment plan that articulates the youth's self-calming interventions consistent with treatment targets, goals and objectives. The purpose of the safety plan is to help the youth regain control and avoid escalation into crisis.

	c. The discharge component of the treatment plan will be developed that specifies discharge criteria directly linked to behaviors/symptoms that resulted in the admission, time frame for discharge and any aftercare resources needed to transition the youth or young adult to independence. 8. If the services of a Paraprofessional support worker for skills training is needed and recommended by the treatment team, then the Therapist will provide clinical direction to the Paraprofessional support worker (PSW) as follows: (see service standard for Independent Living Skills Paraprofessional Support p. 94): a. Develop a clear plan for use of the Paraprofessional's services in collaboration with the youth/young adult. This should include the estimated length of the service and how the support provided by the paraprofessional will be transitioned to family members and/or natural community supports. b. Maintain regular and frequent direct contact with the youth/young adult and family, particularly during the initial stages of intervention. This should include scheduled meetings every week. c. Work concurrently with the Paraprofessional and the youth/young adult or family for limited amounts of time (up to 2 hours/week) in order to plan the use of the Paraprofessional's time and to model for or coach the Paraprofessional in how to work with the youth/young adult or family members.
Admission Criteria	**All** of the following criteria are met: 1. The identified young adult or youth meets at least one (1) Service Eligibility criteria for CAMHD (as described in General Standards, Section B, Access & Availability), is registered with a Branch and has an assigned CC; 2. The youth must be sixteen (16) through twenty (20) years; 3. Pre-admission meeting is held with the youth/young adult, family/guardian, CC and other relevant treatment members to identify treatment targets to be addressed in the treatment and safety plan and reflected in the realistic discharge criteria along with expectations of family/guardian involvement in the treatment process. 4. Young adult/youth must be identified as needing intensive outpatient services focused on promoting growth toward independent living with measurable objectives and discharge criteria for this service as established in the pre-admission meeting; 5. The youth adult/youth and/or family are amenable to actively working with program staff for the duration of the expected program period.

Initial Authorizations	Pre-admission meeting: Maximum of eight (8) units [two (2) hours] may be authorized by the Branch Clinical Lead for the IILS Therapist to attend a pre-admission meeting with the youth/young adult present. Initial authorization may be up to ninety-six (96) units [twenty-four (24) hours] per month for three (3) months with review and approval by the Branch Clinical Lead. Daily billing must not exceed sixteen (16) units [four (4) hours] per day. Unit = 15 minutes Level of Care = 6112 If extensive support services are needed to help the youth/young adult gain independent living skills, these should be provided through the use of Independent Living Skills Paraprofessional Support (p. 94) which can be authorized concurrently. When a PSW is added to this service, additional units up to two hundred twenty four (224) [fifty-six (56) hours] may be authorized. The combined total for both the Therapist and the PSW must not exceed three hundred twenty (320) units [eighty (80) hours] per month. Daily billing must not exceed sixteen (16) units [four (4) hours] per day for the Therapist and PSW combined. When the Therapist and the PSW work conjointly with the youth/young adult, only the Therapist's time will be counted toward the daily and monthly maximums. Conjoint work is limited to eight (8) units [two (2) hours] per week.
Reauthorization	Reauthorization may be up to ninety-six (96) units [twenty-four (24) hours] per month for (2) two months with review and approval of the Branch Clinical Lead. Daily billing must not exceed sixteen (16) units [four (4) hours] per day. Request for continued stay reviews must be submitted no more than twenty one (21) calendar days and no less than seven (7) calendar days before the end date of the initial authorization or any reauthorizations. Unit = 15 minutes Level of Care = 6112 The number of hours authorized each month should be determined by the needs of the youth/young adult, should meet medical necessity criteria, and should decrease as progress is made. Any request for reauthorization beyond five (5) months must be reviewed and approved by the Branch Utilization Review Team.
Continuing Stay Criteria	**All** of the following criteria are met as determined by clinical review: 1. The young adult/youth meets admission criteria and is actively involved in treatment interventions and treatment planning and continues to have deficits in several areas of skills necessary for independent living; 2. Progress in relation to specific targeted symptoms or

	impairments is clearly evident and can be described in objective terms, but goals of treatment have not yet been achieved; 3. The documented treatment and safety plan is individualized and appropriate to the individual's changing condition with realistic, measurable and achievable goals, objectives and discharge criteria directed toward independence. The treatment plan has been shared with relevant team members. 4. The treatment plan includes a formulated discharge plan that is directly linked to the behaviors and/or symptoms that resulted in admission, and begins to identify appropriate post service resources. 5. There is documented evidence of active family involvement in treatment as required by the treatment plan or there is active documented efforts being made to involve them unless it is documented as contraindicated. 6. There is reasonable expectation that continued treatment will remediate the symptoms and/or improve behaviors or there is reasonable evidence that the youth will decompensate or experience relapse if services are discontinued; and 7. There is a documented active attempt at coordination of care with other relevant behavioral health providers when appropriate. If coordination is not successful, the reason(s) are documented.
Discharge Criteria	<u>Youth is no longer in need of or eligible for this service due to **one** (1) of the following criteria:</u> 1. The young adult/youth is no longer eligible for CAMHD services. As part of discharge, the CC will help coordinate transfer to appropriate treatment services in the least disruptive manner possible; 2. The youth/young adult's documented treatment plan goals and objectives have been substantially met and can be transitioned to independence as evidenced by one (1) of the following: a. The young adult/young person reaches a level of functioning that allows for transition to independent living; or b. The young adult/youth has attained the knowledge and supports necessary to sustain treatment outcomes and/or to support a successful life in the community. 3. The young adult/youth and family no longer wants to participate in this service and revokes consent with no imminent danger to self or others. 4. The youth/young adult or parent/guardian is not participating in treatment or in following program rules and regulations. The non-participation is of such a degree that treatment at this level of care is rendered ineffective, despite multiple (at least 3) documented attempts to address non-participation issues; 5. Youth/young adult has demonstrated minimal or no progress toward treatment goals for three (3) month period and appropriate modification of plans has been made and

	implemented with no significant success, suggesting the youth is not benefiting from Intensive Independent Living Skills service at this time; or 6. The youth/young adult meets criteria for a more intensive level of care;
Service Exclusions	Intensive Independent Living Skills is not considered medically necessary and will not be authorized under the following circumstances: 1. Not offered at the same time as any out-of-home service, unless the young adult/youth is expected to discharge from the service within thirty (30) days of referral. 2. Not offered at the same time as Intensive In-Home Intervention, Multisystemic Therapy, or Functional Family Therapy except when the young adult/youth has a planned discharge from the service within two (2) weeks of referral. 3. No admissions and/or continued stays which are solely for parent/guardian convenience and not related to the care and treatment of a youth. 4. No admissions that are being sought solely for convenience of child protective services housing, as an alternative to incarceration within juvenile justice, as an alternative to specialized schooling, or simply as respite.
Clinical Exclusions	Youth in need of immediate crisis stabilization because of active suicidal, homicidal, or psychotic behavior. Once stable, youth who otherwise meet the eligibility criteria may be referred into the program.

Staffing Requirements:

In addition to the staffing requirement listed in the general standards, these staff requirements must be followed. If the standards referenced here differ from those in the general standards, these staffing requirements will supersede the general standards.

1. The program has a QMHP experienced in providing transitional services to youth/young adults with serious emotional and behavioral challenges and who is knowledgeable in evidenced-based treatments is responsible for clinical supervision, program oversight, and active guidance to staff.
2. IILS Therapists must, at minimum, be a MHP with experience providing transition to independent living services to youth/young adults with serious emotional and behavioral challenges.
3. The IILS Therapist working directly with the young adult or youth/family may partner with a PSW or team of PSWs as needed with the recommendation of the treatment team and authorized by the Branch Clinical Lead. The PSW will work under the direct guidance of the IILS Therapist to meet the specific identified needs (see standard for Independent Living Skills Paraprofessional Support page 94)
4. The program is required to have a QMHP who provides twenty-four (24) hours on-call coverage, seven (7) days a week.
5. The ratio shall not exceed twelve (12), youth/young adult per therapist at any time with the consideration that at least two (2) of the twelve (12) youth/young adults will be stepping down from

care. Staff to client ratio takes into consideration evening and weekend hours, needs of special populations, and geographical areas to be covered.

Clinical Operations

In addition to the clinical operation requirements listed in the general standards, these requirements must be followed. If the standards referenced here differ from those in the general standards, these clinical operation requirements will supersede the general standards.

1. Services must be available twenty-four (24) hours a day, seven (7) days a week, through on-call arrangements with practitioners skilled in crisis based interventions.
2. A preadmission meeting is required to obtain youth, family, CC, and other relevant team members' input into symptoms/behavior that are the targets of treatment and reflected in the goals and objectives in the MHTP. A safety plan will be developed that identifies effective youth self-calming interventions that will be incorporated into the youth's MHTP/crisis plan. The preadmission meeting also facilitates the development of the youth's discharge plan, including the development of concrete, realistic, measurable discharge criteria and projected timeframe for discharge.
3. The Contractor has an intake policy and procedure that includes integration of information available on the youth/young adult/family in the treatment planning to ensure appropriate and effective treatment. Program also has an established protocol for orienting the youth/young adult and family to the service.
4. A complete intake assessment is provided focusing on the young person's needs in the areas of housing, employment, education, social, financial and health/mental domains in support of acquiring independent living skills. Intake assessments may be completed within three (3) calendar days of intake by one individual or by a multidisciplinary team, but a QMHP must be involved to assure adequate integration of available clinical information into treatment planning.
5. A treatment plan that identifies targets of treatment that are reflective of the youth's admission behaviors/symptom/skill deficits and the development of realistic goals, objectives, and discharge criteria will be developed within ten (10) days of admission as part of the initial assessment process. The treatment plan and safety plan component will be evaluated and revised as necessary as treatment proceeds and will include the youth, family/guardian and other relevant treatment team members.
6. As part the of the treatment planning, a discharge plan will be developed with the youth/young adult and family that specifies realistic discharge criteria directly linked to behaviors/symptoms/skill deficits that resulted in the admission, timeframe for discharge and any aftercare resources needed to support to independence.
7. Intensive Independent Living Skills services are individually designed for each youth/young adult in full partnership with the family or other support system to minimize intrusion and maximize independence.
8. The majority of services [eighty percent (80%) are provided face-to-face with youth/young adult and their family.
9. The Contractor has written policies and procedures in place for managing crises effectively and efficiently through the direct interventions of its professional clinical staff. Included in these procedures is the handling of emergency and crisis situations that describe methods for triaging youth who require more intensive interventions. Request for police /crisis hotline assistance are limited to situations of imminent risk or harm to self or others and requires consult with the program QMHP prior to, during or after the call for assistance. The QMHP must follow-up to ensure the crisis situation has stabilized, debrief the incident and provide triage for youth/young adults needing more intensive interventions and document their efforts in the youth/young adult's chart.

10. The Contractor shall have the ability to deliver services in various environments, such as homes (birth, kin, adoptive and foster), schools, jails, homeless shelters, juvenile detention centers, street locations, etc.
11. The Contractor has policies which govern the provision of services in natural settings and which document that it respects youth/young adult's and/or family's right to privacy and confidentiality when services are provided in these settings.
12. The Contractor has policies and procedures governing the provision of outreach services, including methods for protecting the safety of staff who engage in outreach activities.
13. The Contractor has policies and procedures around the use of personal vehicles for outreach services and for transporting clients when necessary.
14. The Contractor must have an Intensive Independent Living Skills organizational plan that addresses the following:
    a. Description of the particular skill-building interventions, coordination, crisis intervention and wraparound service models utilized, types of intervention practiced, and typical daily schedule for staff;
    b. Description of the staffing pattern and how staff are deployed to ensure that the required staff-to-youth/young adult ratios are maintained, including how unplanned staff absences, illnesses, etc. are accommodated;
    c. Description of the hours of operation, the staff assigned and types of services provided to youth/families;
    d. Description as to how the plan for services is modified or adjusted to meet the needs specified in each youth's individual plan.
    e. Description of the qualifications of the QMHP experienced in evidenced-based treatment who supervises the treatment program and assumes clinical responsibility.
15. The Contractor must perform a Summary Annual Evaluation for SEBD eligible youth in their care their care at the time the annual evaluation is due for youth who have received at least three (3) months of services from the Contractor. See Summary Annual Evaluation performance standard in Section II, Part C.
16. Please see Section I General Standards for additional clinical operation requirements:
    - E. Co-Occurring Disorders;
    - G. Referral Process for Services:
        - Referral Acceptance;
    - H. CAMHD Continuity of Care;
    - I. Staffing;
    - J. Supervision;
    - K. Evaluation of Staff Performance;
    - L. Credentialing Requirements;
    - O. Service Quality;
    - P. Minimum Reporting Requirements;
    - Q. Risk Management:
        - Criminal, Child Abuse, and Background Screening;
        - Safety;
        - Restraints and Seclusion;
        - Sentinel Events and Incidents;
        - Police.

Documentation

In addition to the documentation requirements listed in the general standards, these requirements must also be followed. If the standards referenced here differ from those in the general standards, these documentation requirements will supersede the general standards.

1. A written treatment plan and current safety plan identifying targets of treatment with realistic goals, objective and discharge criteria linked to the admission behavior/symptoms/skill deficits will be submitted to the CAMHD Branch with ten (10) calendar days of admission. This documentation is required for any re-authorization of Intensive Independent Living Skills service.
2. IILS Therapist must provide a written progress note for each face-to-face contact with the youth/young adult, and for indirect service activities (e.g. team meeting participation, phone calls with team members) that are billed. Progress notes must document the course of treatment including a description of the interventions implemented, youth's response, and interpretation of the effectiveness of the intervention in addressing treatment plan goals/objectives. The note must include the date of service, the length of session, type of therapy provided and specific treatment goals addressed. The notes shall be fully dated and signed by the writer and supervisor if needed. The original note must be maintained in the agency's master youth file within 24 hours of service.
3. When a PSW is involved with a youth/young adult, their progress notes shall be co-signed by the IILS therapist; the Monthly Treatment and Progress Summary must be completed by the IILS therapist and must include descriptions of the work done by the PSW when applicable.
4. Please see Section I General Standards for additional documentation requirements:
    - F. Service Planning:
        - Mental Health Treatment Plan including safety, crisis and discharge planning. If any major changes occur in the course of treatment, all components of the MHTP should be updated;
        - Discharge Summary;
    - N. Maintenance of Service Records:
        - Progress Notes;
    - P. Minimum Reporting Requirements:
        - Monthly Treatment and Progress Summary.

I. INDEPENDENT LIVING SKILLS PARAPROFESSIONAL SUPPORT (ILS PS)

Definition	This service augments Intensive Independent Living Skills (IILS) therapy (see page 85) by supplying trained paraprofessional personnel who provide intensive support for youth and young adults transitioning to independence. This service is offered on a short-term basis, and it must include intervention services such as one-to-one skills training, supportive counseling, positive behavioral support, coaching, modeling, and data collection. These services must be provided in close accordance with specific goals and objectives as delineated in the youth's Mental Health Treatment Plan. The Paraprofessional Support Worker (PSW) will work under the close guidance of the youth's assigned IILS therapist. This is not a stand-alone service, and it may not be used in a school setting.
Services Offered	All Independent Living Skills Paraprofessional Support Services are provided in coordination with Intensive Independent Living Skills therapy and coordinated with the work of the youth's IILS therapist. The activities of the PSW may include: 1. Implementing crisis and safety plans and providing crisis intervention and de-escalation. 2. Working with the identified youth/young adult to support skill-building interventions being offered by the therapist which may include any of the following: a. Self-care skills (i.e. cooking, laundry, house-cleaning, personal hygiene); b. Social skills, including communication and problem-solving in personal relationships; c. Basic personal finances (i.e. developing a budget, balancing a checkbook; utilizing credit); d. Emotion regulation skills, including anger control and conflict management; 3. Providing support to address vocational and other transition-related issues which may include any of the following: a. Investigating fields and jobs that might be of interest; b. Doing volunteer work in areas consistent with career goals; c. Assessing one's own job-relevant skills and writing a resume; d. Obtaining job applications and interviewing for jobs; e. Finding sources of needed job training, including assistance working with DOE programs, vocation rehab programs, community college programs, GED programs, etc.; and f. Coaching and support to help the young adult/youth stick with challenging training and job experiences. 4. Collecting detailed information about problematic behavior to help the therapist design effective interventions 5. Working conjointly with the primary therapist to plan interventions and to develop agreements with the family about the paraprofessional's schedule and activities. This can include the therapist's modeling the specific ways the paraprofessional should work with the youth/young adult and family, demonstrating skills for them to practice, etc. (Concurrent work must be no more than 2 hours/week)

Admission Criteria	**All** of the following criteria must be met: 1. The identified youth meets at least one (1) of the Service Eligibility criteria for CAMHD (as described in General Standards, Section B, Access & Availability), is registered with a Branch and has an assigned CC; 2. The youth must be age sixteen (16) through twenty (20) years; 3. The youth has been admitted into a CAMHD-contracted Intensive Independent Living Skills Therapy service; 4. The identified youth has a DSM-IV psychiatric disorder which significantly interferes with his/her ability to function independently; 5. There must be a reasonable expectation that including this service as part of the treatment will remediate symptoms and/or improve behaviors: 6. The Intensive Independent Living Skills MHTP identifies this service and measurable objectives for outcomes of this service prior to initiation of the service; and 7. The youth/young adult agrees to participate fully in the service.
Initial Authorization	Authorization for this service is the same authorization as the Intensive Independent Living Skills therapy. Initial authorization of the PSW may be up to an additional two hundred twenty four (224) units [fifty-six (56) hours] for one (1) month with review and approval of the Branch Clinical Lead. Unit = fifteen (15) minutes Level of Care = 6112 The combined total for both the Therapist and the PSW must not exceed three hundred twenty (320) units [eighty (80) hours] per month. Daily billing must not exceed sixteen (16) units [four (4) hours] per day for the Therapist and PSW combined. When the Therapist and the PSW work conjointly with the youth/young adult and family, only the therapist's time will be counted toward the daily and monthly maximums. Conjoint work is limited to eight (8) units [two (2) hours] per week.
Reauthorization	Reauthorization for this service is the same authorization as the Intensive Independent Living Skills therapy. Reauthorization of the PSW may be up to two hundred twenty four (224) units [fifty-six (56) hours] monthly for two (2) months with review and approval of the Branch Clinical Lead. The combined total hours for both the IILS therapist and the PSW must not exceed three hundred twenty (320) units [eighty hours] per month. Daily billing must not exceed sixteen (16) units [four (4) hours] per day. Unit = fifteen (15) minutes Level of Care = 6112 The number of hours authorized each month for the combined time of the IILS therapist and the PSW should be determined by the needs of the youth and family as spelled out in the treatment plan. The service must meet medical necessity and should decrease as progress is made.

	Any reauthorization request for paraprofessional services beyond three (3) months must be reviewed by the Branch Utilization Review Team.
Continuing Stay Criteria	**All** of the following criteria are met as determined by clinical review: 1. Youth and family are actively involved in treatment and all admission criteria continue to be met; 2. A written MHTP with measurable goals describing the activities of the PSW has been received by the CC; 3. Progress in relation to specific targeted symptoms or impairments is clearly evident and can be described in objective terms, but the goals of treatment have not yet been achieved. Data on progress have been presented in a visual or tabular format showing changes over time, and reviewed with the family and treatment team; 4. The documented treatment and safety plan is individualized and appropriate to the individual's changing condition with realistic, measurable and achievable goals, objectives and discharge criteria directed toward stabilization to allow treatment to continue in a less restrictive environment. The treatment plan has been shared with relevant team members; 5. The treatment plan includes a formulated discharge plan that is directly linked to the behaviors and/or symptoms that resulted in admission, and begins to identify appropriate post Intensive Independent Living Skills resources; 6. There is a reasonable expectation that the youth and family will make progress toward reaching the goals and objectives identified in the youth's Treatment Plan during the next four (4) weeks; and 7. The youth's progress in not sufficient to allow termination of the paraprofessional support services.
Discharge Criteria	Youth is no longer in need of or eligible for this service due to **one** (1) of the following criteria: 1. The youth is no longer eligible for CAMHD services. As part of discharge, the CC will help coordinate transfer to appropriate treatment services in the least disruptive manner possible; 2. The youth/family or young adult no longer wants to participate in this service and revokes consent without imminent danger to self or others; 3. Targeted symptoms and/or maladaptive behaviors have abated to a level of severity which no longer requires paraprofessional services as documented by substantial attainment of goals related to the work of the PSW in the MHTP; 4. Youth/family has demonstrated minimal or no progress toward treatment goals for at least a two (2) month period (this may include documented non-participation in services), and appropriate modifications of the MHTP have been made and implemented with no significant success, and the Branch Clinical Lead has determined that the youth is not benefiting from this

	service at this time; or 5. Youth exhibits new symptoms and/or maladaptive behaviors that cannot be addressed safely and effectively through this service as determined by the Branch Clinical Lead.
Service Exclusions	<u>Independent Living Skills Paraprofessional Support is not considered medically necessary and will not be authorized under the following circumstances:</u> 1. Not offered at the same time as any out-of-home service except in cases where the youth has a planned discharge from out-of home care within thirty (30) days. Intensive Independent Living Skills can begin to work with the youth/young adult for up to thirty (30) days. Paraprofessional services can be used as part of the transition services. 2. This service is not utilized as a substitute for Personal Assistant (PA) services (such as those provided by the Developmental Disabilities Division) or as a substitute for Skills Trainer Services or tutoring (such as those provided by the Dept. of Education). Paraprofessional support is not used to supervise visits with birth parents or to transport for family visits in place of services provided by Child Protective Services.
Clinical Exclusions	Youth in need of immediate crisis stabilization because of active suicidal, homicidal, or psychotic behavior are excluded. Once stable, youth who otherwise meet the eligibility criteria may be referred into the program. IIH may be provided to hospitalized youth who are still stabilizing as part of a transition back to the home.

Staffing Requirements

In addition to the staffing requirements listed in the general standards, these staffing requirements must be followed. If the standards referenced here differ from those in the general standards, these staffing requirements will supersede the general standards.

1. Independent Living Skills Paraprofessional Support is provided by a Contract Agency that also provides Intensive Independent Living Skills therapy. The Contract Agency ensures that the program includes:
   a. The program has a QMHP experienced in providing transitional services to youth/young adults with serious emotional and behavioral challenges and who is knowledgeable in evidenced-based treatments is responsible for clinical supervision, program oversight, and active guidance to staff.
   b. IILS Therapists must, at minimum, be a credentialed MHP with experience providing transition to independent living services to youth/young adults with serious emotional and behavioral challenges works with the youth/young adult and provides direct oversight and supervision to the PSW.
   c. The ILS PSW is credentialed as a paraprofessional and works under the direction of the IILS Therapist. (See the Standard for Intensive Independent Living Skills Therapy, p. 84)
2. The contractor is required to have a QMHP who provides twenty-four (24) hour on-call coverage seven (7) days a week.
3. The ratio shall not exceed twelve (12), families per paraprofessional support at any time with the consideration that at least two (2) of the twelve (12) families will be stepping down to a less intensive level of care. This staff to family ratio takes into consideration evening and weekend hours, needs of special populations, and geographical areas to be covered.

Clinical Operations

In addition to the clinical operation requirements listed in the general standards, these requirements must be followed. If the standards referenced here differ from those in the general standards, these clinical operation requirements will supersede the general standards. Please see also the Clinical Operations requirements for Intensive In-Home Therapy (p. XX).

1. Services must be available on a flexible schedule to meet the needs of the youth/young adult or family.
2. The program must provide emergency coverage, including phone access to a supervisor, twenty-four (24) hours a day, seven (7) days a week, through on-call arrangements with practitioners skilled in crisis and family based interventions.
3. Independent Living Skills Paraprofessional Support must be provided through a cohesive team approach and services must be flexible with the capacity to address concrete therapeutic and environmental issues in order to stabilize the crisis situation as soon as possible. Services are evidence-based, family-centered, strengths based, culturally competent, active and rehabilitative, and delivered primarily in the individual's home or other locations in the community.
    a. Team services are individually designed for each youth, in full partnership with the family, to minimize intrusion and maximize strengths and independence. Services are normally more intensive at the beginning of treatment and decrease over time as the individual and/or family's strengths and coping skills develop.
    b. All (100%) of the services provided by the Paraprofessional Support Worker are provided face-to-face with youth and their families. Indirect services such as attending IEP meetings and discussing the case with the Care Coordinator are provided by the IILS Therapist involved in the case.
4. Service delivery by the paraprofessional is based on an appropriate and effective treatment plan developed by the youth's IILS therapist.
5. The Contractor must have the ability to deliver services in various environments, such as homes (birth, kin, adoptive and foster), homeless shelters, juvenile detention centers, street locations, etc.
6. The Contractor has policies, which govern the provision of services in natural settings and which document that it respects youths' and/or families' right to privacy and confidentiality when services are provided in these settings.
7. The Contractor has established policies and procedures for handling emergency and crisis situations that describe the responsibilities of the Paraprofessional Support Worker.
8. Each Contractor has policies and procedures governing the provision of outreach services, including methods for protecting the safety of staff who engage in outreach activities.
9. Each Contractor has policies and procedures around the use of personal vehicles for outreach services and for transporting clients when necessary.
10. Approval of supervised staff's case and progress notes must be documented by the supervising QMHP. Progress notes will be made available to the Branch upon request.
11. The Contractor must have an Intensive Independent Living Skills organizational plan that addresses the following:
    a. Description of the particular skill-building interventions, coordination, crisis intervention and wraparound service models utilized, types of intervention practiced, and typical daily schedule for staff;
    b. Description of the staffing pattern and how staff are deployed to ensure that the required staff-to-youth/young adult ratios are maintained, including how unplanned staff absences, illnesses, etc. are accommodated;
    c. Description of the hours of operation, the staff assigned and types of services provided to youth/families;

d. Description as to how the plan for services is modified or adjusted to meet the needs specified in each youth's individual plan.
e. Description of the qualifications of the QMHP experienced in evidenced-based treatment who supervises the treatment program and assumes clinical responsibility.

12. Please see Section I General Standards for additional clinical operation requirements:
    - E. CAMHD Co-Occurring Disorders;
    - G. Referral Process for Services:
        - Referral Acceptance;
    - H. CAMHD Continuity of Care;
    - I. Staffing;
        - Supervision;
    - K. Evaluation of Staff Performance;
    - L. Credentialing Requirements;
    - O. Service Quality;
        - Minimum Reporting Requirements;
    - Q. Risk Management:
        - Criminal, Child Abuse, and Background Screening;
        - Safety;
        - Restraints and Seclusion;
        - Sentinel Events and Incidents;
        - Police.

Documentation

In addition to the documentation requirements listed in the general standards, these requirements must be followed. If the standards referenced here differ from those in the general standards, these documentation requirements will supersede the general standards.

1. The IILS MHTP must include specific goals and objectives related to the work of the PSW, and these goals must be appropriate and focused on changes necessary to allow the youth/ young adult to live independently. The youth's IILS therapist is responsible for developing the plan prior to the PSW's involvement.
2. PSWs must provide a written progress note for each face-to-face contact with the youth and/or family.
3. Progress notes must document the course of treatment including a description of the interventions implemented, youth/ young adult's response, and interpretation of the effectiveness of the intervention in addressing treatment plan goals/objectives. The note must include the date of service, the length of session, type of therapy provided and specific treatment goals addressed. The notes shall be fully dated and signed by the writer and supervisor. The original note must be maintained in the agency's master youth file within 24 hours of service.
4. The Monthly Treatment and Progress Summary must be completed by the IILS therapist and must include descriptions of the work done by the PSW.
5. Please see Section I, General Standards for additional documentation requirements:
    - N. Maintenance of Service Records:
        - Progress Notes.

J. THERAPEUTIC RESPITE HOME (TRH)

Definition	Therapeutic Respite Homes provide short-term care and supervision for youth with emotional and/or behavioral challenges in a supportive environment as a planned part of their treatment. These homes provide structured relief to the youth to prevent disruptions in the regular living arrangement. The goal of Therapeutic Respite Home services is to provide rest and relief to the youth and to help the youth achieve their highest level of functioning. Therapeutic Respite Home is not provided as a stand-alone service, and there is close coordination of this service with other on-going mental health treatment services.
Services Offered	1. Services are provided in a Transitional Family Home and are available twenty-four (24) hours a day/seven (7) days a week. 2. Culturally relevant recreational and social activities that support the development of interpersonal relationships and life skills through modeling and coaching. 3. Positive behavioral supports, social skills training, observation and supervision of the youth. 4. Regular communication with the youth's primary caregiver and with other service providers to assure coordination of care. 5. Medication administration if needed. 6. The contractor provides on-call crisis intervention and supports to the respite home on a twenty-four (24) hour basis.
Admission Criteria	<u>All of the following criteria are met</u>: 1. The identified youth meets at least one (1) Service Eligibility criteria for CAMHD (as described in General Standards, Section B, Access & Availability) is registered with a Branch, and has an assigned CC; 2. Youth resides in the family home or in a DHS resource family Home; 3. Youth receives intensive in-home or outpatient treatment services through CAMHD. 4. The CSP identifies Therapeutic Respite Home as necessary to preserve the youth's living situation and specifies how and when the service will be utilized.
Initial Authorizations	Initial authorization may be up to two (2) units per month for three months with review and approval of the Branch Clinical Lead. Unit = one (1) day Level of Care = 28940 A maximum of two (2) units [forty-eight (48) hours] may be used in any single episode but must not exceed this amount in a single episode. Authorization may not exceed six (6) units per quarter.
Reauthorization	Reauthorization may be up to two (2) units per month for three months with review and approval of the Branch Clinical Lead. Unit = One (1) day Level of Care = 28940

	A maximum of two (2) units [forty-eight (48) hours] may be used in any single episode but must not exceed this amount in a single episode. Any request for re-authorization beyond six (6) months must be reviewed and approved by the Branch Utilization Review Team and Clinical Lead. Authorization may not exceed six (6) units per quarter and twenty-four (24) units per year.
Continuing Stay Criteria	**All** admission criteria continue to be met.
Discharge Criteria	**One** (1) of the following criteria is met: 1. The youth no longer eligible for CAMHD services. As part of discharge, the CC will help coordinate transfer to appropriate treatment services in the least disruptive manner possible; 2. The youth/family no longer wants to participate in this service and revokes consent; 3. The youth or family stops participating in home-based or outpatient mental health treatment services; 4. Family has been provided at least twenty-four (24) hours of Therapeutic Respite Home services; 5. Youth has been in Therapeutic Respite Home for 48 hours. 6. Youth requires a higher level of care and is transferred out of Therapeutic Respite Home Service.
Service Exclusions	Therapeutic Respite Home is not considered medically necessary and will not be authorized under the following circumstances: 1. Not offered at the same Hospital-Base Residential service, any Community-Based Residential program, or Transitional Family Home service. 2. No admissions and/or continued stays which are solely for parent/guardian convenience and not related to the mental health care and treatment of the youth.
Clinical Exclusions	1. Youth in need of immediate crisis stabilization because of active suicidal, homicidal, or psychotic behavior. 2. Youth's clinical issues interfere with the safe provision of services in this level of care.

Staffing Requirements:
In addition to the staffing requirements listed in the general standards, these staff requirements must be followed. If the standards referenced here differ from those in the general standards, these staffing requirements will supersede the general standards.

1. Transitional Family parents must be licensed with the Department of Human Services prior to service initiation.
2. Transitional families are required to receive at least two (2) hours a month of supervision from a Contractor's QMHP or MHP. One (1) hour of the required supervision may be multi-family or group supervision.

3. The program has a QMHP experienced in providing service to youth/families and who is knowledgeable of evidenced-based treatments is responsible for the Therapeutic Respite Home program and for those in care and provides on-call coverage twenty-four (24) hours per day/seven (7) days a week.
4. The program has a QMHP or MHP who is responsible for communicating with CCs and relevant service providers to assure that respite families have current information about the youth and that treatment is coordinated across service settings.
5. Youth who are unable to attend regularly scheduled day activities (e.g. school, work) must be provided supervision and therapeutic structure by program staff.
6. All transitional parents must be trained in the provision of short-term care for youth with emotional and/or behavioral challenges, including training on medication administration.

Clinical Operations

In addition to the clinical operation requirements listed in the general standards, these requirements must be followed. If the standards referenced here differ from those in the general standards, these clinical operation requirements will supersede the general standards.

1. Services are available twenty-four (24) hours a day, seven (7) days a week.
2. The Therapeutic Respite Home will have no more than two (2) minor youth in the home and no more than two (2) therapeutic respite youth in placement with them, unless a waiver is requested and approved by CAMHD. There shall be a minimum of one (1) adult at home whenever the youth is present. The agency shall ensure additional staff support as necessary.
3. In addition to all requirements for licensure of transitional families, Contractors will ensure that all transitional family parents receive at least twenty (20) hours of initial orientation to include: orientation to the Contractor agency; orientation to the Hawaii Child-Serving System and the role of Transitional Family Care; understanding children and youth with emotional disturbances; providing positive behavioral support to children and adolescents; how to work as part of a treatment team; how to relate to the transitional youth's parents and family members; a review of State laws regarding child abuse and neglect reporting, reporting criminal behavior, and threats regarding suicide and homicide; and be trained in CPR and First Aid.
4. On an on-going basis, transitional family parents shall receive at least twenty (20) hours of training annually on topics related to mental health special needs youth. Documentation of all transitional family training is the responsibility of the Contractor.
5. Upon contract execution, all Contractors of Transitional Family Homes Services shall submit a list of families with all of the following information required on the TFH Profile Form (See Appendix 8). The Contractor will provide updates to this list as they occur to the CAMHD Utilization Management Section of the Clinical Services Office that shall maintain the information in accordance with all confidentiality requirements.
6. The Contractor must have written policies and procedures and train staff on securing and storing medications; labeling and administering medications as ordered by a physician; recording medication administration, youth request for adjustment or change, and any side effects and notifying physician or advanced practice registered nurse immediately of possible side effects; and disposing of medications.
7. The program actively engages the youth in planned, structured, therapeutic activities, rooted in evidence-based treatment, throughout the day. There is a predictable and orderly routine that allows the youth to develop and enhance interpersonal skills and behaviors.
8. The Therapeutic Respite Home program has clear procedures, which specify its approach to positive evidence-based behavior management. These procedures must clearly delineate methods of training and implementation of positive evidence-based behavioral interventions.

9. The Contractor has established policies and procedures in place for preventing and managing crises effectively and efficiently through the direct interventions of its professional staff. Included in these procedures are descriptions of methods for handling emergency and crisis situations and triaging youth who require more intensive interventions. Request for police assistance or crisis hotline assistance is limited to situations of imminent risk of harm to self or others and requires consult with the program QMHP prior to, during, or after the call for assistance. The QMHP must follow-up to ensure the crisis situation has stabilized, debrief the incident and provide triage for youth needing more intensive interventions and documents their effort in the youth's chart.
10. Emergency contact information for the parent(s) or caregiver(s) is provided to the transitional parent prior to or upon admission.
11. Please see Section I General Standards for additional clinical operation requirements:
    - E. CAMHD Co-Occurring Disorders;
    - G. Referral Process for Services:
        - Referral Acceptance;
    - H. CAMHD Continuity of Care;
    - I. Staffing;
    - J. Supervision;
    - K. Evaluation of Staff Performance;
    - L. Credentialing Requirements;
    - O. Service Quality;
    - P. Minimum Reporting Requirements;
    - Q. Risk Management:
        - Criminal, Child Abuse, and Background Screening;
        - Safety;
        - Restraints and Seclusion;
        - Sentinel Events and Incidents;
        - Police.

Documentation

In addition to the documentation requirements listed in the general standards, these requirements must also be followed. If the standards referenced here differ from those in the general standards, these documentation requirements will supersede the general standards.

1. Therapeutic Respite Home Parents shall maintain progress notes that provide a) daily attendance log indicating the youth's presence or absence from the home including absences of twenty-four (24) hours or more and b) provide daily progress notes as documentation of treatment progress, events or activities youth engaged in and developmental milestones achieved. These notes shall be fully dated and signed by the respite parent, originals of which shall be placed in the agency's master youth file within seven (7) calendar days. These respite home progress notes may be in the form of a checklist or written note.
2. Please see Section I General Standards for additional documentation requirements:
    - F. Service Planning:
        - Discharge Summary;
    - N. Maintenance of Service Records:
        - Progress Notes.
    - P. Minimum Reporting Requirements:
        - Monthly Treatment and Progress Summary.

K. MULTIDIMENSIONAL TREATMENT FOSTER CARE (MTFC)

Definition	Multidimensional Treatment Foster Care (MTFC) services are intensive family-based services provided in a foster family setting to youth with a history of delinquent and/or disruptive behaviors and emotional challenges. The two (2) major aims of MTFC are: 1. To create opportunities so that youth are successfully able to live in foster families rather than in group or institutional settings, and 2. To simultaneously prepare parents, relatives, or other aftercare resources to provide these same youth with effective parenting so that positive changes made in the MTFC setting can be sustained over the long run. MTFC is an evidence-based treatment intervention which utilizes trained and supervised foster parents to: 1. Provide youth in care with close supervision; 2. Provide youth with fair and consistent limits and consequences; 3. Provide a supportive relationship with the youth; and 4. Minimize association with peers who may be a bad influence. Youth in MTFC are generally capable of attending their home school or an alternative community-based educational/vocational program. Placements generally range from six (6) to nine (9) months. This level of care is primarily intended as an alternative to Therapeutic Group Home or Community-based Residential service.
Services Offered	1. The program has an intake process that includes introducing the youth and family to the program, review and assessment of existing documentation to integrate into the treatment plan within their milieu. 2. Maintain collateral contacts with the CC. 3. Crisis management 24 hours/day, 7 days/week as needed. 4. MTFC Foster Parents provide closely supervised behavioral interventions via an individualized level and point system and contingent positive and negative consequences. 5. The MTFC Clinical Supervisor participates in weekly face-to-face meetings with all foster parents and with all Clinical Team members in order to monitor each youth's progress, discusses treatment strategies, and effectively tracks outcomes. 6. The MTFC Parent Daily Report (PDR) Caller maintains daily contact with all foster parents in order to monitor progress via the collection of behaviorally based data. 7. MTFC Foster Parents coordinate with school personnel via a Daily School Card in order to strengthen effective academic support in the home setting. 8. An MTFC Peer Counselor provides individualized pro-social activities coaching for each youth weekly.

	9. The MTFC Individual Therapist provides weekly sessions with each youth in support of individualized behavioral approaches developed over time in the MTFC setting. 10. The MTFC Family Therapist provides weekly evidence-based therapy to the youth's family of origin with an emphasis on family-based implementation of individualized behavioral approaches developed in the MTFC setting. 11. Active, ongoing treatment is based on measurable goals and objectives that are part of the youth's CSP and MHTP. Treatment is focused on returning the youth home or, for youth in DHS custody, on successful transition to a kinship placement, long-term foster family, or independent living program.
Admission Criteria	**All** of the following criteria are met: 1. The identified youth meets at least one (1) of the Service Eligibility criteria for CAMHD (as described in General Standards, Section B, Access & Availability) is registered with a Branch, and has an assigned CC; 2. The youth must be age eleven (11) through seventeen (17); 3. The youth must be identified as needing an out-of-home service due to severe and persistent problem behavior. The CSP identifies this service and measurable objectives for outcomes of this service prior to admission; 4. There must be reasonable expectation that the youth and family can benefit from MTFC within six (6) to nine (9) months; 5. An adequate trial of active treatment at a less restrictive level had been unsuccessful or given serious consideration and found to be inappropriate. This level of care is primarily intended as an alternative to group or residential treatment; and 6. The youth must have an adult/parental figure able to assume the long term parenting role and to actively participate with MTFC service providers for the duration of treatment.
Initial Authorizations	Initial authorization may be up to thirty-one (31) units per month for three (3) months with review and approval of the Branch Clinical Lead. Unit = One (1) day Level of Care = 28601
Reauthorization	Reauthorization may be up to thirty-one (31) units per month for up to five (5) months with review and approval of the Branch Clinical Lead. Request for continued stay reviews must be submitted no more than twenty one (21) calendar days and no less than seven (7) calendar days before the end date of the initial authorization. Unit = One (1) day Level of Care = 28601 Any request for re-authorization beyond eight (8) months must be reviewed and approved by the Branch Utilization Review Team.

Continuing Stay Criteria	**All** of the following criteria are met as determined by clinical review: 1. Youth is actively involved in the treatment process and continues to meet admission criteria; 2. Progress in relation to specific targeted symptoms or impairments is clearly evident and can be described in objective terms, but goal of treatment have not yet been achieved; 3. Services are being provided as indicated in the CSP and MHTP and there are regular and timely assessments and documentation of youth/family response to services. Timely and appropriate modifications are made to services and plan as needed; 4. The youth continues to exhibit willful delinquent and disruptive behavior indicating that MTFC is the most appropriate means of addressing those needs; and 5. There is reasonable expectation that continued treatment will remediate the symptoms and/or improve behaviors or there is reasonable evidence that the youth will decompensate or experience relapse if services are discontinued.
Discharge Criteria	Youth is no longer in need of or eligible for this service due to **one** of the following criteria: 1. The youth is no longer eligible for CAMHD services. As part of discharge, the CC will help coordinate transfer to appropriate treatment services in the least disruptive manner possible; 2. The youth's documented treatment plan goals and objectives have been substantially met and can be transitioned to a less intensive level of treatment; 3. The youth/family no longer wants to participate in this service and revokes consent with no imminent danger to self or others; 4. Youth has demonstrated minimal or no progress toward treatment goals for a three (3) month period and appropriate modifications of the treatment plan have been made and implemented with no significant success, suggesting the youth is not benefiting from this services at this time; 5. Youth exhibits new symptoms and/or maladaptive behaviors which cannot be safely and effectively addressed through this service; 6. The youth or parent/guardian is non-participatory in treatment or in following program rules and regulations. The non-participation is of such a degree that treatment at this level of care is rendered ineffective, despite multiple (at least 3) documented attempts to address non-participation issues; or 7. The youth has the knowledge and supports necessary to sustain treatment outcomes and to support a successful transition to a permanent placement.

Service Exclusions	Multidimensional Treatment Foster Care is not considered medically necessary and will not be authorized under the following circumstances: 1. No treatment outside the MTFC program should co-occur during placement with the exception of medication management, as needed. 2. Not offered at the same time as any out-of-home service. 3. Not offered at the same time as any Intensive In-Home Intervention, Intensive Independent Living Skills, Multisystemic Therapy, or Functional Family Therapy services except where the youth will be transitioned out of the MTFC and into the identified service within thirty (30) days referral. 4. No admissions and/or continued stays which are solely for parent/guardian convenience and not related to the care and treatment of the youth. 5. No admissions that are being sought solely for convenience of child protective services housing, as an alternative to incarceration within juvenile justice, as an alternative to specialized schooling, or simply as respite.
Clinical Exclusions	1. Youth for whom a primary caregiver cannot be identified despite extensive efforts to locate all extended family, adult friends, and other potential surrogate caregivers. 2. Youth whose cognitive capacity prevents effectively working with MTFC's point and level system. 3. Youth in need of immediate crisis stabilization because of active suicidal, homicidal, or psychotic behavior. 4. Youth with a currently active thought disorder or other severe mental illness. Once stable, youth who otherwise meet the eligibility criteria may be referred into the program.

Staffing Requirements

In addition to the staffing requirements listed in the general standards, these staff requirements must be followed. If the standards referenced here differ from those in the general standards, these staffing requirements will supersede the general standards.

1. Foster parents must be licensed with the Department of Human Services prior to initiating services.
2. Foster parents (at least one parent) are required to receive at least two (2) hours of supervision per month from the MTFC clinical supervisor.
3. The MTFC clinical supervisor must be a QMHP who oversees all MTFC staff and is responsible for all clinical decisions made.
4. The individual therapist must be an MHP.
5. The family therapist must be an MHP.
6. Peer Counselor is a paraprofessional.
7. The PDR caller will typically be a paraprofessional with previous foster care or data entry experience.

Clinical Operations

In addition to the clinical operation requirements listed in the general standards, these requirements must be followed. If the standards referenced here differ from those in the general standards, these clinical operation requirements will supersede the general standards.

1. Services are available twenty-four (24) hours a day, seven (7) days a week.
2. Contractor is to follow all applicable professional practice standards and ethical guidelines.
3. The Contractor provides foster parents with a written plan for providing emergency and psychiatric care prior to youth being treated in the family home.
4. In addition to all requirements for licensure of transitional families, Contractors will ensure that all transitional family parents receive at least twenty (20) hours of initial orientation to include: orientation to the Contractor agency; orientation to the Hawaii Child-Serving System and the role of Transitional Family Care; understanding children and youth with emotional disturbances; providing positive behavioral support to children and adolescents; how to work as part of a treatment team; how to relate to the transitional youth's parents and family members; a review of state laws regarding child abuse and neglect reporting, reporting criminal behavior, and threats regarding suicide and homicide; how to access Contractor's respite homes and be trained in CPR and first-aid.
5. On an ongoing basis, transitional family parents shall receive at least twenty (20) hours of training annually on topics related to mental health special needs youth. Documentation of all transitional family training is the responsibility of the Contractor.
6. Program has an intake process that includes introducing the youth and family/guardian to the program, review and assessment of existing documentation to integrate into the treatment and safety plan within their milieu.
7. The home may have biological and/or adopted minor youth in the home and no more than one (1) foster youth in the home, unless a waiver is requested and approved by MTFC for a sibling group placed together. There shall be a minimum of one (1) adult at home whenever the youth(s) is present. The Contractor shall provide additional staff support as necessary.
8. Upon contract execution, all Contractors of Multidimensional Treatment Foster Care services shall submit a list of foster families with all of the following information required on the Therapeutic Foster Home Profile Form (See Appendix 8). The Contractor will provide updates to this list as they occur to the CAMHD Utilization Management Section of the Clinical Services Office that shall maintain the information in accordance with all confidentiality requirements.
9. The Contractor must have written policies and procedures and train staff on securing and storing medications; labeling and administering medications as ordered by a physician; recording medication administration, youth request for adjustment or change, and any side effects and notifying physician or advanced practice registered nurse immediately of possible side effects; and disposing of medications.
10. The Contractor must have written policies and procedures that ensure that TFH parents plan for the youth's regular medical and dental services, and keep the provider agency informed of any health problems or any changes that adversely affect the youth in foster care.
11. The Contractor must have clear procedures, which specify its approach to positive evidence-based behavior management and to evidence-based family therapy interventions. These procedures must clearly delineate methods to be used for the training and implementation of these evidence-based behavioral interventions.
12. The Contractor has established procedures/protocols in place for managing crises effectively and efficiently through the direct interventions of its professional staff. Included in these procedures are descriptions of methods for handling emergency and crisis situations and triaging youth who require more intensive interventions. Request for police assistance or crisis hotline assistance is limited to situations of imminent risk of harm to self or others and requires consult with the program QMHP prior to, during, or after the call for assistance. The QMHP must follow-up to ensure the crisis

situation has stabilized, debrief the incident and provide triage for youth needing more intensive interventions and documents their effort in the youth's chart.

13. When the Contractor has documented the clinical need for Ancillary support services of one-on-one staffing, the Contractor will request the assistance of the CAMHD Brach where the youth is registered to seek approval from the CAMHD Medical Director or designee for such staffing to help stabilize the youth.
14. The Contractor must perform a Summary Annual Evaluation for SEBD eligible youth in their care at the time the annual evaluation is due for youth who have received at least three (3) months of services from the Contractor. See Summary Annual Evaluation performance standard in Section II, Part C.
15. Eight (8) therapeutic passes are allowed per episode of care for each youth in the program to assist him/her in meeting the MHTP goals as defined in the general standards. These passes must be preapproved and used for therapeutic purposes and requires program to have contact with youth/family while on pass and debrief each pass.
16. Authorization of therapeutic passes beyond the threshold of eight (8) passes must undergo a Branch Utilization Review Team clinical review including reviewing documentation of previously issued therapeutic passes to ensure the passes are being utilized in accordance with the general standards prior to authorization.
17. Up to seven (7) consecutive bed hold days may be used to reserve the bed for a youth who is absent from the program for an acute admission or detainment in the Detention Home per episode. For youth on runaway status from the program, a maximum of three (3) consecutive days may be authorized to hold the bed per elopement.
18. Youth who are discharged from the program due to acute admission, detainment or runaway status, will be given priority readmission if admission is sought within a two (2) week period from discharge.
19. Please see Section I General Standards for additional clinical operation requirements:
    - E. CAMHD Co-Occurring Disorders;
    - G. Referral Process for Services:
        - Referral Acceptance;
    - H. CAMHD Continuity of Care;
    - I. Staffing;
    - J. Supervision;
    - K. Evaluation of Staff Performance;
    - L. Credentialing Requirements;
    - O. Service Quality;
    - P. Minimum Reporting Requirements;
    - Q. Risk Management:
        - Criminal, Child Abuse, and Background Screening;
        - Safety;
        - Restraints and Seclusion;
        - Sentinel Events and Incidents;
        - Police;
    - W. Bed Hold and Therapeutic Passes:
        - Bed hold;
        - Therapeutic Pass.

Documentation

In addition to the documentation requirements listed in the general standards, these requirements must be followed. If the standards referenced here differ from those in the general standards, these documentation requirements will supersede the general standards.

1. A written treatment plan identifying targets of treatment with realistic goals, objective and discharge criteria linked to the admission behavior/symptoms will be submitted to the CAMHD Branch with ten (10) calendar days of admission. This documentation is required for any re-authorization of Multidimensional Treatment Foster Care services.
2. Individual and Family Therapy progress notes must document the course of treatment including a description of the interventions implemented, youth's response, and interpretation of the effectiveness of the intervention in addressing treatment plan goals/objectives. The note must include the date of treatment, length of the session, type of therapy provided, and specific treatment goals addressed. The notes shall be fully signed by the writer and supervisor if needed. The original note must be maintained in the agency's master youth file within 24 hours of service.
3. MTFC Parents shall maintain progress notes that provide a) daily attendance log indicating the youth's presence or absence from the home including absences of twenty-four (24) hours or more and b) provide daily progress notes as documentation of treatment progress, events or activities youth engaged in and developmental milestones achieved. These notes shall be fully dated and signed by the MTFC parent, originals of which shall be placed in the agency's master youth file within seven (7) calendar days. These foster home progress notes may be in the form of a checklist or written note.
4. Contractor must complete all documentation requirements specific to MTFC.
5. Please see Section I General Standards for additional documentation requirements:
    - F. Service Planning:
        - Mental Health Treatment Plan including safety, crisis and discharge planning. If any major changes occur in the course of treatment, the all components of the MHTP should be updated;
        - Discharge Summary;
    - N. Maintenance of Service Records:
        - Progress Notes;
    - P. Minimum Reporting Requirements:
        - Monthly Treatment and Progress Summary.

L. TRANSITIONAL FAMILY HOME (TFH)

Definition	This service is an intensive, short-term community-based treatment service provided in a family home setting for youth with emotional and behavioral challenges. These homes provide a normative, community-based environment with therapeutic parental supervision, home structure, and support for youth capable of demonstrating growth in such a setting. This setting provides a supportive platform for family therapy and treatment to occur with the goal of reuniting youth with their family or other longer term family home. These youth are generally capable of attending their home school or an alternative community educational or vocational program. Such homes may also be beneficial for youth in transition from a more restrictive placement as these homes offer a family-like orientation. This level of care is appropriate for youth in need of treatment placements of six (6) to eight (8) months and/or shorter-term crisis stabilization of one (1) to three (3) months.
Services Offered	1. Evidence-based interventions, including positive behavioral support delivered in the Transitional Family Home and positive behavioral support and parent management training for the family of origin/guardian. 2. Weekly Family Therapy with the youth and the family of origin, or guardian in the youth's step down placement. The therapist's role is to support the family's implementation of the individualized behavioral approaches developed in the TFH setting that can be used in the longer term family home setting. The program meets weekly with the identified caregiver from the first week the youth begins treatment, to provide parent education, information, and skill building as necessary for them to implement the recommended best practice interventions. 3. When DHS has permanent custody, a DHS identified adult/parental figure able to assume long-term parenting responsibilities will participate in the weekly family therapy* sessions. If no such parental figure exists, the DHS social worker will participate in monthly family therapy session to help the youth develop long-term permanency plans. 4. Weekly evidenced-based Individual Therapy* provided to each youth to address issues identified in the MHTP. The therapist's role is to support the youth's adjustment in the transitional home, to provide support for the youth and to help him/her acquire and practice the skills needed to transition to their family or origin or post-treatment placement. a. For older adolescents who need to prepare for independent living, opportunities will be provided to learn/enhance skills necessary to live independently in the community upon discharge. Youth will be linked to educational, vocational, employment, health services and community resources.

*See performance standard for service referenced.

	5. Culturally relevant recreational and social group activities that that support the development of interpersonal relating and life skills. 6. Coordination with school personnel to implement and provide academic support in the transitional home setting. 7. Treatment team participates in regular meetings (no less than once a month) with transitional home parents in order to monitor the youth's progress and discuss treatment strategies and services. 8. A documented treatment plan that identifies targets of treatment connected to realistic goals, objectives, and discharge criteria will be developed as part of the initial assessment process and includes information from the pre-admission meeting. A safety plan and larger crisis plan will also be developed to help identify interventions that are helpful in addressing target behavior. The treatment plan will be evaluated and revised as necessary as treatment proceeds and will include the youth, family/guardian and other relevant treatment team members. a. The crisis plan component of the treatment plan includes a safety plan that identifies the youth's problematic behaviors, triggers and preferred means of calming or regaining control. The safety plan is an essential component of the larger crisis plan. The safety plan is part of the treatment plan that articulates the youth's self-calming interventions consistent with treatment targets, goals and objectives. The purpose of the safety plan is to help the youth regain control and avoid escalation into crisis. b. The discharge component of the treatment plan will be developed that specifies discharge criteria directly linked to behaviors/symptoms that resulted in the admission, time frame for discharge and any aftercare resources needed to transition the youth to a less restrictive level of treatment. 9. Treatment is designed to include all members of the family, not just the specific youth through regular family therapy and therapeutic home passes. 10. If the youth is involved in treatment with another behavioral health provider(s) then, with proper consent, the Transitional Family Home provider will notify any other behavioral health provider(s) of the youth's current status to ensure care is coordinated.
Admission Criteria	**All** of the following criteria are met: 1. The identified youth meets at least one (1) of the Service Eligibility criteria for CAMHD (as described in General Standards, Section B, Access & Availability) is registered with a branch and has an assigned CC; 2. The youth must be between the ages of three (3) and seventeen (17);

	3. Youth is not sufficiently stable to be treated outside of a structured therapeutic setting as evidenced by one of the following: a. Moderate impairment in at least three (3) domains of the youth's life (i.e., home, community, moods/emotions), b. Recent history of successful treatment in a higher level of care and needing transitional support, or c. Recent history of unsuccessful treatment in a lower level of care and need more structure and support before returning to pre-treatment environment; 4. Pre-admission meeting is held with the youth, family/guardian, CC and other relevant treatment members to identify treatment targets to be addressed in the treatment and safety plan and reflected in the realistic discharge criteria along with expectations of family/guardian involvement in the treatment process; 5. The CSP identifies this service and includes measurable objectives and discharge criteria as established in the pre-admission meeting; 6. If the youth's primary problem is a disruptive behavioral disorder there must be documentation of the use of one of the available evidenced-based treatments for disruptive behavior disorders (MST, FFT MTFC) unless there is documentation of clear and compelling clinical evidence that the youth is inappropriate for one of these approaches at this time; 7. Youth's documented needs can appropriately be met in a structured and consistent family-like environment; 8. Family/guardian agree to active involvement in treatment and planning meetings; and 9. Youth agrees to active involvement in treatment.
Initial Authorization	Initial authorization may be up to thirty-one (31) units per month for three (3) months with review and approval of the Branch Clinical Lead. Unit = One (1) day Level of Care = 28401
Reauthorization	Reauthorization may be up to thirty-one (31) units per month for up to three (3) months with review and approval of the Branch Clinical Lead. Request for continued stay reviews must be submitted no more than twenty one (21) calendar days and no less than seven (7) calendar days before the end date of the initial authorization or any reauthorization. Unit = One (1) day Level of Care = 28401 Any request for reauthorization beyond eight (8) months must be reviewed and approved by the Branch Utilization Review Team.

Continuing Stay Criteria	**All** of the following criteria are met as determined by clinical review: 1. Youth is actively involved in the treatment process and continues to meet admission criteria; 2. Progress in relation to specific targeted symptoms or impairments is clearly evident and can be described in objective terms, but goal of treatment have not yet been achieved; 3. The documented treatment and safety plan is individualized and appropriate to the individual's changing condition with realistic, measurable and achievable goals, objectives and discharge criteria directed toward stabilization to allow treatment to continue in a less restrictive environment. The treatment plan has been shared with relevant team members; 4. The treatment plan includes a formulated discharge plan that is directly linked to the behaviors and/or symptoms that resulted in admission, and begins to identify appropriate post Transitional Family Home resources; 5. There is documented evidence of active family/guardian involvement in treatment as required by the treatment plan at least weekly or there is active documented effort being made to involve them unless it is documented as contraindicated.; 6. There is reasonable expectation that continued treatment will remediate the symptoms and/or improve behaviors or there is reasonable evidence that the youth will decompensate or experience relapse if services are discontinued; and 7. There is a documented active attempt at coordination of care with relevant behavioral health providers when appropriate. If coordination is not successful, the reason(s) are documented.
Discharge Criteria	Youth is no longer in need of or eligible for this service due to **one** (1) of the following criteria: 1. The youth's documented treatment plan goals and objectives have been substantially met and can be transitioned to a less intensive level of treatment; 2. Targeted symptoms/behaviors have abated in severity which no longer requires this level of care and the treatment can now be managed at a less intensive level of care; 3. The youth meets criteria for a more intensive level of care; 4. The youth is no longer eligible for CAMHD services. As part of discharge, the CC will help coordinate transfer to appropriate treatment services in the least disruptive manner possible; 5. The youth/family no longer wants to participate in this service and revokes consent with no imminent danger to self or others; 6. The youth or parent/guardian is not participating in treatment or in following program rules and regulations. The non-participation is of such a degree that treatment at this level of care is rendered ineffective, despite multiple (at least 3) documented attempts to address non-participation issues; or **7.** Youth has demonstrated minimal or no progress toward treatment goals for a three (3) month period and appropriate

	modification of plans has been made and implemented with no significant success, and there is no reasonable expectation of progress at this level of care nor is it required to maintain the current level of function.
Service Exclusions	<u>Transitional Family Home is not considered medically necessary and will not be authorized under the following circumstances:</u> 1. Not offered at the same time as any out-of-home service. 2. Not offered at the same time as any Intensive In-Home Intervention, Multisystemic Therapy, Functional Family Therapy Intensive In-Home or Intensive Independent Living Skills services *except* where the youth will be transitioned out of the TFH and into the identified service within thirty (30) days referral. 3. No admissions and/or continued stays which are solely for parent/guardian convenience and not related to the care and treatment of the youth. 4. No admissions that are being sought solely for convenience of child protective services housing, as an alternative to incarceration within juvenile justice, as an alternative to specialized schooling, or simply as respite.
Clinical Exclusions	Youth in need of immediate crisis stabilization because of active suicidal, homicidal, or psychotic behavior. Once stable, youth who otherwise meet the eligibility criteria may be referred into a transitional family home.

Staffing Requirements:
In addition to the staffing requirements listed in the general standards, these staff requirements must be followed. If the standards referenced here differ from those in the general standards, these staffing requirements will supersede the general standards.

1. Transitional Family parents must be a licensed Foster Home with the Department of Human Services prior to service initiation.
2. Transitional families are required to receive at least two (2) hours a month of supervision from a Contractor's QMHP or MHP. One (1) hour of the required supervision may be multi-family or group supervision.
3. The program has a QMHP or a QMHP supervised MHP with experience in providing service to youth/families and who is knowledgeable of evidenced-based and best practice treatments is responsible for the Transitional Family Home program and for those in care and provides on-call coverage twenty-four (24) hours per day/seven (7) days a week.

Clinical Operations
In addition to the clinical operation requirements listed in the general standards, these requirements must be followed. If the standards referenced here differ from those in the general standards, these clinical operation requirements will supersede the general standards.

1. Services are available twenty-four (24) hours a day, seven (7) days a week.
2. Contractor is to follow all applicable professional practice standards and ethical guidelines.
3. The program provides transitional parents with a written plan for providing emergency and psychiatric care prior to youth being treated in the family home.

4. In addition to all requirements for licensure of transitional families, Contractors will ensure that all transitional family parents receive at least twenty (20) hours of initial orientation to include: orientation to the Contractor agency; orientation to the Hawaii Child-Serving System and the role of Transitional Family Care; understanding children and youth with emotional disturbances; providing positive behavioral support to children and adolescents; how to work as part of a treatment team; how to relate to the transitional youth's parents and family members; a review of state laws regarding child abuse and neglect reporting, reporting criminal behavior, and threats regarding suicide and homicide; how to access Contractor's respite homes and be trained in CPR and first aid.
5. On an ongoing basis, transitional family parents shall receive at least twenty (20) hours of training annually on topics related to mental health special needs youth. Documentation of all transitional family training is the responsibility of the Contractor.
6. A preadmission meeting is required to obtain youth, family, CC, and other relevant team members' input into symptoms/behavior that are the targets of treatment and reflected in the goals and objectives in the MHTP. A safety plan will be developed that identifies effective youth self-calming interventions that will be incorporated into the youth's MHTP/crisis plan. The preadmission meeting also facilitates the development of the youth's discharge plan, including the development of concrete, realistic, measurable discharge criteria and projected timeframe for discharge.
7. The program will have an intake process that includes introducing the youth and family/guardian to the program, review and assessment of existing documentation to integrate into the treatment plan and safety plan within their milieu.
8. Families/guardians are actively involved and participate in team meetings, therapy sessions, and other activities. The Family/guardian(s) are engaged in opportunities to gain knowledge and practice of what works in the program setting that can be transferred to the home and community environment. Every effort to include parents/guardians in the treatment process must be documented and the use of Telehealth video conferencing or telephone conferencing to facilitate family therapy sessions must be utilized for families/guardians that are unable to attend in person.
9. The transitional family home will have no more than two (2) minor youth in the home and no more than two (2) transitional youth in placement with them, unless a waiver is requested and approved by CAMHD. There shall be a minimum of one (1) adult at home whenever the youth is present. The agency shall ensure additional staff support as necessary to meet this requirement.
10. A QMHP or QMHP-supervised MHP provides weekly best practice family therapy services to the family of origin/guardian of each youth in placement as well as weekly best practice treatment to each youth in the program. If this QMHP is unable to provide the services, the Contractor shall ensure that there is coverage of duties so that the weekly services are continued.
11. Upon contract execution, all Contractors of Transitional Family Homes Services shall submit a list of families with all of the following information required on the TFH Profile Form (See Appendix B-15). The Contractor will provide updates to this list as they occur to the CAMHD Utilization Management Section of the Clinical Services Office that shall maintain the information in accordance with all confidentiality requirements.
12. The Contractor must have written policies and procedures and train staff on securing and storing medications; labeling and administering medications as ordered by a physician; recording medication administration, youth request for adjustment or change, and any side effects and notifying physician or advanced practice registered nurse immediately of possible side effects; and disposing of medications.
13. The Contractor must have written policies and procedures that ensure that TFH parents plan for the youth's regular medical and dental services, and keep the provider agency informed of any health problems or any changes that adversely affect the youth in TFH care.
14. The Contractor must have written policies and procedures, which specify its approach to positive behavior management and to best practice family therapy interventions. These procedures must

clearly delineate methods to be used for the training and implementation of these behavioral interventions.

15. The Contractor has established policies and procedures in place for preventing and managing crises effectively and efficiently through the direct interventions of its professional staff. Included in these procedures are descriptions of methods for handling emergency and crisis situations and triaging youth who require more intensive interventions. Request for police assistance or crisis hotline assistance is limited to situations of imminent risk of harm to self or others and requires consult with the program QMHP prior to, during, or after the call for assistance. The QMHP must follow-up to ensure the crisis situation has stabilized, debrief the incident and provide triage for youth needing more intensive interventions and documents their effort in the youth's chart.
16. When the provider has documented the clinical need for Ancillary support services of one-on-one staffing, the Contractor will request the assistance of the CAMHD Brach where the youth is registered to seek approval from the CAMHD Medical Director or designee for such staffing to help stabilize the youth.
17. The Contractor must perform a Summary Annual Evaluation for SEBD eligible youth in their care at the time the annual evaluation is due for youth who have received at least three (3) months of services from the Contractor. See Summary Annual Evaluation performance standard in Section II, Part C.
18. Eight (8) therapeutic passes are allowed per episode of care for each youth in the program to assist him/her in meeting the MHTP goals as defined in the general standards. These passes must be preapproved and used for therapeutic purposes and requires program to have contact with youth/family while on pass and debrief each pass.
19. Authorization of therapeutic passes beyond the threshold of eight (8) passes must undergo a Branch Utilization Review Team clinical review including reviewing documentation of previously issued therapeutic passes to ensure the passes are being utilized in accordance with the general standards prior to authorization.
20. Up to seven (7) consecutive bed hold days may be used to reserve the bed for a youth who is absent from the program for an acute admission or detainment in the Detention Home per episode. For youth on runaway status from the program, a maximum of three (3) consecutive days may be authorized to hold the bed per elopement.
21. Youth who are discharged from the program due to acute admission, detainment or runaway status, will be given priority readmission if admission is sought within a two (2) week period from discharge.
22. Please see Section I General Standards for additional clinical operation requirements:
    - E. CAMHD Co-Occurring Disorders;
    - G. Referral Process for Services:
        - Referral Acceptance;
    - H. CAMHD Continuity of Care;
    - I. Staffing;
    - J. Supervision;
    - K. Evaluation of Staff Performance;
    - L. Credentialing Requirements;
    - O. Service Quality;
    - P. Minimum Reporting Requirements;
    - Q. Risk Management:
        - Criminal, Child Abuse, and Background Screening;
        - Safety;
        - Restraints and Seclusion;
        - Sentinel Events and Incidents;
        - Police;
    - W. Bed Hold and Therapeutic Passes:

- Bed Hold;
- Therapeutic Pass.

Documentation

In addition to the documentation requirements listed in the general standards, these requirements must be followed. If the standards referenced here differ from those in the general standards, these documentation requirements will supersede the general standards.

1. A written treatment plan and current safety plan identifying targets of treatment with realistic goals, objective and discharge criteria linked to the admission behavior/symptoms will be submitted to the CAMHD Branch with ten (10) calendar days of admission. This documentation is required for any re-authorization of Transitional Family Home services
2. Individual and Family Therapy progress notes must document the course of treatment including a description of the interventions implemented, youth's response, and interpretation of the effectiveness of the intervention in addressing treatment plan goals/objectives. The note must include the date of treatment, length of the session, type of therapy provided, and specific treatment goals addressed. The notes shall be fully signed by the writer and supervisor if needed. The original note must be maintained in the agency's master youth file within 24 hours of service.
3. Transitional Family Home Parents shall maintain progress notes that provide a) daily attendance log indicating the youth's presence or absence from the home including absences of twenty-four (24) hours or more and b) provide daily progress notes as documentation of treatment progress, events or activities youth engaged in and developmental milestones achieved. These notes shall be fully dated and signed by the TFH parent, originals of which shall be placed in the agency's master youth file within seven (7) calendar days. These Transitional Family Home progress notes may be in the form of a checklist or written note.
4. Please see Section I General Standards for additional documentation requirements:
    - F. Service Planning:
        - Mental Health Treatment Plan including transition, safety, crisis and discharge planning. If any major changes occur in the course of treatment, the all components of the MHTP should be updated;
        - Discharge Summary;
    - N. Maintenance of Service Records:
        - Progress Notes;
    - P. Minimum Reporting Requirements:
        - Monthly Treatment and Progress Summary.

M. COMMUNITY-BASED RESIDENTIAL LEVEL III (CBR III)

Definition	Community-Based Residential programs provide twenty-four (24), seven (7) days a week treatment and supervision in a safe and therapeutic environment. This service provides youth with integrated service planning to address the behavioral, emotional and/or family problems, which prevent the youth from taking part in family and/or community life. Services are provided in the context of a comprehensive, multidisciplinary and individualized treatment plan based on the youth's clinical status and response to treatment. These programs are designed for those youth in need of a structured program that includes onsite education, diagnostic, and treatment services to enhance social skills and activities of daily living that cannot be provided in the community. The treatment primarily provides social, psychosocial, educational, and rehabilitative training and focuses on family/guardian reintegration. Action family/guardian involvement through family therapy is a key element of reintegration into home, school, and community life. Community-Based Residential programs may be specialized but all programs must treat mental health and substance abuse symptoms.
Services Offered	1. Time-limited evidenced-based treatment interventions, milieu-based programming, educational program, and activities designed to improve the functioning of the youth served with integrated service planning. 2. A normalized routine, an orderly schedule and therapeutic activities designed to improve behavior and functioning and support the development of daily living and independent living skills. 3. Opportunities for the youth to engage in age-appropriate structured recreational activities that support the development of positive social and interpersonal skills. 4. The treatment is family-centered and includes evidence-based interventions which must include weekly individual*, family* and group therapy* in support of safely transitioning the youth to his/her home/community. 5. Medication administration and monitoring. 6. On-site educational program that addresses the educational goals and objectives identified in the youth's IEP (if applicable). 7. Structured pre-vocational and vocational training activities as applicable. 8. Integrated individualized substance abuse counseling and education as indicated in youth's plan. 9. A documented treatment plan that identifies targets of treatment connected to realistic goals, objectives, and discharge criteria will be developed as part of the initial assessment process and includes information from the pre-admission meeting. A safety plan and larger crisis plan will also be developed to help identify interventions that are helpful

* See performance standard for service referenced.

	in addressing target behavior. The treatment plan will be evaluated and revised as necessary as treatment proceeds and will include the youth, family/guardian and other relevant treatment team members. a. The crisis plan component of the treatment plan includes a safety plan that identifies the youth's problematic behaviors, triggers and preferred means of calming or regaining control. The safety plan is an essential component of the larger crisis plan. The safety plan is part of the treatment plan that articulates the youth's self-calming interventions consistent with treatment targets, goals and objectives. The purpose of the safety plan is to help the youth regain control and avoid escalation into crisis. b. The discharge component of the treatment plan will be developed that specifies discharge criteria directly linked to behaviors/symptoms that resulted in the admission, time frame for discharge and any aftercare resources needed to transition the youth to a less restrictive level of treatment. 10. Treatment is designed to include all members of the family, not just the specific youth through regular family therapy and therapeutic home passes. 11. If the youth is involved in treatment with another behavioral health provider(s) then, with proper consent, the Community-Based Residential provider will notify any other behavioral health provider(s) of the youth's current status to ensure care is coordinated.
Admission Criteria	**All** of the following criteria must be met: 1. The identified youth meets at least one (1) Service Eligibility criteria for CAMHD (as described in General Standards, Section B, Access & Availability) is registered with a branch and has an assigned CC; 2. The youth must be between the ages of twelve (12) to eighteen (18) years of age; 3. Pre-admission meeting is held with the youth, family/guardian, CC and other relevant treatment members to identify treatment targets to be addressed in the treatment and safety plan and reflected in the realistic discharge criteria along with expectations of family/guardian involvement in the treatment process; 4. There is clinical evidence that the youth would be at risk to self or others if not in a residential treatment program as evidenced by one of the following: a. Severe functional impairment in at least three (3) domains of the youth life (i.e. home, school, community), b. Recent history (past two (2) months) of suicidal/homicidal ideation or severely impulsive or aggressive behavior, or c. Substance dependency as evidenced by cravings and/or withdrawal symptoms not so severe as to require hospitalized treatment;

	5. The CSP identifies this treatment and includes measurable objectives and discharge criteria for this service as established in the pre-admission meeting; 6. Documentation of an adequate trial of active treatment in a less restrictive level of care has been unsuccessful or there is clear and compelling documented clinical evidence that the youth is inappropriate for a trail of less restrictive treatment; 7. If the youth is diagnosed with a disruptive disorder, the documentation must include the use of one of the evidenced-based treatments (MST, FFT, MTFC) before seeking Community-Based Residential admission, unless there is clear and compelling documented clinical evidence that the youth is inappropriate for an evidenced-based treatment at this time; 8. Family/guardian agree to active involvement in treatment and planning meetings; and 9. Youth agrees to active involvement in treatment.
Initial Authorizations	Initial authorization may be up to thirty-one (31) units per month for a maximum of three (3) months with review and approval of the Branch Clinical Lead. Unit = one (1) day Level of Care = 30201
Reauthorization	Reauthorization may be up to thirty-one (31) units monthly for two months with review and approval of the Branch Clinical Lead. Request for continued stay reviews must be submitted no more than twenty-one (21) calendar days and no less than seven (7) calendar days before the end date of the initial authorization or any reauthorization. Unit = one (1) day Level of Care = 30201 Any request for reauthorization beyond five (5) months must be reviewed and approved by the Branch Utilization Review Team.
Continuing Stay Criteria	**All** of the following are met as determined by clinical review: 1. Youth is actively involved in treatment process and continues to meet admission criteria; 2. Progress in relation to specific targeted symptoms or impairments is clearly evident and can be described in objective terms, but the goals of treatment have not yet been achieved; 3. The documented treatment plan is individualized and appropriate to the youth's changing condition with realistic, measureable and achievable goals, objectives and discharge criteria directed toward stabilization to allow treatment to continue in a less restrictive environment. The treatment plan has been shared with the relevant team members; 4. The treatment plan includes a formulated discharge plan that is directly linked to the behaviors and/or symptoms that resulted in admission, and begins to identify post Community-Based Residential resources;

	5. There is documented evidence of active family involvement in treatment as required by the treatment plan at least weekly or there is active documented efforts being made to involve them unless it is documented as contraindicated; 6. There is a reasonable expectation that continued treatment will remediate the symptoms and/or behaviors or there is reasonable evidence that the youth will decompensate or experience relapse if services are discontinued; and 7. There is documented active attempt at coordination of care with relevant providers when appropriate. If coordination is not successful, then reason(s) are documented.
Discharge Criteria	Youth is no longer in need of or eligible for this service due to **one** (1) of the following criteria: 1. The youth's documented treatment plan goals and objectives have been substantially met; 2. Targeted symptoms/behaviors have abated in severity which no longer requires this level of care and the treatment can now be managed at a less intensive level of care; 3. The youth is no longer eligible for CAMHD services. As part of discharge, the CC will help coordinate transfer to appropriate treatment services in the least disruptive manner possible; 4. The youth/family no longer wants to participate in this service and revokes consent with no imminent danger to self or others; 5. The youth or parent/guardian is not participating in treatment or in following the program rules and regulations. The non-participation is of such a degree that treatment at this level of care is rendered ineffective, despite multiple (at least 3) documented attempts to address the non-participation issues; 6. Youth has demonstrated minimal or no progress toward treatment goals for a three (3) month period and appropriate modifications of the MHTP have been made and implemented with no significant success, and there is no reasonable expectation of progress at this level of care nor is it required to maintain the current level of functioning; or 7. Youth exhibits new symptoms and/or maladaptive behaviors which cannot be safely and effectively addressed through this service.
Service Exclusions	Community-Based Residential is not considered medically necessary and will not be authorized under the following conditions: 1. Not offered at the same time as any out-of-home services. 2. Not offered at the same time as Intensive In-Home, Multisystemic Therapy, Functional Family Therapy or Intensive Independent Living Skills services except where the youth will be discharged from Community Base Residential Level III within thirty (30) days of the referral. 3. Admission and/or continued stays which are solely for parent/guardian convenience and not related to the care and treatment of a youth.

	4. The admission is being used solely for of child protective services housing, as an alternative to incarceration within juvenile justice, as an alternative to specialized schooling or simply as respite.
Clinical Exclusions	Youth in need of immediate crisis stabilization because of active suicidal, homicidal, or psychotic behavior. Once stable, youth who otherwise meet the eligibility criteria may be referred into the program.

Staffing Requirements:
In addition to the staffing requirements listed in the general standards, these staff requirements must be followed. If the standards referenced here differ from those in the general standards, these staffing requirements will supersede the general standards.

1. The program has a QMHP who is knowledgeable in evidenced-based treatment. The QMHP is responsible for the treatment program and for those in care providing on-call coverage twenty-four (24) hours per day/seven (7) days a week.
2. The staff of the program must include:
   a. Licensed psychiatrist on staff or contracted consultant
   b. QMHP
   c. MHP
   d. Licensed registered nurse
   e. CSAC on staff or contracted consultant
   f. Paraprofessional residential counselor or child care workers
   g. Depending on the needs of the youth, the services of qualified professional and specialist in medicine, education, disabilities, speech, occupational and physical therapy, recreation and dietetics are available to the organization (either staff or contract).
3. A ratio of one (1) staff to four (4) youth is maintained at all times with a minimum of two (2) staff on duty per living unit. Staff is always in attendance whenever youth are present.
4. The overnight shift will maintain a staff to youth ratio of 1:6. Two staff must be on duty per living unit with one (1) staff awake during overnight shifts.
5. Additional personnel are available and called to duty in emergencies or are scheduled to meet any special needs during busy or more stressful periods such as for one-to-one (1:1) watches, new admissions, staff escort to emergency units, etc.
6. Staffing schedules shall reflect overlap in shift hours to accommodate the exchange of information for continuity of the youths' treatment, adequate numbers of staff reflective of the tone of the unit, appropriate staff gender mix, and the consistent presence and availability of a professional staff.
7. Youth that are ill or otherwise unable to attend school must be supervised by an available staff wherever the youth is located.
8. The teacher will have the assistance of at least one (1) behavioral support staff at all times in each classroom to provide necessary therapeutic redirection and interventions. In the event that staff needs to leave an educational activity for any length of time, the program provides additional staff to keep the ratio one to four (1:4).
9. CAMHD expects the Contractor to ensure the educational components of the program, including its teaching staff, meet all CAMHD CAMHPS requirements, even if this component is under a separate contract with the DOE.

10. The CSAC will provide integrated substance abuse counseling and education based on the individual needs of the youth. If a CSAC consultant is being utilized, the consultant must have input into the integrated substance abuse treatment components and be available for case presentation and assessment as needed.
11. The psychiatrist (staff or consultant) provides psychiatric services at intervals of at least one (1) face-to-face visit per month with each youth served. The Contractor must assure that each youth receives the needed psychiatric services through the agency psychiatrist or private practitioner if the youth is involved with one.
12. The psychiatrist is available for psychiatric emergencies, assessments, and consultation. The psychiatrist is on site for emergencies that merit face-to-face services within one (1) hour of the call for assistance, and make direct arrangements with a community hospital in the event that a youth is in need of possible hospitalization. The psychiatrist must follow-up to ensure the youth is admitted to the hospital and/or is available to debrief the situation if needed. This will be duly documented and kept on file at the program.
13. There is an established protocol for appropriate qualified medical coverage in the absence of the designated psychiatrist due to illness or vacation.
14. A licensed registered nurse in on staff to establish the system of operations for administering or supervising residents' medications, and medical needs or requirements, monitoring the residents' response to medications, tracking and attending to dental and medical needs, and training direct care staff to administer medication and proper protocols.

Clinical Operations

In addition to the clinical operation requirements listed in the general standards, these requirements must be followed. If the standards referenced here differ from those in the general standards, these clinical operation requirements will supersede the general standards.

1. Services are available twenty-four (24) hours a day, seven (7) days a week.
2. The program will not exceed eight (8) youths per unit.
3. The Contractor is to follow all applicable professional practice standards and ethical guidelines.
4. The Contractor must adhere to all applicable facility licensing requirements/regulations.
5. A preadmission meeting is required to obtain youth, family, CC, and other relevant team members' input into symptoms/behavior that are the targets of treatment and reflected in the goals and objectives in the MHTP. A safety plan will be developed that identifies effective youth self-calming interventions that will be incorporated into the youth's MHTP/crisis plan. The preadmission meeting also facilitates the development of the youth's discharge plan, including the development of concrete, realistic, measurable discharge criteria and projected timeframe for discharge.
6. The program will have an intake process that includes introducing the youth and family/guardian to the program, review and assessment of existing documentation to integrate into the treatment plan and safety plan within their milieu.
7. A treatment plan that identifies targets of treatment that are reflective of the youth's admission behaviors/symptom and the development of realistic goals, objectives, and discharge criteria will be developed within ten (10) days of admission as part of the initial assessment process. The treatment plan and safety plan component will be evaluated and revised as necessary as treatment proceeds and will include the youth, family/guardian and other relevant treatment team members.
8. As part the of the treatment planning, a discharge plan will be developed with the family that specifies realistic discharge criteria directly linked to behaviors/symptoms that resulted in the admission, time frame for discharge and any aftercare resources needed to transition the youth to a less restrictive level of treatment.
9. Planned use of community resources are appropriate when transitioning a youth back to the community, but require careful consideration of the risk assessment and treatment gains before

engaging in any step-down process. The use of community resources as attending public school must be documented in the discharge plan with specific timeframes and specific discharge criteria.

10. Families/guardians are actively involved and participate in team meetings, therapy sessions, and other activities. The Family/guardian(s) are engaged in opportunities to gain knowledge and practice of what works in the program setting that can be transferred to the home and community environment. Every effort to include parents/guardians in the treatment process must be documented and the use of Telehealth video conferencing or telephone conferencing to facilitate family therapy sessions must be utilized for families/guardians that are unable to attend in person.
11. The program actively engages the youth in planned, structured, therapeutic activities throughout the day, seven (7) days a week. There is a predictable and orderly routine that allows the youth to develop and enhance interpersonal skills and pro-social behaviors.
12. The physical setting is home-like and furnished appropriate to the youths' developmental age. The youth are encouraged to appropriately decorate and maintain their personal space.
13. Educational services are provided within the program and are guided by the youths' IEP, as appropriate. The program works with the DOE to insure adherence to the youths' IEP and appropriateness of the educational services being provided. The credits earned while in treatment will be accepted by the receiving school and counted towards school credits. The program also works closely with the DOE to insure a smooth transition back to the home school or alternative transition plans for those who are not returning to their home schools.
14. The Contractor has written policies and procedures that specify its approach to positive behavior management. These procedures must clearly delineate its methods for training and implementation for positive behavioral interventions.
15. the Contractor must have written policies and procedures and train staff on securing and storing medications; labeling and administering medications as ordered by a physician; recording medication administration, youth request for adjustment or change, and any side effects and notifying physician or advanced practice registered nurse immediately of possible side effects; and disposing of medications.
16. The Contractor has established policies and procedures in place for managing crises effectively and efficiently through the direct interventions of its professional clinical and medical staff. Included in these procedures are descriptions of methods for handling emergency situations and debriefing any crises that occur and triaging youth who require more intensive interventions. Request for police assistance or crisis hotline assistance is limited to situations of imminent risk of harm to self or others and requires consultation with program QMHP prior to, during, or after the call for assistance. The QMHP will determine if psychiatric interventions is needed and deploy the psychiatrist as needed. The QMHP or Psychiatrist must follow-up to ensure the crisis situation has stabilized, debrief the incident and provide triage for youth needing more intensive interventions and document their efforts in the youth's chart.
17. When the Contractor has documented the clinical need for Ancillary support services of one-on-one staffing, the Contractor will request the assistance of the CAMHD Branch where the youth is registered to seek approval from the CAMHD Medical Director or designee for such staffing to help stabilize the youth.
18. The Contractor must perform a Summary Annual Evaluation for SEBD eligible youth in their care at the time the annual evaluation is due for youth who have received at least three (3) months of services from the Contractor. See Summary Annual Evaluation performance standard in Section II, Part C.
19. Five (5) therapeutic passes are allowed per episode of care for each youth in the program to assist him/her in meeting the MHTP goals as defined in the general standards. These passes must be preapproved and used for therapeutic purposes and requires the program to have contact with youth/family while on pass and to debrief each pass.
20. Authorization of therapeutic passes beyond the threshold of five (5) passes must undergo a Branch Utilization Review Team clinical review including reviewing documentation of previously

issued therapeutic passes to ensure the passes are being utilized in accordance with the general standards prior to authorization.

21. Up to seven (7) consecutive bed hold days may be used to reserve the bed for a youth who is absent from the program for an acute admission or detainment in the Detention Home per episode. For youth on runaway status from the program, a maximum of three (3) consecutive days may be authorized to hold the bed per elopement.
22. Youth who are discharged from the program due to acute admission, detainment or runaway status will be given priority readmission if admission is sought within two (2) week period from discharge date.
23. Please see Section I General Standards for additional clinical operation requirements:
    - E. CAMHD Co-Occurring Disorders;
    - G. Referral Process for Services:
        - Out of Home Referrals;
        - Waitlist;
        - Access to services;
    - H. CAMHD Continuity of Care;
    - I. Staffing:
        - Orientation and Training and Training Requirements for CAMHD Contactors;
    - J. Supervision;
    - K. Evaluation of Staff Performance;
    - L. Credentialing Requirements;
    - M. Medication Monitoring / Tracking;
    - O. Service Quality;
    - P. Minimum Reporting Requirements;
    - Q. Risk Management:
        - Criminal, Child Abuse, and Background Screening;
        - Safety;
        - Restraints and Seclusion;
        - Sentinel Events and Incidents;
        - Police;
    - W. Bed Hold and Therapeutic Passes:
        - Bed hold;
        - Therapeutic Pass.

Documentation

In addition to the documentation requirements listed in the general standards, these requirements must be followed. If the standards referenced here differ from those in the general standards, these documentation requirements will supersede the general standards.

1. A written treatment plan identifying targets of treatment with realistic goals, objective and discharge criteria linked to the admission behavior/symptoms will be submitted to the CAMHD Branch with ten (10) days of admission. This documentation is required for any re-authorization of Community-Based Residential services
2. Progress notes should document the course of treatment including a description of the interventions implemented, youth's response, and interpretation of the effectiveness of the intervention in addressing treatment plan goals/objectives, date, length and type of therapy provided for each day the youth is in the program. The notes shall be fully dated and signed by the writer and supervisor if needed. Originals of which shall be maintained in the agency's master youth file within 24 hours of service.
    a. Individual/family/group therapy progress notes are place in the chart.

b. The psychiatrist ‘s must document at least one monthly face-to-face progress note in the youth’s chart
c. Every nursing contact, including medication administration must be documented and placed in the youth’s chart within 24-hours of service.
d. At least once a week progress notes by the responsible educational/recreational/occupational specialist are placed in the chart.

3. Please see Section I General Standards for additional documentation requirements:
   - F. Service Planning:
     - Mental Health Treatment Plan including safety, crisis and discharge planning. If any major changes occur in the course of treatment, the all components of the MHTP should be updated;
     - Discharge Summary;
   - N. Maintenance of Service Records:
     - Progress Notes;
   - P. Minimum Reporting Requirements:
     - Monthly Treatment and Progress Summary;
     - CAMHD Attendance and Encounter Records.

N. COMMUNITY-BASED RESIDENTIAL – LEVEL II (CBR II)

Definition	Community-Based Residential programs provide twenty-four (24) hour care and integrated evidence-based and best practice treatment that address the behavioral and emotional problems related to sexual offending, aggression or deviance, both adjudicated and non-adjudicated offenses, that prevent the youth from taking part in family and/or community life. These programs are designed for those youth who pose a moderate risk to the community and whose need can best be met in a structured program of small group living that includes educational, recreational, and occupational services. Community-Based Residential programs Level II provide support and assistance to the youth and the family to: 1) promote healthy sexual values and behaviors; 2) reduce and control deviant sexual arousal patterns; 3) help youth to develop victim empathy and appreciate feelings of others; 4) help youth accept full responsibility and be accountable for sexually abusive or antisocial behavior; 5) identify and change cognitive distortions or thinking errors that support or trigger offending; 6) develop and integrate relapse prevention strategies; 7) identify family dysfunction, issues, or problems that act to support minimization, denial, disruption of treatment, or trigger re-offending and; 8) provide management of other behavioral or emotional problems including trauma resulting from prior physical, sexual, and/or emotional abuse.
Services Offered	1. Evidence-based treatment interventions and a supportive milieu. 2. A normalized routine, an orderly schedule and therapeutic activities designed to improve behavior and functioning and support the development of appropriate daily living and independent living skills. 3. Opportunities for the youth to engage in age-appropriate structured and recreational activities that support the development of positive social and interpersonal skills. 4. Psychotherapies and other treatments that address youth in the target population defined above. 5. The treatment is family-centered and includes evidenced-based interventions which must include weekly individual*, family* and group therapy* in support of safely transitioning the youth to his/her home/community. 6. Medication administration and monitoring. 7. On-site educational program that addresses the educational goals and objectives identified in the youth's IEP as applicable. 8. Integrated individualized substance abuse counseling and education as indicated in the youth's plan. 9. Structured pre-vocational and vocational training activities as applicable.

* See performance standard for service referenced.

	10. A documented treatment plan that identifies targets of treatment connected to realistic goals, objectives, and discharge criteria will be developed as part of the initial assessment process and includes information from the pre-admission meeting. A safety plan and larger crisis plan will also be developed to help identify interventions that are helpful in addressing target behavior. The treatment plan will be evaluated and revised as necessary as treatment proceeds and will include the youth, family/guardian and other relevant treatment team members. a. The crisis plan component of the treatment plan includes a safety plan that identifies the youth's problematic behaviors, triggers and preferred means of calming or regaining control. The safety plan is an essential component of the larger crisis plan. The safety plan is part of the treatment plan that articulates the youth's self-calming interventions consistent with treatment targets, goals and objectives. The purpose of the safety plan is to help the youth regain control and avoid escalation into crisis. b. The discharge component of the treatment plan will be developed that specifies discharge criteria directly linked to behaviors/symptoms that resulted in the admission, time frame for discharge and any aftercare resources needed to transition the youth to a less restrictive level of treatment. 11. Treatment is designed to include all members of the family, not just the specific youth through regular family therapy and therapeutic home passes. 12. If the youth is involved in treatment with another behavioral health provider(s) then, with proper consent, the Community-Based Residential provider will notify any other behavioral health provider(s) of the youth's current status to ensure care is coordinated.
Admission Criteria	**All** of the following criteria are met: 1. The identified youth meets at least one (1) of the Service Eligibility criteria for CAMHD (as described in General Standards, Section B, Access & Availability) is registered with a Branch, and has an assigned CC; 2. The youth must be a male between the ages of twelve (12) and eighteen (18); 3. All of the following criteria are met: a. The youth has a severe emotional and/or behavioral disorder(s); b. The youth is know to engage in sexually deviant or aggressive behaviors with or without adjudication; c. Identified as need specialized treatment and poses a moderate risk to others; and d. Youth is able to participate in and benefit from the milieu and there is reasonable expectation that treatment will remediate symptoms and/or improve behaviors;

	4. Pre-admission meeting is held with the youth, family/guardian, CC and other relevant treatment members to identify treatment targets to be addressed in the treatment and safety plan and reflected in the realistic discharge criteria along with expectations of family/guardian involvement in the treatment process; 5. The CSP identifies this service and measurable objectives and discharge criteria for this service as established in the pre-admission meeting; 6. Documentation of an adequate trial of active treatment at a less restrictive level has been unsuccessful or there is clear and compelling documented clinical evidence that the youth is inappropriate for a trial of less restrictive services; 7. If the youth is diagnosed with a disruptive disorder, the documentation must include the use of one of the evidenced-based treatments (MST, FFT, MTFC) before seeking Community-Based Residential admission, unless there is clear and compelling documented clinical evidence that the youth is inappropriate for an evidenced-based treatment at this time; 8. Family/guardian agree to active involvement in treatment and planning meeting; and 9. Youth agrees to active involvement in treatment.
Initial Authorizations	Initial authorization may be up to thirty-one (31) units per month for a maximum of three (3) months with review and approval of the Branch Clinical Lead. Unit = one (1) day Level of Care = 30303
Reauthorization	Reauthorization may be up to thirty-one (31) units monthly for a maximum of three (3) months with approval of the Branch Clinical Lead. Request for continued stay reviews must be submitted no more than twenty-one (21) calendar days and no less than seven (7) calendar days before the end date of the initial authorization or any reauthorization. Unit = one (1) day Level of Care = 30303 Any request for reauthorization beyond ten (10) months must be reviewed and approved by the Branch Utilization Review Team.
Continuing Stay Criteria	**All** of the following criteria are met as determined by clinical review: 1. Youth is actively involved in treatment process and continues to meet admission criteria; 2. Progress in relation to specific targeted symptoms or impairments is clearly evident and can be described in objective terms, but goals of treatment have not yet been achieved; 3. The documented treatment plan is individualized and appropriate to the youth's changing condition with realistic, measurable and achievable goals, objectives and discharge criteria directed toward stabilization to allow treatment to

	continue in a less restrictive environment. The treatment plan has been shared with relevant team members; 4. The treatment plan includes a formulated discharge plan that is directly linked to the behaviors and/or symptoms that resulted in admission, and begins to identify appropriate post Community-Based Residential resources; 5. There is documented evidence of active family involvement in treatment as required by the treatment plan at least weekly or there is active documented effort being made to involve them unless it is documented as contraindicated; 6. There is reasonable expectation that continued treatment will remediate the symptoms and/or improve behaviors or there is reasonable evidence that the youth will decompensate or experience relapse if services are discontinued; and 7. There is a documented active attempt at coordination of care with relevant providers when appropriate. If coordination is not successful, the reason(s) are documented.
Discharge Criteria	Youth is no longer in need of or eligible for this service due to **one** (1) of the following criteria: 1. The youth's documented treatment plan goals and objectives have been substantially met; 2. Targeted symptoms/behaviors have abated in severity which no longer requires this level of care and the treatment can now be managed at a less intensive level of care; 3. The youth is no longer eligible for CAMHD services. As part of discharge, the CC will help coordinate transfer to appropriate treatment services in the least disruptive manner possible; 4. The youth/family no longer wants to participate in this service and revokes consent with no imminent danger to self or others; 5. The youth or parent/guardian is not participating in treatment or in following program rules and regulations. The non-participation is of such a degree that treatment at this level of care is rendered ineffective, despite multiple (at least 3) documented attempts to address non-participation issues; 6. Youth has demonstrated minimal or no progress toward treatment goals for a three (3) month period and appropriate modification of plan has been made and implemented with no significant success, and there is no reasonable expectation of progress at this level of care nor is it required to maintain the current level of function; or 7. Youth exhibits new symptoms and/or maladaptive behaviors which cannot be safely and effectively addressed through this service.
Service Exclusions	Community-Based Residential is not considered medically necessary and will not be authorized under the following conditions: 1. Not offered at the same time as any out-of-home services.

	2. Not offered at the same time as Intensive In-Home, Multisystemic Therapy, Function Family Therapy or Intensive Independent Living Skills service, except in cases where the youth has a planned discharge from Community-based Residential Level II within thirty (30) days of referral. 3. Admission and/or continued stays which are solely for parent/guardian convenience and not related to the care and treatment of a youth. 4. The admission is being used solely for of child protective services housing, as an alternative to incarceration within juvenile justice, as an alternative to specialized schooling or simply as respite.
Clinical Exclusions	Youth in need of immediate crisis stabilization because of active suicidal, homicidal, or psychotic behavior. Once stable, youth who otherwise meet the eligibility criteria may be referred into the program.

Staffing Requirements:
In addition to the staffing requirements listed in the general standards, these staff requirements must be followed. If the standards referenced here differ from those in the general standards, these staffing requirements will supersede the general standards.

1. Program must have documentation that staff providing services is trained and experienced in treatment of youth with sexually aggressive and/or deviant behavior. The documented training shall include topics such as offender characteristics, normal and deviant sexual development, offense cycle, overview of the major components of the treatment program, the role of families in treatment, staff issues such as personal issues/reactions/beliefs, dealing with manipulation, and stress and burnout prevention.
2. The program has a QMHP who is knowledgeable of evidenced-based treatment. The QMHP is responsible for the treatment program and for those in care providing on-call coverage twenty-four (24) hours per day/seven (7) days a week.
3. Staff providing therapy must be a licensed QMHP or QMHP-supervised MHP experienced in treating youth with sexual offending and mental health needs and have a minimum of three (3) years direct experience in this area.
4. Program staff will include:
   a. Licensed psychiatrist on staff or contracted consultant
   b. Licensed psychologist on staff or contracted consultant
   c. QMHP
   d. MHP
   e. Licensed Registered Nurse
   f. SCAC on staff or contracted consultant
   g. Paraprofessional residential counselors or childcare workers
   h. Depending on the needs of the youth, the services of qualified professionals and specialists in medicine, education, recreation, dietetics, etc., are available among the organization's personnel or through cooperative arrangements.
5. A staffing ratio of one (1) staff to four (4) youth is maintained at all times with a minimum of two (2) staff on duty per shift per living unit. Staff is always in attendance whenever youth are present.
6. Additional personnel are available and called to duty in emergencies or are scheduled to meet any special needs during busy or more stressful periods such as for one-to-one (1:1) watches, new admissions, staff escort to emergency units, etc.

7. Staffing schedules shall reflect overlap in shift hours to accommodate the exchange of information for the continuity of the youths' treatment, adequate numbers of staff reflective of the tone of the unit, appropriate staff gender mix, and the consistent presence and availability of a professional staff for role modeling.
8. Youth that are ill or otherwise unable to attend school must be supervised by an available staff wherever the youth is located.
9. The teacher will have the assistance of at least one (1) behavioral support staff at all times in each classroom to provide necessary therapeutic redirection and interventions. In the event that staff needs to leave an educational activity for any length of time, the program provides additional staff to keep the staff to student ratio at least one-to-four (1:4).
10. CAMHD expects the Contractor to ensure the educational components of the program, including its teaching staff, meet all CAMHD CAMHPS requirements, even if this component is under a separate contract with the DOE.
11. The CSAC will provider integrated substance abuse counseling and education based on the individual needs of the youth as documented in the treatment plan. If a CSAC consultant is being utilized, the consultant must have input into the integrated substance abuse treatment components and be available for case presentation and assessments as needed.
12. The psychiatrist (staff or consultant) provides psychiatric services at intervals of at least one (1) face-to-face visit a week. The Contractor must assure that each youth receives the needed psychiatric services either through the agency psychiatrist or private practitioner if the youth is involved with one.
13. The psychiatrist is available for psychiatric emergencies, assessments, and consultation. The psychiatrist is on-site for those emergencies that merit face-to-face services within one (1) hour of the call for assistance, and makes direct arrangements with a community hospital in the event a youth is in need of possible hospitalization. The psychiatrist must follow-up to ensure the youth is admitted to the hospital and/or is available to debrief the situation if needed. This will be duly documented and kept on file at the program.
14. There is an established protocol for appropriate, qualified medical coverage in the absence of the designated psychiatrist due to illness or vacation.
15. A licensed registered nurse is on staff to establish the system of operations for administering or supervising residents' medications, and medical needs or requirements, monitoring the residents' responses to medications, tracking and attending to dental and medical needs, and training direct care staff to medications and proper protocols.

Clinical Operations

In addition to the clinical operation requirements listed in the general standards, these requirements must be followed. If the standards referenced here differ from those in the general standards, these clinical operation requirements will supersede the general standards.

1. Services are available twenty-four (24) hours a day, seven (7) days a week.
2. The program will not exceed eight (8) youth.
3. The Contractor is to follow all applicable professional practice standards and ethical guidelines.
4. The Contractor must adhere to all applicable facility licensing requirements/regulations.
5. The Contractor is cognizant of community safety and risk issues and has written policies, procedures, and the mechanisms to effectively manage these issues.
6. The program is physically secure at all times. Twenty-four (24) hour supervision is provided to the youth. Behavioral/treatment plans are closely adhered to with consistency among the staff throughout the programming.
7. A preadmission meeting is required to obtain youth, family, CC, and other relevant team members' input into symptoms/behavior that are the targets of treatment and reflected in the goals and objectives in the MHTP. A safety plan will be developed that identifies effective youth self-calming

interventions that will be incorporated into the youth's MHTP/crisis plan. The preadmission meeting also facilitates the development of the youth's discharge plan, including the development of concrete, realistic, measurable discharge criteria and projected timeframe for discharge.

8. The Program has an intake process that includes introducing the youth and family to the program, review and assessment of existing documents to integrate into the treatment and safety plan within their milieu.
9. A treatment plan that identifies targets of treatment that are reflective of the youth's admission behaviors/symptom and the development of realistic goals, objectives, and discharge criteria will be developed within ten (10) days of admission as part of the initial assessment process. The treatment plan and safety plan component will be evaluated and revised as necessary as treatment proceeds and will include the youth, family/guardian and other relevant treatment team members.
10. As part the of the treatment planning, a discharge plan will be developed with the family that specifies realistic discharge criteria directly linked to behaviors/symptoms that resulted in the admission, time frame for discharge and any aftercare resources needed to transition the youth to a less restrictive level of treatment.
11. Planned use of community resources are appropriate when transitioning a youth back to the community, but require careful consideration of the risk assessment and treatment gains before engaging in any step-down process. The use of community resources as attending public school must be documented in the discharge plan with specific timeframes and specific discharge criteria.
12. The Program has the ability to conduct a risk assessment with respect to offending behavior as part of ongoing treatment and assessment. Risk assessments should inform the planning process regarding when, where and how an individual can or should be transitioned to a more or less intensive level of treatment. The assessment and substantial attainment of realistic treatment plan goals and objectives will indicate when treatment should end rather than relying on completion of all program components as criteria.
13. The Program must have the ability continue treatment for youth stepping down from a higher level of care. The Program must assess the youth's treatment gains and engage the youth in the treatment process at the youth's level of readiness and not at the beginning of the curriculum unless the youth's assessment indicates treatment must begin over.
14. The program actively engages youth in planned, structured, therapeutic activities throughout the day, seven (7) days a week. There is a predictable and orderly routine that allows youth to develop and enhance social, interpersonal and independent living skills.
15. The physical setting is home-like and furnished appropriate to the youths' developmental age. The youth are encouraged to appropriately decorate and maintain their personal space.
16. Families/guardians are actively involved and participate in team meetings, therapy sessions, and other activities. The family/guardian(s) are engaged in opportunities to gain knowledge and practice of what works in the program setting that can be transferred to the home and community environment. Every effort to include parents/guardians in the treatment process must be documented and the use of Telehealth video conferencing or telephone conferencing to facilitate family therapy sessions must be utilized for families who are unable to attend in person.
17. Educational services are provided within the program and are guided by the youth's IEP as applicable. The program works with the DOE to ensure appropriateness of the educational services and the credits earned while in treatment will be accepted by the receiving school and counted towards school credits. The program works closely with the DOE to ensure adherence to the youth's IEP and a smooth transition back to the home school or alternative transition plans for those who are not returning to their home schools.
18. The Contractor must have written policies and procedures and train staff on securing and storing medications; labeling and administering medications as ordered by a physician; recording medication administration, youth request for adjustment or change, and any side effects and notifying physician or advanced practice registered nurse immediately of possible side effects; and disposing of medications.

19. The Contractor has established policies and procedures in place for managing crises effectively and efficiently through the direct interventions of its professional clinical and medical staff. Included in these procedures are descriptions of methods for handling emergencies situations and debriefing any crises that occur and triaging youth who require more intensive interventions. Request for police assistance or crisis hotline assistance is limited to situations of imminent risk of harm to self or others and requires consult with program QMHP prior to, during, or after the call for assistance. The QMHP will determine if the psychiatric intervention is needed and deploy the Psychiatrist as needed. The QMHP or Psychiatrist must follow-up to ensure the crisis situation has stabilized, debrief the incident and provide triage for youth needing more intensive interventions and documents their effort in the youth's chart.
20. When the Contractor has documented the clinical need for Ancillary support services of one-on-one staffing, the Contractor will request the assistance of the CAMHD Branch where the youth is registered to seek approval from the CAMHD Medical Director or designee for such staff to help stabilize the youth.
21. The Contractor must perform a Summary Annual Evaluation for SEBD eligible youth in their care at the time the annual evaluation is due for youth who have received at least three (3) months of services from the Contractor. See Summary Annual Evaluation performance standard in Section II, Part C.
22. Five (5) therapeutic passes are allowed per episode of care for each youth in the program to assist him/her in meeting the MHTP goals as defined in the general standards. These passes must be preapproved and used for therapeutic purposes and requires the program to have contact with youth/family while on pass and to debrief each pass.
23. Authorization of therapeutic passes beyond the threshold of five (5) passes must undergo a Branch Utilization Review Team clinical review including reviewing documentation of previously issued therapeutic passes to ensure the passes are being utilized in accordance with the general standards prior to authorization.
24. Up to seven (7) consecutive bed hold days may be used to reserve the bed for a youth who is absent from the program for an acute admission or detainment in the Detention Home per episode. For youth on runaway status from the program, a maximum of three (3) consecutive days may be authorized to hold the bed per elopement.
25. Youth who are discharged from the program due to acute admission, detainment or runaway status will be given priority readmission if admission is sought within a two (2) week period from discharge date.
26. Please see Section I General Standards for additional clinical operation requirements:
    - E. CAMHD Co-Occurring Disorders;
    - G. Referral Process for Services:
        - Referral Acceptance;
    - H. CAMHD Continuity of Care;
    - I. Staffing:
    - J. Supervision;
    - K. Evaluation of Staff Performance;
    - L. Credentialing Requirements;
    - M. Medication Monitoring / Tracking;
    - O. Service Quality;
    - P. Minimum Reporting Requirements;
    - Q. Risk Management:
        - Criminal, Child Abuse, and Background Screening;
        - Safety;
        - Restraints and Seclusion;
        - Sentinel Events and Incidents;

    - Police;
  - W. Bed Hold and Therapeutic Passes:
    - Bed hold;
    - Therapeutic Pass.

Documentation

In addition to the documentation requirements listed in the general standards, these requirements must be followed. If the standards referenced here differ from those in the general standards, these documentation requirements will supersede the general standards.

1. A written treatment plan identifying targets of treatment with realistic goals, objective and discharge criteria linked to the admission behavior/symptoms will be submitted to the CAMHD Branch with ten (10) days of admission. This documentation is required for any re-authorization of Community-Based Residential services
2. Progress notes should document the course of treatment including a description of the interventions implemented, youth's response, and interpretation of the effectiveness of the intervention in addressing treatment plan goals/objectives, date, length and type of therapy provided for each day the youth is in the program. The notes shall be fully dated and signed by the writer and supervisor if needed. Originals of which shall be maintained in the agency's master youth file within 24 hours of service.
   a. Individual/family/group therapy progress notes are place in the chart.
   b. The psychiatrist 's must document at least one weekly face-to-face progress note in the youth's chart
   c. Every nursing contact, including medication administration must be documented and placed in the youth's chart within 24-hours of service.
   d. At least once a week progress notes by the responsible educational/recreational/occupational specialist are placed in the chart.
3. Please see Section I General Standards for additional documentation requirements:
   - F. Service Planning:
     - Mental Health Treatment Plan including safety, crisis and discharge planning. If any major changes occur in the course of treatment, the all components of the MHTP should be updated;
     - Discharge Summary;
   - N. Maintenance of Service Records:
     - Progress Notes;
   - P. Minimum Reporting Requirements:
     - Monthly Treatment and Progress Summary;
     - CAMHD Attendance and Encounter Records.
4. The written risk assessment using empirically supported risk assessment instruments is advised and may include collateral information such as:
   - The victim's statement;
   - Reports from the victim's therapist, when available;
   - Juvenile justice records;
   - Psychiatric records;
   - Information from previous placements; and
   - School reports.

In addition, the assessor conducts a clinical interview. If available, the family is interviewed for information pertinent to decision making. The results of risk assessment instruments are not the sole criteria for decision-making.

O. COMMUNITY-BASED RESIDENTIAL – LEVEL I (CBR I)

Definition	Community-Based Residential I program provides twenty-four (24) hour locked care and integrated evidence-based treatment that address the behavioral and emotional problems related to sexually aggressive or deviant offending behavior, that prevents the youth from taking part in family and/or community life. This program is designed for those youth who pose a high risk to the community and whose needs can best be met in a structured program of small group living that includes educational, recreational, and occupational services. High Risk Community-Based Residential program Level I provides support and assistance to the youth and the family to: 1) promote healthy sexual values and behaviors; 2) reduce and control deviant sexual arousal patterns; 3) help youth to develop victim empathy and appreciate feelings of others; 4) help youth display responsible and accountable behavior for sexually abusive or antisocial behavior with minimizing risk of reoffending and externalizing blame; 5) identify and change cognitive distortions or thinking errors that support or trigger offending ; 6) develop and integrate relapse prevention strategies; 7) identify family dysfunction, issues, or problems that act to support minimization, denial, disruption of treatment, or trigger reoffending and; 8) provide management of other behavioral or emotional problems.
Services Offered	1. Evidence-based treatment interventions and a supportive milieu. 2. A normalized routine, an orderly schedule and therapeutic activities designed to improve behavior and functioning and support the development of appropriate daily living and independent living skills. 3. Opportunities for the youth to engage in age-appropriate structured and recreational activities that support the development of positive social and interpersonal skills. 4. Psychotherapies and other treatments that address youth in the target population defined above. 5. The treatment is family-centered and includes evidenced-based interventions which must include weekly individual*, family* and group therapy* in support of safely transitioning the youth to his/her home/community. 6. Medication administration and monitoring. 7. On-site educational program that addresses the educational goals and objectives identified in the youth's IEP as applicable. 8. Integrated individualized substance abuse counseling and education as indicated in the youth's plan. 9. Structured pre-vocational and vocational training activities as applicable.

* See performance standard for service referenced.

	10. A documented treatment plan that identifies targets of treatment connected to realistic goals, objectives, and discharge criteria will be developed as part of the initial assessment process and includes information from the pre-admission meeting. A safety plan and larger crisis plan will also be developed to help identify interventions that are helpful in addressing target behavior. The treatment plan will be evaluated and revised as necessary as treatment proceeds and will include the youth, family/guardian and other relevant treatment team members. a. The crisis plan component of the treatment plan includes a safety plan that identifies the youth's problematic behaviors, triggers and preferred means of calming or regaining control. The safety plan is an essential component of the larger crisis plan. The safety plan is part of the treatment plan that articulates the youth's self-calming interventions consistent with treatment targets, goals and objectives. The purpose of the safety plan is to help the youth regain control and avoid escalation into crisis. b. The discharge component of the treatment plan will be developed that specifies discharge criteria directly linked to behaviors/symptoms that resulted in the admission, time frame for discharge and any aftercare resources needed to transition the youth to a less restrictive level of treatment. 11. Treatment is designed to include all members of the family, not just the specific youth through regular family therapy and therapeutic home passes. 12. If the youth is involved in treatment with another behavioral health provider(s) then, with proper consent, the Community-Based Residential provider will notify any other behavioral health provider(s) of the youth's current status to ensure care is coordinated.
Admission Criteria	**All** of the following criteria must be met: 1. The identified youth meets at least one (1) of the Service Eligibility criteria for CAMHD (as described in General Standards, Section B, Access & Availability) is registered with a Branch and has an assigned CC; 2. The youth must be a male between the ages of twelve (12) and eighteen (18); 3. All of the following criteria are met: a. The youth has a severe emotional and/or behavioral disorder(s), b. adjudicated for a sexual offense; c. Identified as needing specialized treatment as he presents a high risk to others; and d. Youth is able to participate in and benefit from the milieu and there is reasonable expectation that treatment will remediate symptoms and/or improve behaviors;

	4. Pre-admission meeting is held with the youth, family/guardian, CC and other relevant treatment members to identify treatment targets to be addressed in the treatment and safety plan and reflected in the realistic discharge criteria along with expectations of family/guardian involvement in the treatment process; 5. The CSP identifies this service and measurable objectives and discharge criteria for this service as established in the pre-admission meeting; 6. Documentation of an adequate trial of active treatment at a less restrictive level has been unsuccessful or there is clear and compelling documented clinical evidence that the youth is inappropriate for a trial of less restrictive services; 7. If the youth is diagnosed with a disruptive disorder, the documentation must include the use of one of the evidenced-based treatments (MST, FFT, MTFC) before seeking Community-Based Residential admission, unless there is clear and compelling documented clinical evidence that the youth is inappropriate for an evidenced-based treatment at this time; 8. Family/guardian agree to active involvement in treatment and planning meeting; and 9. Youth agrees to active involvement in treatment.
Initial Authorizations	Initial authorization may be up to thirty-one (31) units per month for a maximum of three (3) months with review and approval of the Branch Clinical Lead. Unit = one (1) day Level of Care = 30403
Reauthorization	Reauthorization may be up thirty-one (31) units monthly for a maximum of three (3) months with review and approval of the Branch Clinical Lead. Request for continued stay reviews must be submitted no more than twenty one (21) calendar days and no less than seven (7) calendar days before the end date of the initial authorization or any reauthorization. Unit = one (1) day Level of Care = 30403 Any request for reauthorization beyond ten (10) months must be reviewed and approved by the Branch Utilization Review Team.
Continuing Stay Criteria	**All** of the following criteria are met as determined by clinical review: 1. Youth is actively involved in treatment process and continues to meet admission criteria; 2. Progress in relation to specific targeted symptoms or impairments is clearly evident and can be described in objective terms, but goal of treatment have not yet been achieved;

	3. The documented treatment plan is individualized and appropriate to the youth's changing condition with realistic, measurable and achievable goals, objectives and discharge criteria directed toward stabilization to allow treatment to continue in a less restrictive environment. The treatment plan has been shared with relevant team members; 4. The treatment plan includes a formulated discharge plan that is directly linked to the behaviors and/or symptoms that resulted in admission, and begins to identify appropriate post Community-Based Residential resources; 5. There is documented evidence of active family involvement in treatment as required by the treatment plan at least weekly or there is active documented effort being made to involve them unless it is documented as contraindicated; 6. There is reasonable expectation that continued treatment will remediate the symptoms and/or improve behaviors or there is reasonable evidence that the youth will decompensate or experience relapse if services are discontinued; and 7. There is a documented active attempt at coordination of care with relevant providers when appropriate. If coordination is not successful, the reason(s) are documented.
Discharge Criteria	<u>Youth is no longer in need of or eligible for this service due to **one** (1) of the following criteria:</u> 1. The youth's documented treatment plan goals and objectives have been substantially met; 2. Targeted symptoms/behaviors have abated in severity which no longer requires this level of care and the treatment can now be managed at a less intensive level of care; 3. The youth is no longer eligible for CAMHD services. As part of discharge, the CC will help coordinate transfer to appropriate treatment services in the least disruptive manner possible; 4. The youth/family no longer wants to participate in this service and revokes consent with no imminent danger to self or others; 5. The youth or parent/guardian is not participating in treatment or in following program rules and regulations. The non-participation is of such a degree that treatment at this level of care is rendered ineffective, despite multiple (at least 3) documented attempts to address non-participation issues; 6. Youth has demonstrated minimal or no progress toward treatment goals for a three (3) month period and appropriate modification of plan has been made and implemented with no significant success, and there is no reasonable expectation of progress at this level of care nor is it required to maintain the current level of function; or 7. Youth exhibits new symptoms and/or maladaptive behaviors which cannot be safely and effectively addressed through this service.

Service Exclusions	Community-Based Residential is not considered medically necessary and will not be authorized under the following conditions: 1. Not offered at the same time as any out-of-home services. 2. Not offered at the same time as Intensive In-Home Intervention, Multisystemic Therapy, Functional Family Therapy, or Intensive Independent Living Skills, except where the youth will be transitioned out and into the identified service within thirty (30) days of the referral.
Clinical Exclusions	Youth in need of immediate crisis stabilization because of active suicidal, homicidal, or psychotic behavior. Once stable, youth who otherwise meet the eligibility criteria may be referred into the program.

Staffing Requirements:
In addition to the staffing requirements listed in the general standards, these staff requirements must be followed. If the standards referenced here differ from those in the general standards, these staffing requirements will supersede the general standards.

1. Program must have documentation that staff providing services is trained and experienced in treatment of youth with sexually aggressive or deviant offending behavior. The documented training shall include topics such as offender characteristics, normal and deviant sexual development, offense cycle, overview of the major components of the treatment program, the role of families in treatment, staff issues such as personal issues/reactions/beliefs, dealing with manipulation, and stress and burnout prevention.
2. The licensed psychiatrist or psychologist is responsible for the treatment program and for those in care, and provides on-call coverage twenty-four (24) hours per day, seven (7) days a week.
3. A QMHP who is experienced in evidence-based treatment supervises the treatment program and the residential staff.
4. Staff providing therapy must be a licensed QMHP or QMHP-supervised MHP experienced in treating youth with sexual offending and mental health needs and have a minimum of three (3) years direct experience in this area.
5. Program staff will include:
   a. Licensed psychiatrist on staff or contracted consultant
   b. Licensed psychologist on staff or contracted consultant
   c. QMHP
   d. MHP
   e. Licensed Registered Nurse
   f. CSAC on staff or contracted consultant
   g. Paraprofessional residential counselors or childcare workers
   h. Depending on the needs of the youth, the services of qualified professionals and specialists in medicine, education, recreation, dietetics, etc., are available among the organization's personnel or through cooperative arrangements.
6. A staffing ratio of one (1) staff to four (4) youth is maintained at all times with a minimum of two (2) staff on duty per shift per living unit. Staff is always in attendance whenever youth are present.
7. Additional personnel are available and called to duty in emergencies or are scheduled to meet any special needs during busy or more stressful periods such as for one-to-one (1:1) watches, new admissions, staff escort to emergency units, etc.

8. Staffing schedules shall reflect overlap in shift hours to accommodate the exchange of information for the continuity of the youths' treatment, adequate numbers of staff reflective of the tone of the unit, appropriate staff gender mix, and the consistent presence and availability of a professional staff for role modeling.
9. Youth that are ill or otherwise unable to attend school must be supervised by an available staff wherever the youth is located.
10. The teacher will have the assistance of at least one (1) behavioral support staff at all times in each classroom to provide necessary therapeutic redirection and interventions. In the event that staff needs to leave an educational activity for any length of time, the program provides additional staff to keep the staff to student ratio at least one-to-four (1:4).
11. CAMHD expects the Contractor to ensure the educational component of the program, including its teaching staff, meet all CAMHD CAMHPS requirements, even if this component is under a separate contract with the DOE.
12. The CSAC will provider integrated substance abuse counseling and education based on the individual needs of the youth as documented in the treatment plan. If a CSAC consultant is being used, the consultant must have input into the integrated substance abuse treatment components and be available for case presentation and assessments as needed.
13. The program staff psychiatrist or consultant provides psychiatric services at intervals of at least one (1) face-to-face visit a week. The provider must assure that each youth receives the needed psychiatric services either through the agency psychiatrist or private practitioner.
14. The psychiatrist is available for medical psychiatric emergencies, assessments, and consultation. The psychiatrist is on-site for those emergencies that merit face-to-face services within one (1) hour of the call for assistance, and makes direct arrangements with a community hospital in the event a youth is in need of possible hospitalization. The psychiatrist must follow-up to ensure the youth is admitted to the hospital and/or is available to debrief the situation if needed. This will be duly documented and kept on file at the program.
15. There is an established protocol for appropriate, qualified medical coverage in the absence of the designated psychiatrist due to illness or vacation.
16. A licensed registered nurse is on staff or contracted to establish the system of operations for administering or supervising residents' medications, and medical needs or requirements, monitoring the residents' responses to medications, tracking and attending to dental and medical needs, and training direct care staff to medications and proper protocols.

Clinical Operations

In addition to the clinical operation requirements listed in the general standards, these requirements must be followed. If the standards referenced here differ from those in the general standards, these clinical operation requirements will supersede the general standards.

1. Services are available twenty-four (24) hours a day, seven (7) days a week.
2. The Contractor is to follow all applicable professional practice standards and ethical guidelines.
3. The Contractor must adhere to all applicable facility licensing requirements/regulations.
4. The program must operate in a secure, locked facility. Twenty-four (24) hour supervision is provided to the youth. Behavioral/treatment plans are closely adhered to with consistency among staff throughout the programming.
5. The program is cognizant of community safety and risk issues and has policies, procedures, and the mechanisms to effectively manage these issues.
6. A preadmission meeting is required to obtain youth, family, CC, and other relevant team members' input into symptoms/behavior that are the targets of treatment and reflected in the goals and objectives in the MHTP. A safety plan will be developed that identifies effective youth self-calming interventions that will be incorporated into the youth's MHTP/crisis plan. The preadmission meeting

also facilitates the development of the youth's discharge plan, including the development of concrete, realistic, measurable discharge criteria and projected timeframe for discharge

7. The Program has an intake process that includes introducing the youth and family to the program, review and assessment of existing documents to integrate into the treatment and safety plan within their milieu.
8. A treatment plan that identifies targets of treatment that are reflective of the youth's admission behaviors/symptom and the development of realistic goals, objectives, and discharge criteria will be developed within ten (10) days of admission as part of the initial assessment process. The treatment plan and safety plan component will be evaluated and revised as necessary as treatment proceeds and will include the youth, family/guardian and other relevant treatment team members.
9. As part the of the treatment planning, a discharge plan will be developed with the family that specifies realistic discharge criteria directly linked to behaviors/symptoms that resulted in the admission, time frame for discharge and any aftercare resources needed to transition the youth to a less restrictive level of treatment.
10. Planned use of community resources are appropriate when transitioning a youth back to the community, but require careful consideration of the risk assessment and treatment gains before engaging in any step-down process. The use of community resources as attending public school must be documented in the discharge plan with specific timeframes and specific discharge criteria.
11. The Program has the ability to conduct a risk assessment with respect to offending behavior as part of ongoing treatment and assessment. Risk assessments should inform the planning process regarding when, where and how an individual can or should be transitioned to a more or less intensive level of treatment. The assessment and substantial attainment of realistic treatment plan goals and objectives will indicate when treatment should end rather than relying on completion of all program components as criteria.
12. Consistent with the current literature, CAMHD does not support the routine use of PPG in the treatment of adolescents who have sexually offended as it does not broadly increase treatment efficacy and adds risks associated with the invasive procedure. Such methods may be justified on a case by case basis.
13. The Program must have the ability continue treatment for youth stepping up from a lower level of care. The Program must assess the youth's treatment gains and engage the youth in the treatment process at the youth's level of readiness and not at the beginning of the curriculum unless the youth's assessment indicates treatment must begin over.
14. The program actively engages youth in planned, structured, therapeutic activities throughout the day, seven (7) days a week. There is a predictable and orderly routine that allows youth to develop and enhance interpersonal skills and behaviors.
15. The physical setting is home-like and furnished appropriate to the youths' developmental age. The youth are encouraged to appropriately decorate and maintain their personal space.
16. Families/guardians are actively involved and participate in team meetings, therapy sessions, and other activities. The family/guardian(s) are engaged in opportunities to gain knowledge and practice of what works in the program setting that can be transferred to the home and community environment. Every effort to include parents/guardians in the treatment process must be documented and the use of Telehealth video conferencing or telephone conferencing to facilitate family therapy sessions must be utilized for families who are unable to attend in person.
17. Educational services are provided within the program and are guided by the youth's IEP as applicable. The program works with the DOE to ensure appropriateness of the educational services and the credits earned while in treatment will be accepted by the receiving school and counted towards school credits. The program works closely with the DOE to ensure adherence to the youth's IEP and a smooth transition back to the home school or alternative transition plans for those who are not returning to their home schools.
18. The Contractor must have written policies and procedures and train staff on securing and storing medications; labeling and administering medications as ordered by a physician; recording

medication administration, youth request for adjustment or change, and any side effects and notifying physician or advanced practice registered nurse immediately of possible side effects; and disposing of medications.

19. The Contractor has established policies and procedures in place for managing crises effectively and efficiently through the direct interventions of its professional clinical and medical staff. Included in these procedures are descriptions of methods for handling emergencies situations and debriefing any crises that occur and triaging youth who require more intensive interventions. Request for police assistance or crisis hotline assistance is limited to situations of imminent risk of harm to self or others and requires consult with program QMHP prior to, during, or after the call for assistance. The QMHP will determine if the psychiatric intervention is needed and deploy the Psychiatrist as needed. The QMHP or Psychiatrist must follow-up to ensure the crisis situation has stabilized, debrief the incident and provide triage for youth needing more intensive interventions and documents their effort in the youth's chart.
20. When the Contractor has documented the clinical need for Ancillary support services of one-on-one staffing, the Contractor will request the assistance of the CAMHD Branch where the youth is registered to seek approval from the CAMHD Medical Director or designee for such staff to help stabilize the youth.
21. The Contractor must perform a Summary Annual Evaluation for SEBD eligible youth in their care at the time the annual evaluation is due for youth who have received at least three (3) months of services from the Contractor. See Summary Annual Evaluation performance standard in Section II, Part C.
22. Five (5) therapeutic passes are allowed per episode of care for each youth in the program to assist him/her in meeting the MHTP goals as defined in the general standards. These passes must be preapproved and used for therapeutic purposes and requires the program to have contact with youth/family while on pass and to debrief each pass.
23. Authorization of therapeutic passes beyond the threshold of five (5) passes must undergo a Branch Utilization Review Team clinical review including reviewing documentation of previously issued therapeutic passes to ensure the passes are being utilized in accordance with the general standards prior to authorization.
24. Up to seven (7) consecutive bed hold days may be used to reserve the bed for a youth who is absent from the program for an acute admission or detainment in the Detention Home per episode. For youth on runaway status from the program, a maximum of three (3) consecutive days may be authorized to hold the bed per elopement.
25. Youth who are discharged from the program due to acute admission, detainment or runaway status will be given priority readmission if admission is sought within a two (2) week period from discharge date.
26. Please see Section I General Standards for additional clinical operation requirements:
    - E. CAMHD Co-Occurring Disorders;
    - G. Referral Process for Services:
        - Referral Acceptance;
    - H. CAMHD Continuity of Care;
    - I. Staffing;
    - J. Supervision;
    - K. Evaluation of Staff Performance;
    - L. Credentialing Requirements;
    - M. Medication Monitoring / Tracking;
    - O. Service Quality;
    - P. Minimum Reporting Requirements;
    - Q. Risk Management:
        - Criminal, Child Abuse, and Background Screening;

  - Safety;
  - Restraints and Seclusion;
  - Sentinel Events and Incidents;
  - Police;
- W. Bed Hold and Therapeutic Passes:
  - Bed hold;
  - Therapeutic Pass.

Documentation

In addition to the documentation requirements listed in the general standards, these requirements must be followed. If the standards referenced here differ from those in the general standards, these documentation requirements will supersede the general standards.

1. A written treatment plan identifying targets of treatment with realistic goals, objective and discharge criteria linked to the admission behavior/symptoms will be submitted to the CAMHD Branch with ten (10) days of admission. This documentation is required for any re-authorization of Community-Based Residential services
2. Progress notes should document the course of treatment including a description of the interventions implemented, youth's response, and interpretation of the effectiveness of the intervention in addressing treatment plan goals/objectives, date, length and type of therapy provided for each day the youth is in the program. The notes shall be fully dated and signed by the writer and supervisor if needed. Originals of which shall be maintained in the agency's master youth file within 24 hours of service.
   a. Individual/family/group therapy progress notes are place in the chart.
   b. The psychiatrist 's must document at least one weekly face-to-face progress note in the youth's chart
   c. Every nursing contact, including medication administration must be documented and placed in the youth's chart within 24-hours of service.
   d. At least once a week progress notes by the responsible educational/recreational/occupational specialist are placed in the chart.
3. Please see Section I General Standards for additional documentation requirements:
   - F. Service Planning:
     - Mental Health Treatment Plan including safety, crisis and discharge planning. If any major changes occur in the course of treatment, the all components of the MHTP should be updated;
     - Discharge Summary;
   - N. Maintenance of Service Records:
     - Progress Notes;
   - P. Minimum Reporting Requirements:
     - Monthly Treatment and Progress Summary;
     - CAMHD Attendance and Encounter Records.
4. The written risk assessment using empirically supported risk assessment instruments is advised and may include collateral information such as:
   - The victim's statement;
   - Reports from the victim's therapist, when available;
   - Juvenile justice records;
   - Psychiatric records;
   - Information from previous placements; and
   - School reports.

In addition, the assessor conducts a clinical interview. If available, the family is interviewed for information pertinent to decision making. The results of risk assessment instruments are not the sole criteria for decision-making.

Written risk assessment and evaluation include the youth's offense history and specific, detailed recommendations about the setting, intensity of intervention, and the level of supervision necessary for treatment.

P. HOSPITAL-BASED RESIDENTIAL (HBR)

Definition	Hospital-Based Residential programs offer the highest level of intensive psychiatric and nursing intervention 24-hours per day, 7 days a week. Hospital-Base Residential service consists of a full range of diagnostic and therapeutic services offered with capability for emergency implementation of medical and psychiatric interventions. This in-patient treatment is designed to treat youth with severe behavioral health conditions that requires rapid stabilization of psychiatric symptoms. This service is required to provide intensive evaluation, medication titration, symptom stabilization and intensive brief treatment of up to sixty (60) days. The highly structured program also provides educational services, family therapy, and integrated service planning through a multi-disciplinary assessment of the youth and skilled milieu of services by trained staff. Services are provided in a locked unit of a licensed inpatient facility.
Services Offered	1. The program offers time-limited, intensive coordinated clinical services by a multi-disciplinary team. The services include assessment (including psychological testing), an intensive structured treatment milieu, an education program, therapy and activities designed to improve the functioning of the youth served with integrated service planning; 2. A child and adolescent psychiatrist is the lead clinician and provides documented observation, assessments and/or treatment at least two (2) times per week. These are individualized to meet the needs of the youth. a. Routine assessments are performed by the psychiatrist to effectively coordinate all treatment, manage medication trials and/or adjustments, minimize serious medication side effects, and provide medical management of all psychiatric and medical problems. b. A psychiatrist is available to direct any psychiatric emergencies. 3. The treatment is family-centered and includes evidence-based interventions which must include weekly individual*, family* and group therapy*, daily educational programming, and other planned activities appropriate to youth's needs in support of safely transitioning the youth to a less restrictive level of care. 4. The program provides therapeutic activities designed to improve behavior and functioning. A normalized routine and an orderly schedule to develop positive interpersonal skills and behaviors. 5. On-site educational program that addresses the educational goals and objectives identified in the youth's IEP as applicable. 6. Integrated individualized substance abuse assessment, counseling and education as indicated in the youth's plan. 7. A documented treatment plan that identifies targets of treatment connected to realistic goals, objectives, and

* See performance standard for service referenced.

	discharge criteria will be developed as part of the initial assessment process and includes information from the pre-admission meeting. The treatment plan will be evaluated and revised as necessary as treatment proceeds and the planning process will include the youth, family/guardian and other relevant treatment team members. a. The crisis plan component of the treatment plan includes a safety plan that identifies the youth's problematic behaviors, triggers and preferred means of calming or regaining control. The safety plan is an essential component of the larger crisis plan. The safety plan is part of the treatment plan that articulates the youth's self-calming interventions consistent with treatment targets, goals and objectives. The purpose of the safety plan is to help the youth regain control and avoid escalation into crisis. b. The discharge component of the treatment plan will be developed that specifies discharge criteria directly linked to behaviors/symptoms that resulted in the admission, time frame for discharge and any aftercare resources needed to transition the youth to a less restrictive level of treatment. 8. Treatment is designed to include all members of the family, not just the specific youth through regular family therapy and therapeutic home passes. 9. If the youth is involved in treatment with another behavioral health provider(s) then, with proper consent, the Hospital-Based Residential provider will notify any other behavioral health provider(s) of the youth's current status to ensure care is coordinated.
Admission Criteria	**All** of the following criteria must be met: 1. The identified youth meets at least one (1) of the Service Eligibility criteria for CAMHD (as described in General Standards, Section B, Access & Availability) is registered with a Branch and has an assigned CC; 2. Pre-admission meeting is held with the youth, family/guardian, CC and other relevant treatment members to identify treatment targets to be addressed in the treatment and safety plan and reflected in the realistic discharge criteria along with expectations of family/guardian involvement in the treatment process; 3. One of the following risk to self, others or property within the past 30 days, with continued risk that does not meet acute criteria must be met: a. Serious risk for self-injury, with an inability to guarantee safety, as manifested by any one of the following: i. Recent, serious, and dangerous suicide attempt with continued risk as demonstrated by poor impulse control or an inability to plan reliably for safety, ii. Current suicidal ideation with intent, realistic plan,

	and/or available means, iii. Recent self-injurious behavior that is severe and dangerous, or iv. Recent verbalization or behavior indicating high risk for severe injury; **or** b. Serious risk of injury to others as manifested by any of the following: i. Active plan, means, and lethal intent to inflict seriously injury to other(s), ii. Recent assaultive behaviors that indicate a high risk for recurrent and serious injury to others, iii. Recent and serious physically destructive acts that indicate a high risk for recurrence and serious injury to others, iv. Active hallucinations, bizarre or delusional behavior, or intoxication resulting in danger to self or others; 4. The youth requires intensive, coordinated multi-disciplinary psychiatric intervention within a locked therapeutic milieu; 5. The youth is able to participate in and benefit from the milieu and there is reasonable expectation that treatment will remediate symptoms and/or improve behaviors or there is reasonable evidence that the youth will decompensate or experience relapse if services are not initiated; 6. The CSP identifies this service, measurable objectives and, discharge criteria for this service as established in the pre-admission meeting; 7. Documentation of an adequate trial of active treatment at a less restrictive level has been unsuccessful or there is clear and compelling documented clinical evidence that the youth is inappropriate for a trial of less restrictive services; 8. If the youth is diagnosed with a disruptive disorder, the documentation must include the use of one of the evidenced-based treatments (MST, FFT, MTFC) before seeking Hospital-Base Residential admission, unless there is clear and compelling documented clinical evidence that the youth is inappropriate for an evidenced-based treatment. 9. Family/guardian agree to active involvement in treatment and planning meetings 10. Youth agrees to active involvement in treatment.
Initial Authorizations	Hospital-Based Residential requires pre-authorization at least two (2) calendar days prior to admission. The initial authorization may be up to fifteen (15) units with review and approval of the CAMHD Medical Director or designee. Unit = one (1) day Level of Care = 31101
Reauthorization	Reauthorization may be up to fifteen (15) units with review and approval of the CAMHD Medical Director or designee. Request for reauthorizations must be submitted at least seven (7) calendar days and no less than three (3) calendar days before the end date

	of initial authorization or any reauthorizations. Unit = one (1) day Level of Care = 31101
Continuing Stay Criteria	**All** of the following criteria are met as determined by clinical review: 1. Youth is actively involved in the treatment process and at least **one** of the following criteria must be met: a. Admitting symptoms/behaviors are present or new and/or preciously unidentified symptoms/behaviors have emerged that continue to meet admission criteria, b. Symptoms continue despite treatment or a reaction to treatment efforts (psychosocial or medication) has caused a regression or unexpected response, c. Symptoms and functional impairments continue despite modifications to treatment plan, or d. Progress in relation to specific targeted symptoms or impairments is clearly evident and can be described in objective terms, but goals of treatment have not yet been achieved; 2. The documented treatment and safety plan is individualized and appropriate to the youth's changing condition with realistic, measurable and achievable goals, objectives and discharge criteria directed toward stabilization to allow treatment to continue in a less restrictive environment. The treatment plan has been shared with relevant team members. 3. The treatment plan includes a formulated discharge plan that is directly linked to the behaviors and/or symptoms that resulted in admission, and begins to identify appropriate post-hospitalization resources. 4. There is documented evidence of active family involvement in treatment as required by the treatment plan at least weekly or there is active documented effort being made to involve them unless it is documented as contraindicated. 5. There is a documented active attempt at coordination of care with other relevant behavioral health providers when appropriate. If coordination is not successful, the reason(s) are documented. 6. There is reasonable expectation that continued treatment will remediate the symptoms and/or improve behaviors or there is reasonable evidence that the youth will decompensate or experience relapse if services are discontinued.
Discharge Criteria	Youth is no longer in need of or eligible for this service due to **one** (1) of the following criteria: 1. The individual's documented treatment plan goals and objectives have been substantially met; 2. The individual no longer meets admission criteria base on one of the following: a. Youth's condition has stabilized sufficiently to permit movement to a less restrictive treatment setting, b. Medication is titrated so that there is no longer a need for

	daily psychiatric/nursing oversight, or c. The youth no longer presents significant imminent risk of harm to self or others; 3. The youth is no longer eligible for CAMHD services. As part of discharge, the CC will help coordinate transfer to appropriate treatment services in the least disruptive manner possible; 4. Youth/family no longer want services and revoke consent with no imminent danger to self or others; 5. The youth or parent/guardian is not participating in treatment or in following program rules and regulations. The non-participation is of such a degree that treatment at this level of care is rendered ineffective, despite multiple (at least 3) documented attempts to address non-participation issues; or 6. Youth meets criteria for acute admission.
Service Exclusions	Hospital Based Residential is not considered medically necessary and will not be authorized under the following circumstances: 1. Not offered at the same time as any out-of-home services. 2. Not offered at the same time as any Intensive In-Home, Multisystemic Therapy, Function Family Therapy or Intensive Independent Living service, except in cases where the youth has a planned discharge from within thirty (30) days of referral. 3. Admissions and/or continued stays which are solely for parent/guardian convenience and not related to the care and treatment of the youth. 4. The admission is being used solely for convenience of child protective services housing, as an alternative to incarceration within juvenile justice, as an alternative to specialized schooling or simply as respite.
Clinical Exclusions	Youth in need of Acute Psychiatric Hospitalization.

Staffing Requirements:
In addition to the staffing requirements listed in the general standards, these staff requirements must be followed. If the standards referenced here differ from those in the general standards, these staffing requirements will supersede the general standards.

1. The services must be provided by a multi-disciplinary team knowledgeable in evidence-based treatment and comprised of the following with the stated ratios:
   a. Child and adolescent board certified psychiatrist 1:16;
   b. Licensed psychologist 1:16;
   c. Intensive Family/Systems Therapist Credentialed LCSW, LMFT, or APRN with specialty training in family 1:12;
   d. Rehabilitation Services Occupational Therapist (OT), Recreational Therapist (RT), and (Certified Substance Abuse Counselor (CSAC). Must include CSAC on staff 1:12;
   e. Nursing Staff:
      - 1st (day) shift 1:4;
      - 2nd (evening) shift 1:4;
      - 3rd (night) shift 1:6;

- One (1) R.N. minimum on each shift; and
- Minimum of two (2) nursing staff at all times.

2. Staff must be CAMHD credentialed as defined in the general standards.
3. CAMHD will delegate to the Hospital-Based Residential programs the credentialing of Qualified Mental Health Professionals only. The Contractor shall follow all CAMHD Credentialing Policies and Procedures related to the credentialing of Mental Health Professionals.
4. CAMHD expects the Contractor to ensure the educational components of the program, including its teaching staff, meet all CAMHD CAMHPS requirements, even if this component is under a separate contract with the DOE.
5. The program must be under the direction of a Hawaii licensed ABPN child and adolescent psychiatrist.
6. Psychiatric coverage is required and a psychiatrist must be a full-time position on the unit.
7. The program staff ratios need to be adjusted during periods when acuity is high or there is greater activity.
8. CAMHD Medical Director will approve a one to one (1:1) staffing ratio when required.
9. Staffing ratios must apply to CAMHD HBR population and cannot be counted at the same time for staffing of acute or other populations.
10. All staff must have an understanding of and ability to assess symptoms, medication issues, and behaviors in order to be able to identify psychiatric situations requiring additional psychiatric or nursing staff assistance.

Clinical Operations

In addition to the clinical operation requirements listed in the general standards, these requirements must be followed. If the standards referenced here differ from those in the general standards, these clinical operation requirements will supersede the general standards.

1. This service must operate within a locked unit of a licensed accredited hospital.
2. Services must be available twenty-four (24) hours a day, seven (7) days a week.
3. A preadmission meeting is required to obtain youth, family, CC, and other relevant team members' input into symptoms/behavior that are the targets of treatment and reflected in the goals and objectives in the MHTP. A safety plan will be developed that identifies effective youth self-calming interventions that will be incorporated into the youth's MHTP/crisis plan. The preadmission meeting also facilitates the development of the youth's discharge plan, including the development of concrete, realistic, measurable discharge criteria and projected timeframe for discharge.
4. Service delivery must be preceded by a thorough assessment of the youth and his/her family which includes preadmission information ensuring appropriate and effective treatment plan can be developed. A Preadmission meeting, Intake, Screening, and Assessment are provided to each youth prior to or upon admission.
5. Comprehensive multi-disciplinary assessments are performed within forty-eight (48) hours and include consideration of evidence-based treatment options, current DSM version assessments on Axes I – V, assessments of youth, family, community strengths/resources, and specific multi-modal treatment recommendations that target the specific bio-psycho-social factors that precipitated the admission and those that can be realistically targeted in treatment to maximize the opportunity for transition to a stable less restrictive level of care. The assessment also includes comprehensive evaluations of the youth's developmental milestones and course; family/systems and contextual influences current and past school, work, or other social role; ability to interact socially (including peer relationships); substance use/abuse; and a summary of all prior psychiatric hospitalizations, medication trials, and other mental health and /or psychosocial interventions including an assessment of their degree of success and/or failure.

6. Psychological testing will be provided as part of the comprehensive assessment to guide differential diagnosis of a mental health disorders.
7. A treatment plan that identifies targets of treatment that are reflective of the youth's admission behaviors/symptom and the development of realistic goals, objectives, and discharge criteria will be developed within ten (10) days of admission as part of the initial assessment process. The treatment plan and safety plan component will be evaluated and revised as necessary as treatment proceeds and will include the youth, family/guardian and other relevant treatment team members.
8. As part the of the treatment planning, a discharge plan will be developed with the family that specifies realistic discharge criteria directly linked to behaviors/symptoms that resulted in the admission, time frame for discharge and any aftercare resources needed to transition the youth to a less restrictive level of treatment.
9. Involvement of parent(s)/guardian(s) is/are essential in the provision of this service and is a necessary tool in enabling the youth to move to less restrictive services. Every effort to include parents in the treatment process must be documented and the use of Telehealth video conferencing or telephone conferencing to facilitate weekly family therapy sessions must be utilized for families who are unable to attend in person.
10. The provider has clear procedures for obtaining preauthorization for any youth requiring Hospital-Based Residential services. CAMHD requires a minimum of two (2) day notice prior to admission. No retro authorization will be issued if prior authorization was not sought by the provider.
11. The CC and Clinical Director will engage in ongoing collaboration with the HBR staff regarding the youth's status and adherence to the treatment plan. Specifically, the HBR staff must work collaboratively with the CC, Clinical Director, youth and family in the development of individualized treatment, discharge criteria and transition plans that are informed by current diagnostic and assessment information.
12. The HBR program has clear procedures for training, which specify its approach to positive behavior supports. These procedures must clearly delineate its methods of training and implementation for positive behavioral intervention.
13. The Contractor has established procedures/protocols in place for managing crises and effectively and efficiently through the direct interventions of its professional clinical and medical staff. Included in these procedures is the handling emergency and crisis situations that describe methods for triaging youth who require more intensive interventions.
14. When the Contractor has documented the clinical need for Ancillary support services of one-on-one staffing, the Contractor will request the assistance of the CAMHD Brach where the youth is registered to seek approval from the CAMHD Medical Director or designee for such staffing to help stabilize the youth.
15. The program provides continuous observation and safe control of behavior (i.e., adequate/appropriate suicidal/homicidal precautions) to protect the patient and others from harm, neglect, and/or serious abuse. These control measures should be used sparingly and under the direction of a child and adolescent psychiatrist. The use of restrictive forms of behavior control must follow JCAHO guidelines.
16. If the program provides services to a mixed population of those in a hospital setting and those who live at home with their families, it assures that all the resident and partial, acute, and hospitalization youth served receive a comprehensive program that meets their needs.
17. Therapeutic passes and bed holds do not exist for Hospital Residential Program. Youth are allowed planned therapeutic outings with family members, but these outings are not allowed to be overnight visits.
18. To ensure continuity of care, providers are required to provide discharge summaries as described in the general standards within seven (7) days of discharge. If hospital procedure prevent this timeline from being met, at a minimum the provider must have written discharge follow-up orders which include the youth's diagnosis at discharge, statement of status at discharge and any recommended

follow-up treatment which is given to the parent/guardian at discharge and sent to the referring CAMHD Branch.

19. Please see Section I General Standards for additional clinical operation requirements:
    - E. CAMHD Co-Occurring Disorders;
    - G. Referral Process for Services:
        - Referral Acceptance;
    - H. CAMHD Continuity of Care;
    - I. Staffing:
    - J. Supervision;
    - K. Evaluation of Staff Performance;
    - L. Credentialing Requirements;
    - M. Medication Monitoring / Tracking;
    - O. Service Quality;
    - P. Minimum Reporting Requirements:
        - CAMHD Admission Summary;
    - Q. Risk Management:
        - Criminal, Child Abuse, and Background Screening;
        - Safety;
        - Restraints and Seclusion;
        - Sentinel Events and Incidents;
        - Police.

Documentation

In addition to the documentation requirements listed in the general standards, these requirements must be followed. If the standards referenced here differ from those in the general standards, these documentation requirements will supersede the general standards.

1. A written admission summary that details the initial diagnosis, mental status, presenting problem, preliminary recommendations and further assessments/testing needed is submitted to the CAMHD Branch within five (5) days of admission.
2. A written treatment plan identifying targets of treatment with realistic goals, objective and discharge criteria linked to the admission behavior/symptoms will be submitted to the CAMHD Branch with ten (10) days of admission. This documentation is required for any re-authorization of Hospital Based Residential services.
3. Progress notes should document the course of treatment including a description of the interventions implemented, youth's response, and interpretation of the effectiveness of the intervention in addressing treatment plan goals/objectives, date, length and type of therapy provided.
    a. The psychiatrist's participation in support of the youth must be documented at least once a week in treatment team meetings and in progress and treatment notes at least three (3) times per week and at least two (2) of these weekly notes reflect face-to-face meetings with the youth.
    b. An RN's progress note showing participation in support of the youth and treatment plan must be documented at least daily for the first week and in each subsequent three (3) day period. Every nursing contact, including medication administration, must be documented and placed in the youth's chart within twenty-four (24) hours of service.
    c. At least one progress note is required per shift throughout the youth's stay.
    d. At least once a week progress notes by the responsible educational/recreational/occupational specialist are placed in the youth's chart.
    e. Weekly individual/family/group therapy progress notes are placed in the chart.
4. Please see Section I General Standards for documentation requirements including the following:
    - F. Service Planning:

  - Mental Health Treatment Plan including safety, crisis and discharge planning. If any major changes occur in the course of treatment, the all components of the MHTP should be updated;
  - Discharge Summary;
- N. Maintenance of Service Records:
  - Progress Notes;
- P. Minimum Reporting Requirements:
  - Monthly Treatment and Progress Summary;
  - CAMHD Attendance and Encounter Records.

SECTION II – PART C:

SUPPORT FOR EMOTIONAL AND BEHAVIORAL DEVELOPMENT PERFORMANCE STANDARD

A. MENTAL HEALTH EVALUATION

Definition	A Mental Health evaluation is a diagnostic assessment which provides needed information concerning a youth's psychosocial functioning. This evaluation may be performed: 1. As part of the initial data collected to determine eligibility for a youth referred for CAMHD services through the SEBD program; 2. To provide needed comprehensive clinical information about a youth enrolled in the SEBD program to assist with coordination of services and treatment planning; and/or 3. To provide focused clinical information addressing specific issues being considered by the youth's treatment team. This strengths-based assessment seeks to identify the needs of the youth in the context of his/her family, community, school and/or current treatment program. This service includes interviews, use of assessment instruments, written reports, and feedback to the youth and the caregiver(s). When a mental health professional determines that psychological testing is needed to address the team's concerns, a separate authorization for the testing may be requested and the Mental Health Evaluation report shall incorporate any psychological testing data collected (see Psychological Testing Standard, p.161).
Services Components	1. Complete the collection of data and write the evaluation report within 30 days of the referral and authorization: a. Document reason for referral, referral source, and presenting concerns based on information provided by the person who initiated the referral and/or the guardian; b. Interview the youth and perform a mental status exam. If desired, the Youth Mental Status Checklist (Appendix 2) may be included in the report; c. Interview the parent(s), guardian, or other caregiver; d. Assessors are requested to utilize Structured Diagnostic Interviews such as the Diagnostic Interview Schedule for Children (DISC), Children's Interview for Psychiatric Syndromes (CHIPS), Schedule for Affective Disorders and Schizophrenia for School Aged Children (K-SADS), or Anxiety Disorders Interview Schedule Child/Parent Version (ADIS-IV); e. Administer questionnaires to the youth/ and caregiver, utilizing instruments appropriate to the referral questions; f. Incorporate the results of any Psychological Testing if completed as part of this evaluation (see Psychological testing standard, p. 161); g. Summarize and synthesize the available information in a clinical formulation and provide current multi-axial diagnoses; h. Offer treatment recommendations, including suggestions regarding treatment modality, priority problems to be targeted, ways to utilize strengths, etc. Recommendations need to specify clinical interventions and techniques that

should be used to target the needs of the youth based on the clinical formulation;

i. Recommendations should describe the intensity of the interventions and restrictiveness of the treatment setting, but MAY NOT name specific levels of care, programs or organizations. (e.g. you may specify that a youth needs 24/7 line of sight supervision in a secure self-contained setting, etc., but do not specify "a locked residential program");
j. Recommendations should include treatment interventions that are provided in the least restrictive manner that will address the needs of the youth and family;
k. Assessors are to provide recommendations on how the youth's progress in treatment should be measured over time;
l. Assessors are to provide recommendations on how the family will be included in treatment to ensure family involvement and maximum treatment benefit;
m. Submit the signed typed report to the CC within thirty (30) days from the date of referral. If more time is needed, the provider must contact the CC with his/her reasons for the time extension requested;
n. The report must be approved by the Branch Clinical Lead before results/recommendations are shared with the youth/parents or other team members. If the report does not meet these standards, it will be returned to the evaluator for amendment; and
o. Upon approval of the report, a feedback session will be authorized and must be conducted with the youth and family/guardian within two (2) weeks. If, after extensive efforts are made (i.e. three attempts), the provider is not able to schedule a face-to-face feedback session, a phone feedback session is the alternative. Inability to contact the family within the specified time must be documented in the progress notes.

2. When performing an initial evaluation, assure that the following information is included in the report:
   a. Information regarding psychosocial, family psychiatric and medical histories, including prenatal and developmental history, and descriptions of the individual's educational, legal and substance abuse status, based on the guardian interview and from other available sources;
   b. Information regarding previous mental health and related services received including medications if any, and their impact. Note previous diagnoses given, and if possible, include dates of these services and diagnoses;
   c. Initial evaluations must include a global measure of psychopathology (e.g. Achenbach checklist, BASC) and a trauma screening measure (e.g. the UCLA PTSD Index); and
   d. A summary table of the Child and Adolescent Functional

	Assessment Scale (CAFAS) must be completed, based on the data collected.
Admission Criteria	**All** of the following criteria must be met: 1. One (1) of the following criteria are met: a. The youth is enrolled with a Branch, and is in the process of eligibility determination for the SEBD program; or b. The identified youth meets SEBD Eligibility criteria for CAMHD (See Appendix 7), is registered with a Branch and has an assigned CC; and 2. The treatment team determines there is a need for additional clinical information on the youth to inform coordination of services and treatment planning, and/or to address specific clinical questions.
Initial Authorizations	Initial authorization may be up to sixteen (16) units [four (4) hours] with approval of the Branch Clinical Lead. Procurement units reflect the time required for completing the review of data and assessment process. The units do not include report-writing time, as it is incorporated in the unit cost. There is no payment for travel time, wait time, no shows, or cancellations. Unit = fifteen (15) minutes Level of Care = 5101 May be authorized at the same time as Psychological Testing (see p. 161) when a comprehensive assessment is needed.
Reauthorizations	Once the completed report is approved by the Branch Clinical Lead, an additional four (4) units may be authorized for a feedback session with the youth/family. Unit = fifteen (15) minutes Level of Care = 5101
Discharge Criteria	**One** (1) of the following criteria is met: 1. The assessment sessions are completed, the typed report has been submitted to the CC, the report has been approved by the Branch Clinical Lead, and the feedback session has been held; or 2. The youth/family no longer wants to participate in this service and revokes consent in writing prior to the completion of the report[1].

[1] The youth/family may revoke consent to be evaluated anytime during the evaluation process, but once the assessment is complete they may only revoke consent for further release of the report beyond CAMHD. CAMHD as the owner of the report will keep a copy on file.

Service Exclusions	Mental Health Evaluation is not considered medically necessary and will not be authorized under the following circumstances: 1. No evaluation that is primarily for educational/vocational purposes. 2. No evaluations on youth whose results may be invalid due to the active influence of a substance, substance abuse withdrawal, or similar cause. 3. No evaluation that is primarily for legal purposes including custody evaluations, parenting assessments, or other court ordered testing. or 4. No evaluation for youth who have had a Mental Health Evaluation within the past 12 months and no new clinical questions have been raised.
Clinical Exclusions	Youth in need of immediate crisis stabilization because of active suicidal, homicidal, or psychotic behavior. Once stable, a youth who otherwise meets the eligibility criteria may be referred into this service;

Staffing Requirements

1. The provider of a Comprehensive Mental Health Evaluation shall meet one of the following requirements:
   a. Credentialed by CAMHD as a Qualified Mental Health Professional (QMHP);

   OR

   b. Credentialed by CAMHD as a Mental Health Professional (MHP);

   AND

   c. Working under the supervision of a QMHP. The supervisor is expected to review all data on which the current report is based, and participate in the interpretation of data and the development of the diagnoses and recommendations. The supervisor is to co-sign the report acknowledging supervisory responsibility for the assessment.
2. Assessors are to follow all applicable professional practice standards and ethical guidelines.

Clinical Operations

1. Direct service providers must coordinate with family/significant others and with other systems of care partners such as education, juvenile justice, child welfare as needed to provide service.
2. Direct service providers must obtain consents to be evaluated and consent to release information to CAMHD. In keeping with informed consent, providers are required to inform the parent/guardian (or the youth if over age 18) that they may revoke the consent to be evaluated anytime during the evaluation process, but once the report is complete they can only revoke the consent to further release beyond CAMHD. CAMHD as owner of the report will still maintain a copy in the file but will not release further. However, this may impact service delivery.

Documentation

1. Progress notes document all assessment activities.
2. The complete written report is submitted to the CC within thirty (30) days from date of referral and authorization.
3. The type written report includes:
   a. Date(s) of assessment and date of report;

b. Identifying information: youth name, date of birth (DOB), legal guardian, home school, grade level, IDEA status;
c. Reason for referral, including specific referral question(s);
d. Sources of information: including review of records, interviews, and assessment tools.
e. The report is signed by the assessor (and his/her supervisor when applicable) acknowledging responsibility for the assessment);
f. The report is typed; and
g. The written report includes all of the clinical information outlined in the standard, above.

4. Professionally recognized standards of ethical practices are followed in all assessments.

B. PSYCHOLOGICAL TESTING

Definition	Psychological testing is the use of one or more standardized measurements, instruments or procedures to observe or record human behavior, and requires the application of appropriate normative data for interpretation or classification. Psychological testing may be used to guide differential diagnosis in the treatment of mental health disorders and disabilities. Testing may also be used to provide an assessment of cognitive and intellectual abilities, personality and emotional characteristics, and Neuropsychological functioning. Psychological testing is performed as one component of a Mental Health Evaluation (see page 156), and it is not authorized as a stand-alone service. Psychological testing results must be integrated into the written Mental Health Evaluation report, and must be utilized to answer the referral question(s).
Services Components	1. Obtain the parent/legal guardian's informed consent to the testing. 2. Review any available past testing reports. 3. Conduct psychological testing with instruments appropriate to the referral questions and the age, functioning level and cultural background of the youth. 4. Score and interpret the test results. 5. Incorporate the test results into the Mental Health Evaluation report.
Admission Criteria	**All** of the following criteria are met: 1. One of the following criteria must be met: a. The youth is enrolled with a Branch, and is in the process of eligibility determination for the SEBD program; or b. The identified youth meets SEBD Eligibility criteria for CAMHD (See Appendix 7), is registered with a Branch and has an assigned CC; and 2. One of the following criteria must be met: a. The clinical team has determined that a mental health evaluation is needed to answer specific clinical questions or guide treatment planning; or b. A mental health professional has determined that psychological testing is needed to supplement interview information in order to address the referral question(s).
Initial Authorizations	Authorization may be up to sixteen (16) units with approval from the Branch Clinical Lead. No more than 24 units of psychological testing may be authorized per 12-month period. Procurement units reflect the time required for completing the review of data and assessment process. The units do not include report-writing time, as it is incorporated in the unit cost. There is no payment for travel time, wait time, no shows, or cancellations. Unit = fifteen (15) minutes Level of Care = 8101

Reauthorization	If under exceptional circumstances additional units are needed for assessment activities, the provider must submit justification for approval by the Branch Clinical Lead. Justification must include an explanation of why the standard authorization was insufficient as well as the details of the specific psychological tests to be utilized.
Discharge Criteria	**One** (1) of the following criteria is met: 1. The psychological testing procedures have been completed and the results have been incorporated into the Mental Health Evaluation report; or 2. The youth/family no longer wants to participate in this service and revokes consent in writing prior to the completion of the report[1].
Service Exclusions	Psychological testing is not considered medically necessary and will not be authorized under the following circumstances: 1. No authorization of testing that is primarily for educational/vocational purposes. 2. No authorization of extensive test battery given to all new clients regardless of individual need. 3. No authorization of testing if results may be invalid due to the active influence of a substance, substance abuse withdrawal, or similar cause. 4. No authorization of testing that is primarily for legal purposes including custody evaluations, parenting assessments, or other court ordered testing. 5. No authorization if requested tests are Experimental or Investigative, antiquated, or not validated. 6. No authorization of testing as a standalone service. Psychological Testing is authorized only when needed as part of a Mental Health Evaluation.
Clinical Exclusions	Youth in need of immediate crisis stabilization because of active suicidal, homicidal, or psychotic behavior. Once stable, youth who otherwise meet the eligibility criteria may be referred into this service.

Staffing Requirements

1. The provider of Psychological Testing must be a CAMHD credentialed QMHP meeting one (1) of the following requirements:
   a. Credentialed by CAMHD as a Qualified Mental Health Professional (QMHP);

   OR

   b. Credentialed by CAMHD as a Mental Health Professional (MHP);

[1] The youth/family may revoke consent to be evaluated anytime during the evaluation process, but once the assessment is complete they may only revoke consent for further release of the report beyond CAMHD. CAMHD as the owner of the report will keep a copy on file.

AND

c. Working under the supervision of a QMHP. The supervisor is expected to review all data on which the current report is based, and participate in the interpretation of data and the development of the diagnosis and recommendations. The supervisor is to co-sign the report acknowledging supervisory responsibility for the assessment.

2. Assessors are to follow all applicable professional practice standards and ethical guidelines.
3. Assessors are expected to provide only those services and utilize only those assessment instruments for which they have received adequate training. Most psychological testing must be performed only by a licensed psychologist or by a psychologist-in-training under the supervision of a licensed psychologist.

Clinical Operations

1. Direct service providers must coordinate with family/significant others and with other systems of care partners such as education, juvenile justice system, child welfare as needed to provide service.
2. Direct service providers must obtain consents to be evaluated and consent to release information to CAMHD. In keeping with informed consent, providers are required to inform the parent/guardian (or the youth if over age 18) that they may revoke the consent to be evaluated anytime during the evaluation process, but once the report is complete they can only revoke the consent to further release beyond CAMHD. CAMHD as owner of the report will still maintain a copy in the file but will not release further. However, this may impact service delivery.

Documentation

1. Progress notes document all assessment activities and describe the tests administered.
2. The complete typed Mental Health Evaluation including the incorporation of testing information is submitted to the CC within thirty (30) days from date of referral and authorization.

C. SUMMARY ANNUAL EVALUATION

Definition	This assessment is performed in order to describe the current status of the youth and his or her circumstances. It is performed yearly, when the Branch Clinical Lead determines that there are no clinical concerns that would call for a more in-depth Mental Health Evaluation to be performed instead. The service includes a brief assessment and report, with feedback to the youth and his/her parent(s) or guardian(s). CAMHD contracted providers that are currently providing services and that have known the youth for at least three (3) months shall provide the Summary Annual Assessment when it is due or as defined in the specific service standard.
Services Components	1. Obtain written informed consent before conducting evaluation. 2. Assessment activities may include a record review and brief interviews with the youth, family members or other collaterals as needed to complete the summary. 3. The CAFAS/PECFAS[1] information should be completed and included in the report. If the provider does not utilize these measures, then the provider should obtain the information from the CC. 4. The ASEBA checklist or other global measure of psychiatric symptoms (e.g. the BASC, Strengths and Difficulties Questionnaire) should be completed scored and interpreted, including Parent, Teacher, and youth self-report versions.[2] If the provider does not utilize these measures the provider should gather this information from the CC, whenever possible. 5. Summarize and synthesize the available information in a clinical formulation and provide current multi-axial diagnoses. 6. Offer treatment recommendations, including suggestions regarding treatment modality, priority problems to be targeted, ways to utilize strengths, etc. 7. Assure that the following information is included in the report: a. Significant changes and/or new information regarding developmental, medical, family, social, educational, legal, substance abuse, medical and psychiatric status, exposure to trauma and use of and reasons for psychotropic medications; b. Summary of treatment and progress over the past year; and c. Behavioral observations and mental status exam (a mental status checklist may be used, see Appendix 2); 8. Strength-based recommendations for any needed changes in the service plan should be included, with suggested goals and measurable objectives. Recommendations will conform to the following:

[1] The PECFAS is the appropriate instrument for children under the age of 6 years.

[2] There are times when the young adult or youth will refuse to complete the symptom checklist, or the parent or teacher is unavailable to complete their comparable versions or does not return the data within the timeline. This should be noted and discussed in the written evaluation report.

	a. Describe and address the needs of the youth and family and build upon strengths; b. Avoid specifying a particular service, program or eligibility status. For example, it should not be specified that youth needs "residential treatment." Instead, recommendations should focus on young adult or youth's particular needs, e.g. "the young adult or youth is in need of close supervision due to..."; and c. Include treatment interventions that are provided in the least restrictive manner that will address the needs of the young adult or youth and family. These may include therapeutic interventions or behavior support strategies; 9. Complete the collection of assessment data and submit the typed signed report to the CC for review by the Branch Clinical Lead within 21 days of the referral and authorization. 10. The report must be approved by the Branch Clinical Lead before results/recommendations are shared with the parents or other team members. If the report does not meet these standards, it will be returned to the evaluator for amendment. 11. Upon approval of the report, a feedback session will be authorized and must be conducted with the youth and family/guardian within two (2) weeks. If, after extensive efforts are made (i.e. three attempts), the provider is not able to schedule a face-to-face feedback session, a phone feedback session is the alternative. Inability to contact the family within the specified time must be documented in the progress notes.
Admission Criteria	<u>All of the following criteria are met</u>: 1. The identified youth meets SEBD Eligibility criteria for CAMHD (See Appendix 7), is registered with a Branch and has an assigned CC; and 2. Youth is in need of a Summary Annual Assessment as part of the comprehensive delivery of services.
Initial Authorizations	Authorization may be up to eight (8) units for evaluation activities by the Branch Clinical Lead, **if evaluation is not required as part of the services being provided.** Procurement units reflect the time required for completing the review of data and assessment process. The units do not include report-writing time, as it is incorporated in the unit cost. There is no payment for travel time, wait time, no shows, or cancellations. Unit = fifteen (15) minutes Level of Care = 5103
Re- Authorization	An additional four (4) units [one (1) hour] may be authorized for a feedback session after the report is approved by the Branch Clinical Lead.

Discharge Criteria	**One** (1) of the following criteria is met: 1. The assessment sessions are complete, the typed report has been submitted to the CC, the report has been approved by the Branch Clinical Lead and the feedback session has been held; 2. The youth/family no longer wants to participate in this service and revokes consent in writing prior to the completion of the report[3].
Service Exclusions	1. No evaluation that is primarily for educational/vocational purposes. 2. No evaluations on youth whose results may be invalid due to the active influence of a substance, substance abuse withdrawal, or similar cause. 3. No evaluation that is primarily for legal purposes including custody evaluations, parenting assessments, or other court ordered testing. 4. No evaluation for youth who have had a Mental Health Evaluation within the past 12 months and no new clinical questions have been raised. 5. Youth who have a Mental Health Evaluation current within one (1) year or those being referred for a more in-depth Mental Health Evaluation. 6. The service currently being provided is required to conduct the assessment as part of the services offered.
Clinical Exclusions	Youth in need of immediate crisis stabilization because of active suicidal, homicidal, or psychotic behavior. Once stable, a youth who otherwise meets the eligibility criteria may be referred into this service.

Staffing Requirements:

1. The provider of a Summary Annual Assessment shall meet one (1) of the following requirements:
   a. Credentialed by CAMHD as a Qualified Mental Health Professional (QMHP);

   OR

   b. Credentialed by CAMHD as a Mental Health Professional (MHP);

   AND

   c. Working under the supervision of a QMHP above. The supervisor is expected to review all data on which the current report is based, and participate in the interpretation of data and the development of the diagnoses and recommendations. The supervisor is to co-sign the report acknowledging supervisory responsibility for the assessment.
2. Assessors are to follow all applicable professional practice standards and ethical guidelines.

[3] The youth/family may revoke consent to be evaluated anytime during the evaluation process, but once the assessment is complete they may only revoke consent for further release of the report beyond CAMHD. CAMHD as the owner of the report will keep a copy on file.

Clinical Operations

1. Direct service providers shall collaborate with family/significant others and with other systems of care partners such as education, juvenile justice, child welfare as needed to provide coordinated services.
2. Direct service providers must obtain consents to be evaluated and consent to release information to CAMHD. In keeping with informed consent, providers are required to inform the parent/guardian (or the youth if over age 18) that they may revoke the consent to be evaluated anytime during the evaluation process, but once the report is complete they can only revoke the consent to further release beyond CAMHD. CAMHD as owner of the report will still maintain a copy in the file but will not release further. However, this may impact service delivery.

Documentation

1. Progress notes document all assessment activities.
2. The complete written report is submitted to the CC within thirty (30) days from date of referral and authorization.
3. The type written report includes:
   a. Date(s) of assessment and date of report;
   b. Identifying information: young adult or youth name, date of birth (DOB), legal guardian, home school, grade level, IDEA status;
   c. Reason for referral, including specific referral question(s);
   d. Sources of information: including review of records, interviews, and assessment tools;
   e. The report is signed by the assessor (and his/her supervisor when applicable) acknowledging responsibility for the assessment);
   f. The report is typed; and
   g. The written report includes all of the clinical information outlined in the standard, above.
4. Professionally recognized standards of ethical practices are followed in all assessments.

D. PSYCHIATRIC EVALUATION

Definition	Psychiatric diagnostic examination, specifically completed by an American Board of Psychiatry and Neurology Board Eligible/Certified Child Psychiatrist, includes history, mental status exam, physical evaluation or exchange of information with the primary physician, and disposition. This service is limited to an initial or follow-up evaluation for medically complex or diagnostically complex youth. This evaluation does not involve psychiatric treatment or medication management.
Services Components	1. Provider is responsible for contacting the youth and family to set up an appointment within one (1) week of referral and authorization. 2. The psychiatrist is expected to review all previously collected data prior to interviewing youth and family. 3. Psychiatric diagnostic evaluation of a patient includes examination of a patient or exchange of information with the primary physician, current mental health treatment providers, the child's school, other informants such as nurses or family members, and the preparation of a report. This baseline initial evaluation includes vital signs (blood pressure and pulse), height, weight, and neurological examination for abnormal movements (using a standardized format such as the AIMS) as well as mental status finding and other appropriate clinical measurements. A detailed history of previous medication trials and the results of such trials is a necessary component of service. The use of systematic and thorough diagnostic interviewing is encouraged. 4. A report is generated to document the nature, chronicity and severity of the disorder, DSM-IV diagnosis and Biopsychosocial recommendations regarding treatment interventions/medication. All recommendations shall be based on the presenting needs of the youth and family following evidence based practices and AACAP practice guidelines. 5. Complete the collection of assessment data and submit the typed signed report to the CC for review by the Branch Clinical Lead within thirty (30) days of the referral and authorization. The report will include the following: a. Behavioral observations and general presentation; b. Description and history of presenting problems; c. Description of current medical issues; d. Any ongoing substance use; e. Current medications; f. Complete Mental Status Examination including current CASII; g. Clinical formulation/Justification of Diagnoses (include severity and duration of diagnoses; for Rule/Out or Provisional diagnoses, explain what needs to occur to obtain a more definite diagnosis); h. Diagnostic impression: DSM-IV –5 Axes; i. Discussion of findings and recommendations with youth

	and family including fully explaining the benefits, risks, and alternatives; j. Reference of adherence to evidenced-based psychopharmacological practice; and k. Recommendations must include what benefits may or may not be expected from the medication in a manner measurable by client, family, and significant members of the treatment team, and how the medication may specifically assist any other concurrent treatments. 6. Assure that services are provided to youth in a safe, efficient manner in accordance with accepted standards and clinical practice. 7. The report must be approved by the Branch Clinical Lead before results/recommendations are shared with the parents or other team members. If the report does not meet these standards, it will be returned to the evaluator for amendment. 8. Upon approval of the report, a feedback session will be authorized and must be conducted with the youth and family/guardian within two (2) weeks. If, after extensive efforts are made (i.e. three attempts), the provider is not able to schedule a face-to-face feedback session, a phone feedback session is the alternative. Inability to contact the family within the specified time must be documented in the progress notes.
Admission Criteria	**All** of the following criteria are met: 1. The identified youth meets SEBD Eligibility criteria for CAMHD (See Appendix 7), is registered with a Branch and has an assigned CC; 2. The youth presents as a medically complex or diagnostically complex needing an initial or follow-up evaluation; and 3. Clinical case review with the Clinical Lead results in the determination that Psychiatric Diagnostic Evaluation may be beneficial to the client.
Initial Authorizations	Authorization may be to eight (8) units with approval from the Branch Clinical Lead. Procurement units reflect the time required for completing the review of data and assessment process. The units do not include report-writing time, as it is incorporated in the unit cost. There is no payment for travel time, wait time, no shows, or cancellations. Unit = fifteen (15) minutes Level of Care = 9101
Reauthorization	Reauthorization of an additional four (4) units may be approved by the Branch Clinical Lead if: 1. The evaluating psychiatrist identifies the need for additional authorization and notifies the CC for Branch Clinical Lead review and approval for one (1) of the following reasons: a. The youth's symptoms and/or maladaptive behaviors during the assessment interviews persist at a level of

	severity such that a complete evaluation has not been achieved; b. New symptoms, maladaptive behaviors, or medical complications have appeared during the interview process which requires an additional session to evaluate. An additional four (4) units [one (1) hour] may be authorized for a feedback session after the report is approved by the Branch Clinical Lead. Unit = fifteen (15) minutes Level of Care = 9101
Discharge Criteria	**One** (1) of the following criteria is met: 1. The Psychiatric Diagnostic Evaluation is complete, the typed report has been submitted to the CC, the report has been approved by the Branch Clinical Lead and the feedback session has been held with the youth/family; 2. Youth exhibits new symptoms or maladaptive behavior, which preclude the ability to safely or effectively complete the evaluation, and youth was referred to a more intensive level of care; or 3. The youth/family no longer wants to participate in this service and revokes consent with no imminent danger to self or others[1].
Service Exclusions	Psychiatric Evaluation is not considered medically necessary and will not be authorized under the following circumstances: 1. No evaluation that is primarily for educational/vocational purposes. 2. No evaluations on youth whose results may be invalid due to the active influence of a substance, substance abuse withdrawal, or similar cause. 3. No evaluation that is primarily for legal purposes including custody evaluations, parenting assessments, or other court ordered testing. 4. No evaluation for youth who have had a Psychiatric Evaluation within the past 12 months and no new clinical questions have been raised. 5. Not offered at the same time as Hospital Based Residential, Partial Hospitalization, and Community-based Residential Level I, II or III. 6. Psychiatric Diagnostic Evaluation is not a stand-alone service, but is part of a larger treatment plan.
Clinical Exclusions	Youth in need of immediate crisis stabilization because of active suicidal, homicidal, or psychotic behavior. Once stable, youth who otherwise meets the eligibility criteria may be referred into this service.

[1] The youth/family may revoke consent to be evaluated anytime during the evaluation process, but once the assessment is complete they may only revoke consent for further release of the report beyond CAMHD. CAMHD as the owner of the report will keep a copy on file.

Staffing Requirements

1. The provider of the Psychiatric Evaluation must be a CAMHD credentialed QMHP meeting the following:
   a. Must be a current Hawaii-licensed psychiatrist; board certified by the American Board of Psychiatry and Neurology (ABPN); and board certified or board eligible in Child/Adolescent Psychiatry.

Clinical Operations

1. Direct service providers must coordinate with family/significant others and with other systems of care partners such as education, juvenile justice, child welfare as needed to provide service.
2. Direct service providers must obtain consents to be evaluated and consent to release information to CAMHD. In keeping with informed consent, providers are required to inform the parent/guardian (or the youth if over age 18) that they may revoke the consent to be evaluated anytime during the evaluation process, but once the report is complete they can only revoke the consent to further release beyond CAMHD. CAMHD as owner of the report will still maintain a copy in the file but will not release further. However, this may impact service delivery.

Documentation

1. Progress notes document all assessment activities.
2. A complete typed report is due to the CC within thirty (30) days from date of referral and authorization. The report is generated to document the nature, chronicity, and severity of the disorder, and recommendations regarding medication. The report will include the following:
   a. Date(s) of assessment and date of report;
   b. Identifying information: youth name, DOB, legal guardian, home school, grade level, IDEA status;
   c. Reason for referral;
   d. Description and history of presenting problem;
   e. Sources of information: including review of records, interviews, and assessment tools;
   f. Substance use history;
   g. Description and history of presenting problems;
      i. Behavioral observations and general presentation;
      ii. Description and history of presenting problems;
      iii. Description of current medical issues;
      iv. Any ongoing substance use;
      v. Current medications;
      vi. Complete Mental Status Examination including CASII;
      vii. Clinical formulation/Justification of Diagnoses (including severity and duration of diagnoses; for Rule/Out or Provisional diagnoses, explain what needs to occur to obtain a more definite diagnosis);
      viii. Diagnostic impression: DSM-IV – 5 Axes;
      ix. Discussion of findings and recommendations with young youth and family including fully explaining the benefits, risks, and alternatives;
      x. Reference of adherence to evidenced-based psychopharmacological practice;
      xi. Recommendations must include what may or may not be expected from the medication in a manner measurable by client, family and significant members of the treatment team, and how the medication may specifically assist any other concurrent treatments; and
      xii. Report is signed by the assessor acknowledging responsibility for the assessment.

E. MEDICATION MANAGEMENT

Definition	The ongoing assessment of the youth's response to medication, symptom management, side effects, adjustment and/or change in medication and in medication dosage. Routine medication management is provided by an American Board of Psychiatry and Neurology Board Eligible/Certified Child Psychiatrist or a Licensed Advanced Practical Registered Nurse with prescription privileges.
Services Components	The provider must begin service within two (2) weeks of referral and authorization unless otherwise indicated by the CC. Medication Management includes the following tasks: 1. Assessing the youth's ongoing need for medication. 2. Reference and adherence to evidence-based psychopharmacological practices. 3. Determining overt physiological effects related to the medications used in the treatment of the youth's psychiatric condition, including side effects. 4. Determining psychological effects of medications used in the treatment of the youth's psychiatric condition using appropriate Rating Scales. 5. Monitoring compliance to prescription medication. 6. Determining impact of medication use on other components of the client's treatment. 7. Renewing prescription(s). 8. Appropriate monitoring of height, weight, vital signs, laboratory test, and neurological findings in a standardized format such as the AIMS when appropriate. 9. Direct observation and assessment as described above are necessary components of medication monitoring. 10. Full documentation of Informed Consent, including a signed description of potential benefits and possible side effects of the prescribed medication that must be placed in the clinical record prior to initiation of medication. The Consent must be signed and dated by the youth's parent(s) or legal guardian.
Admission Criteria	**All** of the following criteria are met: 1. The identified youth meets SEBD Eligibility criteria for CAMHD (See Appendix 7), is registered with a Branch and has an assigned CC; 2. The youth has been evaluated by a psychiatrist, and is deemed in need of medication to treat a behavioral, or other psychiatric disorder to prevent admission to a more restrictive or intensive service level; 3. Once prescribed medication, the youth requires ongoing monitoring for effectiveness and adverse reactions and renewing prescriptions at frequencies consistent with accepted practice. Ongoing routine management requires at least quarterly (every third month) monitoring and documentation; and 4. The CSP includes this service and measurable objectives for outcomes of this service prior to admission.

Initial Authorizations	Authorization may be up to twelve (12) units for the first three (3) months with approval of the Branch Clinical Lead Unit = fifteen (15) minutes Level of Care = 10101
Re-Authorization	Reauthorization is for six (6) units at least quarterly once medications are effectively regulating the affective, behavioral, thought disorder with approval of the Branch Clinical Lead. Ongoing medication monitoring requires discussion between CAMHD Branch Clinical and the contract provider regarding the patient's adjustment. Unit = fifteen (15) minutes Level of Care = 10101
Continuing Stay Criteria	**All** of the following are met as determined by clinical review: 1. Treatment planning is individualized and appropriate to the individual's changing condition with realistic and specific goals and objectives stated. Treatment planning should include active family or other support systems involvement unless contraindicated. 2. Progress in relation to specific symptoms or impairments is clearly evident and can be described in objective terms, but goal of treatment have not yet been achieved, or adjustments in the treatment plan to address lack of progress are evident 3. There is documented active discharge planning from the beginning of treatment; 4. There is a documented active attempt at coordination of care with relevant providers when appropriate. If coordination is not successful, the reason(s) are documented. 5. Unless contraindicated, family/guardian is actively involved in the treatment as required by the treatment plan, or there is active efforts being made and documented to involve them.
Discharge Criteria	Youth is no longer in need of or eligible for this service due to **one** of the following criteria: 1. The youth's symptoms have stabilized and all medications have been discontinued; 2. The youth and family no longer desire psychopharmacological interventions and have withdrawn consent; therefore, the medications have been discontinued; 3. Youth no longer meets eligibility criteria for SEBD program. As part of discharge, psychiatrist will coordinate the transfer of the youth to appropriate treatment services in the least disruptive manner possible; 4. The youth or parent is not participating in treatment and the non-participation is of such a degree that treatment at this level of care is rendered ineffective or unsafe, despite multiple (at least 3) documented attempts to address non-participation issues.

Service Exclusions	Medication Management is not considered medically necessary and will **not** be authorized under any the following circumstances: 1. Not offered at the same time as Hospital-Based Residential, Partial Hospitalization, Community-based Residential Levels I, II and III. 2. Medication Management is not a standalone service, but is part of a larger treatment plan and both youth and family are actively engaged in treatment.
Clinical Exclusions	Youth in need of immediate crisis stabilization because of active suicidal, homicidal, or psychotic behavior. Once stable, youth who otherwise meet the eligibility criteria may be referred for medication monitoring.

Staffing Requirements

The provider of the Medication Management must be a CAMHD credentialed QMHP meeting the following:

1. Must be a current Hawaii-licensed psychiatrist; board certified by the American Board of Psychiatry and Neurology (ABPN); and board certified or board eligible in Child/Adolescent Psychiatry; or
2. An Advanced Practice Registered Nurse (APRN) certified as a Psychiatric Clinical Nurse Specialist with a current Hawaii license/certification with prescription privileges.

Clinical Operations

1. Direct service providers must coordinate with family/significant others and with other systems of care such as education, juvenile justice system, child welfare as needed to provide service.
2. Direct service providers must obtain consents for treatment.
3. Service must be preceded by assessment of youth and culminating in a Mental Health Treatment Plan.

Documentation

1. A written mental health treatment plan identifying targets of treatment with realistic goals, objective and discharge criteria linked to the admission behavior/symptoms will be submitted to the CAMHD Branch with ten (10) days of admission. This documentation is required for any re-authorization of Medication Management services
2. A progress note must be placed within the patient's record within twenty-four (24) hours of the date of service.
3. The progress note must include all of the following information:
   a. Name of patient and CR#;
   b. The date, actual time and duration of the services rendered;
   c. The signature of the Psychiatrist who rendered the service;
   d. The place of service;
   e. Current medications the youth is taking including dosage and intervals when medication is to
   f. be administered;
   g. Side effects or adverse reactions the youth is experiencing;
   h. Conditions in which the youth is refusing or unable to take medications as ordered or if the youth is compliant in taking medications as prescribed;
   i. Whether the medication (s) is effectively controlling symptoms;
   j. Implications for other components of the client's treatment;
   k. Any results from laboratory testing; and

l. Results of any Rating Scales employed.

4. Please see Section I General Standards for additional documentation requirements:
   - F. Service Planning:
     - Discharge Summary;
   - P. Minimum Reporting Requirements:
     - Monthly Treatment and Progress Summary.

F. INDIVIDUAL THERAPY

Definition	Regularly scheduled face-to-face therapeutic services with a youth focused on improving his/her individual functioning. Individual therapy includes interventions such as cognitive-behavioral strategies, motivational interviewing, psycho-education of the youth, skills training, safety and crisis planning, and facilitating access to other community services and supports. Data are gathered regularly through self-monitoring, parent monitoring, or frequent administration of brief standardized measures in order to track progress toward meeting treatment goals. These therapy services are designed to promote healthy independent functioning and are intended to be focused and time-limited, with interventions reduced and discontinued as the youth and family are able to function more effectively. The usual course of treatment is six (6) to twenty-four (24) sessions or six (6) months. This service should be provided in conjunction with at least occasional family therapy sessions, and may include a brief "check-in" with the parent or guardian as part of the individual session.
Services Components	The provider must initiate services within two (2) weeks of referral and authorization unless otherwise indicated by the CC. Individual therapy includes <u>all</u> of the following: 1. Access and review all historical and assessment data available in the youth's clinical record. 2. Meet with the youth and relevant family member(s) in order to engage them in the treatment process and assess and identify relevant issues, needs, and goals for treatment planning. 3. Develop a written MHTP in collaboration with the youth and family. 4. Involve other relevant parties in treatment planning (such as schools, psychiatric providers, extended family members) as indicated and with the permission of the parent/guardian. Regular consultation sessions with the parent(s) or guardian(s) will be conducted as appropriate. 5. Conduct regular sessions to work with the youth to facilitate his/her ability to cope and function in a healthy manner through encouragement, support, evidenced-based interventions, psycho-education, skills training, and linkages to appropriate community services and resources. 6. Review interventions, needs, goals and progress with the youth and family monthly utilizing data regarding the major treatment targets. These data should be collected regularly via self-monitoring, parent monitoring, client/parent ratings, or brief standardized measures. 7. Adjust the treatment plan as needed based on the youth's progress. 8. Assist with discharge planning in collaboration with CC. This may include participation in transitional therapy sessions if the youth is transferred to a new level of care or new provider(s).

Admission Criteria	**All** of the following criteria are met: 1 The identified youth meets SEBD Eligibility criteria for CAMHD (See Appendix 7), is registered with a Branch and has an assigned CC; 2 The CSP includes this service and measurable objectives for outcomes of this service prior to admission; 3 The youth must be identified as needing extra support to increase coping skills and/or manage psychiatric illness; 4 There is reasonable expectation that the youth will benefit from this service, i.e., that therapy will remediate symptoms and/or improve functioning; 5 The youth is willing to participate in the service and the parent or guardian provides consent; and 6 If the youth is diagnosed with a disruptive behavior disorder the use of one of the evidenced-based treatments (MST, FFT, MTFC) has been documented before seeking Individual Therapy, unless there is clear and compelling documented clinical evidence that the youth is inappropriate for an evidenced-based treatment at this time.
Initial Authorizations	Initial authorization may be up to sixteen (16) units per month for three (3) months by the Branch Clinical Lead. The total time in individual therapy sessions is not expected to exceed three (3) hours per week. If more intensive services are needed past a temporary crisis, the youth/family should be referred to another more intensive service (i.e. MST, FFT or Intensive In-Home Therapy) If additional units are needed due to a temporary crisis, the Branch Clinical Lead will review and approve the request for additional units. Note: Telephone contacts and logistical planning/preparation are included in the unit cost. There is no payment for phone calls, travel time, wait time, no-shows, or cancellations. Unit = fifteen (15) minutes Level of Care = 7101
Reauthorization	Reauthorization may be up to sixteen (16) units per month for three (3) months with approval of the Branch Clinical Lead Authorization for continuation of services longer than six months must be reviewed and approved monthly by the Branch Utilization Management Team and Clinical Lead. Unit = fifteen (15) minutes Level of Care = 7101

Continuing Stay Criteria	**All** of the following criteria must be met as determined by clinical review: 1 Youth and family are actively involved in treatment; 2 There are regular and timely progress reviews and documentation of youth's response to interventions. Timely and appropriate modifications to the MHTP are made that are consistent with the youth's status; 3 An appropriate evidenced-base approach is being utilized and it is being provided with adequate fidelity to the model; 4 At least one (1) of the following criteria must be met: a. Youth is demonstrating progress, but goals have not yet been met, there is reason to believe that goals can be met with ongoing therapy services; b. Minimal progress toward treatment goals has been demonstrated, there is reason to believe that goals can be met with ongoing therapy services; c. Symptoms or behaviors persist at a level of severity that was documented upon admission, and the projected time frame for attainment of treatment goals has not been reached. However, a less restrictive service would not adequately meet the youth's needs, and other more intensive services are not considered appropriate at this time. The treatment plan has been adjusted and there is reason to anticipate improved response to the planned approaches; or d. New symptoms have developed, and the behaviors and the behavior can be safely and effectively addressed through individual therapy services with an updated treatment plan.
Discharge Criteria	Youth is no longer in need of or eligible for this service due to **one** (1) of the following: 1 Targeted symptoms and/or maladaptive behaviors have lessened to a level of severity which no longer requires this level of care as documented by substantial attainment of goals in the treatment plan; 2 Youth has demonstrated minimal or no progress toward treatment goals for a three (3) month period and appropriate modifications of plans have been made and implemented with no significant success, suggesting the youth is not benefiting from individual therapy services at this time; 3 Youth exhibits new symptoms and/or maladaptive behaviors which cannot be safely and effectively addressed through individual therapy services; 4 Youth or family is not willing to continue to participate in the services and revoke consent with no imminent danger to self or others; 5 The youth is no longer eligible for SEBD services. As part of discharge, the CC will help coordinate transfer to appropriate treatment services in the least disruptive manner possible;

Service Exclusions	Not offered at the same time as all any Out-of-Home service, Intensive In-Home Therapy or other Intensive Outpatient service (IILS, MST, FFT), unless the Individual Therapy is specialized and designed to address a specific and targeted problem area (e.g. sexual offending behavior) and is needed to augment other services.
Clinical Exclusions	Youth in need of immediate crisis stabilization because of active suicidal, homicidal, or psychotic behavior. Once stable, youth who otherwise meet the eligibility criteria may be referred to this service.

Staffing Requirements

In addition to the staffing requirement listed in the general standards, these staff requirements must be followed. If the standards referenced here differ from those in the general standards, these staffing requirements will supersede the general standards.

1. Individual Therapy services must be provided by personnel that meet one (1) of the following requirements:
   a. Credentialed by CAMHD as a Qualified Mental Health Professional (QMHP);

   OR

   b. Credentialed by CAMHD as a Mental Health Professional (MHP);

   AND

   c. Working under the supervision of a QMHP. The supervisor is expected to review all of the supervisees work in detail.
2. Providers are to follow all applicable professional practice standards and ethical guidelines.

Clinical Operations

In addition to the clinical operation requirements listed in the general standards, these requirements must be followed. If the standards referenced here differ from those in the general standards, these clinical operation requirements will supersede the general standards.

1. Direct service providers shall coordinate with family/significant others and with other systems of care partners such as education, juvenile justice system, child welfare as needed to provide service.
2. Please see Section I General Standards for additional clinical operation requirements:
   - D. Co-Occurring Disorders;
   - F. Referral Process for Services:
     - Referral Acceptance;
   - G. CAMHD Continuity of Care;
   - H. Staffing:
   - I. Supervision;
   - J. Evaluation of Staff Performance;
   - K. Credentialing Requirements;
   - N. Service Quality;
   - O. Minimum Reporting Requirements;
   - P. Risk Management:
     - Criminal, Child Abuse, and Background Screening;
     - Safety;

- Restraints and Seclusion;
- Sentinel Events and Incidents;
- Police.

Documentation

In addition to the documentation requirements listed in the general standards, these requirements must be followed. If the standards referenced here differ from those in the general standards, these documentation requirements will supersede the general standards.

1. A written treatment plan identifying targets of treatment with realistic goals, objective and discharge criteria linked to the admission behavior/symptoms will be submitted to the CAMHD Branch with ten (10) days of admission. This documentation is required for any reauthorization of Individual Therapy services.
2. Progress notes must document the course of treatment including a description of the interventions implemented, youth's response, and interpretation of the effectiveness of the intervention in addressing treatment plan goals/objectives. The note must include the date of service, the length of session, type of therapy provided and specific treatment goals addressed. The notes shall be fully dated and signed by the writer and supervisor if needed. The original note must be maintained in the agency's master youth file within 24 hours of service.
3. Please see Section I General Standards for additional documentation requirements:
    - F. Service Planning:
        - Mental Health Treatment Plan including safety, crisis and discharge planning. If any major changes occur in the course of treatment, the all components of the MHTP should be updated to reflect this;
        - Discharge Summary;
    - N. Maintenance of Service Records:
        - Progress Notes;
    - P. Minimum Reporting Requirements:
        - Monthly Treatment and Progress Summary;
        - CAMHD Attendance and Encounter Records.

G. GROUP THERAPY

Definition	Regularly scheduled, face-to-face therapeutic services for groups of three or more youth for the purpose of addressing symptoms/problems that prevent the development of healthy functioning in the home, school or community. These therapy services are designed to teach specific skills for addressing the symptoms associated with defined disorders or challenges, to provide support for the use of these skills and to provide psychoeducation about mental health issues. Group Therapy services are focused and time-limited. This service can include groups that address youths' needs utilizing a "multi-family group" format, in which the parents or guardian attend the group along with the youth.
Services Components	1. Group therapy services include regularly scheduled face-to-face interventions with three (3) or more youth that are designed to improve home and community functioning in the most natural and appropriate setting. A co-therapist is required for groups of six (6) or more. Groups are focused and time-limited youth may be discharged from the group as targeted goals are reached depending on the structure of the group. 2. Evidence-based treatments are utilized to structure groups. Group therapies may involve verbal instruction and education, modeling, coaching, role-playing, behavioral practice and other group-oriented experiential modalities. 3. Specific goals may include: symptom reduction; increased behavioral control; or improved communication, social, coping, anger management, emotion-regulation, problem solving, or other daily living skills. Interventions should be tailored to address identified youth needs. Services are designed to promote healthy independent functioning and to build upon the natural strengths of the youth and community. 4. Because of the research evidence that group therapy may have risks for disruptive behavior, delinquency, willful misconduct, substance abuse, and some types of eating disorders, particular care is to be used to assure that only appropriately structured, evidence-based treatments are used with these youth and that inappropriate youth are not included in groups. 5. The provider must begin contacting the youth/family within one (1) week of referral and initiate service within four (4) weeks of authorization, unless otherwise indicated by the CC. 6. Specific services include <u>all</u> of the following: a. Accessing and reviewing all historical and assessment data available in the youth's clinical record; b. Meeting with the youth and family to identify relevant issues, needs, and related goals to aid in treatment planning and determine whether a planned group will meet the needs of the youth; c. Participating in phone consultation with the CC to promote the integration of services across domains (home,

	community) as needed; d. Implementing, monitoring, and adjusting interventions as needed to address needs and accomplish objectives and goals of the group; and e. Conducting regular group sessions to work with the youth to address identified needs and goals per the treatment plan.
Admission Criteria	**All** of the following criteria are met: 1. The identified youth meets SEBD Eligibility criteria for CAMHD (See Appendix 7), is registered with a Branch and has an assigned CC; 2. The youth must be age seven (7) through twenty (20) years; 3. The CSP includes this service and measurable objectives for outcomes of this service prior to admission; 4. There is a reasonable expectation that the youth will benefit from this service, i.e., that group therapy will remediate symptoms and/or improve functioning that relate to improved ability to function in the most natural environment; and 5. Group therapy should not be used as a substitute for normalized community youth activities such as organized sports, scouting, paddling, etc. If the goals of the group potentially could be met through such activities, (for example: developing social skills and friendships, increasing self-esteem, gaining mastery), Group Therapy may be used only if there is documented evidence that the youth has not been able to be successful in this kind of normalized activity.
Initial Authorizations	Initial authorization of one (1) group sessions per week may be authorized for up to three (3) months by the Branch Clinical Lead. If sessions are one (1) hour, sixteen (16) units per month can be authorized. If sessions are two (2) hours, thirty-two (32) units per month can be authorized. Note: Billable time is limited to time spent in face-to-face therapy with the youth**.** Telephone contacts and logistical planning/ preparation are included in the unit cost. There is no payment for travel time, wait time, no-shows, or cancellations. In the case of multi-family groups, providers can bill for the youth only. Unit = fifteen (15) minutes Level of Care = 7102
Reauthorization	Reauthorization may be up to a three (3) additional months with approval of the Branch Clinical Lead. The units authorized will depend on the planned length of each group session. Any request for authorization beyond six (6) months must be approved by Branch Utilization Review Team and Clinical Lead.

	Unit = fifteen (15) minutes Level of Care = 7102
Continuing Stay Criteria	**All** of the following criteria must be met: 1. The evidence-based group therapy program has not been completed; 2. Youth actively involved in treatment; 3. There are regular and timely assessments and documentation of the youth's response to the treatment; 4. At least one (1) of the following criteria must be met: a. Youth is demonstrating progress, but goals have not yet been met, and there is reason to believe that goals can be met with ongoing therapy services; b. Minimal progress toward treatment goals has been demonstrated, and there is reason to believe that goals can be met with ongoing therapy services; c. Symptoms or behaviors persist at a level of severity that was documented upon admission, and the projected time frame for attainment of treatment goals has not been reached. However, a less restrictive service would not adequately meet the youth's needs, and other more intensive services are not considered appropriate at this time. The treatment plan has been adjusted and there is reason to anticipate improved response to the planned approaches; or d. New symptoms have developed, and the behaviors can be safely and effectively addressed through therapy services with an updated treatment plan.
Discharge Criteria	Youth is no longer in need of or eligible for this level of service due to **one** (1) of the following: 1. The evidenced based, group therapy program has been completed; 2. Targeted symptoms and/or maladaptive behaviors have abated to a level of severity which no longer requires this level of care as documented by substantial attainment of goals; 3. Youth has demonstrated minimal or no progress toward treatment goals for a three (3) month period**,** suggesting the youth is not benefiting from group therapy services at this time; 4. Youth exhibits new symptoms which cannot be safely and effectively addressed through group therapy services; 5. Youth is no longer willing to participate in this service; or 6. The youth is no longer eligible for SEBD services. As part of discharge, the CC will help coordinate transfer to appropriate treatment services in the least disruptive manner possible.
Service Exclusions	Not offered at the same time as all any Out-of-Home service, Intensive In-Home Therapy or other Intensive Outpatient service (IILS, MST, FFT), unless the Group Therapy is specialized and designed to address a specific and targeted problem area (e.g. sexual offending behavior) is needed to augment other services.

Clinical Exclusions	1. Youth in need of immediate crisis stabilization because of active suicidal, homicidal or psychotic behavior. Once stable, youth who otherwise meet the eligibility criteria may be referred into this service; 2. Because group interventions pose risks for youth with disruptive behavior, delinquency, willful misconduct, substance abuse, and some types of eating disorders, youth with these diagnoses should be offered only well-structured, evidence-based group interventions and only when the potential benefits are judged to outweigh the potential risks (e.g. a highly structured coping skills group for youth who engages in self-harm behavior when upset and who also shows conduct problems).

Staffing Requirements

In addition to the staffing requirements listed in the general standards, these staff requirements must be followed. If the standards referenced here differ from those in the general standards, these staffing requirements will supersede the general standards.

1. Family Therapy services must be provided by personnel that meet <u>one</u> (1) of the following requirements:
   a. Credentialed by CAMHD as a Qualified Mental Health Professional (QMHP);

   OR

   b. Credentialed by CAMHD as a Mental Health Professional (MHP);

   AND

   c. Working under the supervision of a QMHP. The supervisor is expected to review all of the supervisees work in detail.
2. A co-therapist is required for groups of six (6) or more.
3. Providers are to follow all applicable professional practice standards and ethical guidelines.

Clinical Operations

In addition to the clinical operation requirements listed in the general standards, these requirements must be followed. If the standards referenced here differ from those in the general standards, these clinical operation requirements will supersede the general standards.

1. Direct service providers shall coordinate with family/significant others and with other systems of care partners such as education, juvenile justice system, child welfare as needed to provide service.
2. Please see Section I General Standards for additional clinical operation requirements:
   - D. Co-Occurring Disorders;
   - F. Referral Process for Services:
     - Referral Acceptance;
   - G. CAMHD Continuity of Care;
   - H. Staffing:
   - I. Supervision;
   - J. Evaluation of Staff Performance;
   - K. Credentialing Requirements;
   - N. Service Quality;
   - O. Minimum Reporting Requirements;
   - P. Risk Management:
     - Criminal, Child Abuse, and Background Screening;

- Safety;
- Restraints and Seclusion;
- Sentinel Events and Incidents;
- Police

Documentation

In addition to the documentation requirements listed in the general standards, these requirements must be followed. If the standards referenced here differ from those in the general standards, these documentation requirements will supersede the general standards.

1. A written treatment plan identifying targets of treatment with realistic goals, objective and discharge criteria linked to the admission behavior/symptoms will be submitted to the CAMHD Branch with ten (10) days of admission. This documentation is required for any reauthorization of Group Therapy services.
2. Progress notes must document the course of treatment including a description of the interventions implemented, youth's response, and interpretation of the effectiveness of the intervention in addressing treatment plan goals/objectives. The note must include the date of service, the length of session, type of therapy provided and specific treatment goals addressed. The notes shall be fully dated and signed by the writer and supervisor if needed. The original note must be maintained in the agency's master youth file within 24 hours of service.
3. Please see Section I General Standards for additional documentation requirements:
    - F. Service Planning:
        - Mental Health Treatment Plan including safety, crisis and discharge planning. If any major changes occur in the course of treatment, the all components of the MHTP should be updated to reflect this;
        - Discharge Summary;
    - N. Maintenance of Service Records:
        - Progress Notes;
    - P. Minimum Reporting Requirements:
        - Monthly Treatment and Progress Summary;
        - CAMHD Attendance and Encounter Records

H. FAMILY THERAPY

Definition	Regularly scheduled face-to-face interventions with a youth and his/her family, designed to improve family functioning and treat the youth's emotional challenges. The family therapist helps the youth and family increase their use of effective coping strategies, healthy communication, and constructive problem-solving skills. Data are gathered regularly through self-monitoring, parent monitoring, client/parent ratings or frequent administration of brief standardized measures in order to track progress toward meeting treatment goals. Family Therapy sessions may be held in the course of on-going Individual Therapy with the youth in order to provide opportunities for the therapist to consult with the parent(s) or guardian(s) and review progress toward goals either conjointly with the youth present or separately without the youth present. Family Therapy services are designed to be time-limited with interventions reduced and then discontinued as the youth and family are able to function more effectively.
Services Components	1. The youth is almost always present for family therapy sessions. There are occasions where it is clinically indicated that the youth not be present, the reasons are documented in progress notes and monthly progress summaries. Specific interventions may include: a. Assist the family with developing and maintaining appropriate structure within the home; b. Assist the family to develop effective parenting skills and child behavior management techniques; c. Assist the family to develop increased understanding of the youth's symptoms and problematic behaviors, to develop effective strategies to address these issues, and to build upon strengths; d. Facilitate effective communication and problem solving between family members; e. Facilitate effective communication between family members and other community agencies; and f. Facilitate linkages to community supports and resources. 2. Interventions are evidence-based and tailored to address identified youth and family needs. Services are designed to promote healthy functioning and build upon the natural strengths of youth, family, and community. 3. The provider must begin service within two (2) weeks of referral and authorization unless otherwise indicated by the CC. Specific services the therapist will provide include: a. Review the CSP and all historical and assessment data available in the youth's clinical record; and b. Meet with the youth and relevant family members in order to engage them in the treatment process and identify relevant issues, needs, and related goals for treatment planning. 4. Review interventions, needs, goals and progress with the youth and family monthly utilizing data regarding the major treatment

	targets. These data should be collected regularly via self-monitoring (e.g. monitoring urges to self-harm), parent monitoring (e.g. monitoring incidents of disobedience), client/parent ratings (e.g. parent's rating of behavior over the past week), or brief standardized measures. 5. Adjust the treatment plan as needed based on the youth's progress. 6. Assist with discharge planning in collaboration with the mental health treatment team, including participation in transitional therapy sessions if the family moves on to new providers.
Admission Criteria	**All** of the following criteria are met: 1. The identified youth meets SEBD Eligibility criteria for CAMHD (See Appendix 7), is registered with a Branch and has an assigned CC; 2. The CSP includes this service and measurable objectives for outcomes of this service prior to admission; 3. There is reasonable expectation that the youth and family will benefit from this service, i.e., that family therapy will remediate symptoms and/or improve functioning in the home and community; 4. Youth and family agree to active participation in treatment; and 5. If the youth is diagnosed with a disruptive behavior disorder the use of one of the evidenced-based treatments (MST, FFT, MTFC) has been documented before seeking Family Therapy, unless there is clear and compelling documented clinical evidence that the youth is inappropriate for an evidence-based treatment at this time.
Initial Authorizations	Initial authorization may be up to sixteen (16) units per month for three (3) months may be authorized by the Branch Clinical Lead. The total time in Family Therapy sessions is not expected to exceed three (3) hours a week. If more intensive services are needed (beyond a temporary crisis), the family should be referred to another service (e.g. MST, Intensive In-Home Intervention or Functional Family Therapy). If additional units are needed due to a temporary crisis, the Branch Clinical Lead will review and approve the request for additional units. Note: Telephone contacts and logistical planning/preparation are included in the unit cost. There is no additional payment for phone calls, travel time, wait time, no-shows, or cancellations. Unit = fifteen (15) minutes Level of Care = 7103
Reauthorization	Reauthorization may be up to sixteen (16) units per month for an additional three (3) months may be authorized by the Branch Clinical Lead.

	Any request for authorization beyond six (6) months must be approved by the Branch Utilization Review Team and Clinical Lead. Unit = fifteen (15) minutes Level of Care = 7103
Continuing Stay Criteria	**All** of the following criteria must be met as determined by clinical review: 1. Youth and family are actively involved in treatment; 2. There are regular and timely assessments and documentation of the youth/family's response to interventions, utilizing the data collected by the therapist. Timely and appropriate modifications to the treatment plan are made that are consistent with the youth/family's status; and 3. At least one (1) of the following criteria must be met: a. Youth is demonstrating progress, but goals have not yet been met, and there is reason to believe that goals can be met with ongoing therapy services; b. Minimal progress toward treatment goals has been demonstrated and there is reason to believe that goals can be met with ongoing therapy services; c. Symptoms or behaviors persist at a level of severity that was documented upon admission, and the projected time frame for attainment of treatment goals as documented in the treatment plan has not been reached. However, a less restrictive level of care would not adequately meet the youth's needs, and other more intensive services are not considered appropriate at this time. The treatment plan has been adjusted and there is reason to anticipate improved response to the planned approaches; or d. New symptoms have developed, and the behaviors can be addressed safely and effectively through outpatient therapy services with an updated treatment plan.
Discharge Criteria	Youth and family are no longer in need of or eligible for this level of service due to **one** (1) of the following: 1 Targeted symptoms have improved to a point where the youth no longer requires this level of care as documented by substantial attainment of goals in the treatment plan; 2 Youth and family have demonstrated minimal or no progress toward treatment goals for a three (3) month period and appropriate modification of plans have been made and implemented with no significant success, suggesting the youth and family is not benefiting from family therapy services at this time; 3 Youth exhibits new symptoms and/or behaviors which cannot be addressed safely and effectively through Family Therapy services; 4 Youth and family are not willing to continue with the service and/or have revoked consent with no imminent danger to self

	or others; or 5 The youth is no longer eligible for SEBD services. As part of discharge, the CC will help coordinate transfer to appropriate treatment services in the least disruptive manner possible.
Service Exclusions	Not offered at the same time as any Out-of-Home service, Intensive In-Home or Multisystemic Therapy, or Functional Family Therapy, unless the Family Therapy is specialized and designed to address a specific and targeted problem area (e.g. sexual offending behavior) and is needed to augment other services
Clinical Exclusions	Youth in need of immediate crisis stabilization because of active suicidal, homicidal, or psychotic behavior. Once stable, youth who otherwise meet the eligibility criteria may be referred into this service.

Staffing Requirements

In addition to the staffing requirements listed in the general standards, these staff requirements must be followed. If the standards referenced here differ from those in the general standards, these staffing requirements will supersede the general standards.

1. Family Therapy services must be provided by personnel that meet <u>one</u> (1) of the following requirements:
   c. Credentialed by CAMHD as a Qualified Mental Health Professional (QMHP);

   OR

   d. Credentialed by CAMHD as a Mental Health Professional (MHP);

   AND

   c. Working under the supervision of a QMHP. The supervisor is expected to review all of the supervisees work in detail.
2. Providers are to follow all applicable professional practice standards and ethical guidelines.

Clinical Operations

In addition to the clinical operation requirements listed in the general standards, these requirements must be followed. If the standards referenced here differ from those in the general standards, these clinical operation requirements will supersede the general standards.

1. Direct service providers shall coordinate with family/significant others and with other systems of care such as education, juvenile justice system, child welfare as needed to provide service.
2. Please see Section I General Standards for additional clinical operation requirements:
   - D. Co-Occurring Disorders;
   - F. Referral Process for Services:
     - Referral Acceptance;
   - G. CAMHD Continuity of Care;
   - H. Staffing:
   - I. Supervision;
   - J. Evaluation of Staff Performance;
   - K. Credentialing Requirements;
   - N. Service Quality;
   - O. Minimum Reporting Requirements;
   - P. Risk Management:
     - Criminal, Child Abuse, and Background Screening;

- Safety;
- Restraints and Seclusion;
- Sentinel Events and Incidents;
- Police.

Documentation

In addition to the documentation requirements listed in the general standards, these requirements must be followed. If the standards referenced here differ from those in the general standards, these documentation requirements will supersede the general standards.

1. A written treatment plan identifying targets of treatment with realistic goals, objective and discharge criteria linked to the admission behavior/symptoms will be submitted to the CAMHD Branch with ten (10) days of admission. This documentation is required for any reauthorization of Family Therapy services.
2. Progress notes must document the course of treatment including a description of the interventions implemented, youth's response, and interpretation of the effectiveness of the intervention in addressing treatment plan goals/objectives. The note must include the date of service, the length of session, type of therapy provided and specific treatment goals addressed. The notes shall be fully dated and signed by the writer and supervisor if needed. The original note must be maintained in the agency's master youth file within 24 hours of service.
3. Please see Section I General Standards for additional documentation requirements:
    - F. Service Planning:
        - Mental Health Treatment Plan including safety, crisis and discharge planning. If any major changes occur in the course of treatment, the all components of the MHTP should be updated to reflect this;
        - Discharge Summary;
    - N. Maintenance of Service Records:
        - Progress Notes;
    - P. Minimum Reporting Requirements:
        - Monthly Treatment and Progress Summary;
        - CAMHD Attendance and Encounter Records.

I. PARTIAL HOSPITALIZATION

Definition	Partial hospitalization is a non-residential day treatment program of a licensed JCAHO certified hospital or behavioral health facility. The environment provides a highly structured, intensive milieu treatment with a focus on medical/psychiatric resources. This level of care provides stabilization of youth with serious emotional disturbances, therapeutically supported diversion from inpatient care, and restoration to a level of functioning that enables a youth's return to the community. Partial hospitalization also provides supportive transitional services to youth who are no longer acutely ill and require minimal supervision to avoid risk. The primary goal of the partial hospitalization programs is to keep youth connected with his/her family/community while providing short-term intensive treatment.
Services Offered	1. The program offers time-limited, intensive coordinated clinical services by a multi-disciplinary team. The services include assessment (including psychological testing if needed), intensive structured treatment milieu, an education program, therapy and activities designed to improve the functioning of the youth served with integrated service planning. 2. A child and adolescent psychiatrist is the lead clinician and provides documented observation, assessments and/or treatment at least one (1) times per week. These are individualized to meet the needs of the youth. a. Routine assessments are performed by the psychiatrist to effectively coordinate all treatment, manage medication trials and/or adjustments, minimize serious medication side effects, and provide medical management of all psychiatric and medical problems; and b. A psychiatrist is available during program hours to direct any psychiatric emergencies. 3. The treatment is family-centered and includes evidence-based interventions which must include weekly individual* and family* therapy, at least twice a month group therapy*, daily educational programming, and other planned activities appropriate to youth's needs and as indicated in the treatment plan. 4. The program provides therapeutic activities designed to improve behavior and functioning. A normalized routine and an orderly schedule to develop positive interpersonal skills and behaviors. 5. Onsite educational program that address the educational goals and objectives identified in the youth's IEP as applicable. 6. Integrated individualized substance abuse assessment, counseling and education as indicated in the youth's plan. 7. A documented treatment plan that identifies targets of treatment connected to realistic goals, objectives, and discharge criteria will be developed as part of the initial

* See performance standard for service referenced.

	assessment process and includes information from the pre-admission meeting. The treatment plan will be evaluated and revised as necessary as treatment proceeds and the planning process will include the youth, family/guardian and other relevant treatment team members. a. The crisis plan component of the treatment plan includes a safety plan that identifies the youth's problematic behaviors, triggers and preferred means of calming or regaining control. The safety plan is an essential component of the larger crisis plan. The safety plan is part of the treatment plan that articulates the youth's self-calming interventions consistent with treatment targets, goals and objectives. The purpose of the safety plan is to help the youth regain control and avoid escalation into crisis; and b. The discharge component of the treatment plan will be developed that specifies discharge criteria directly linked to behaviors/symptoms that resulted in the admission, time frame for discharge and any aftercare resources needed to transition the youth to a less restrictive level of treatment. 8. Treatment is designed to include all members of the family, not just the specific youth through regular family therapy. 9. If the youth is involved in treatment with another behavioral health provider(s) then, with proper consent, the Partial Hospitalization provider will notify any other behavioral health provider(s) of the youth's current status to ensure care is coordinated. .
Admission Criteria	**<u>All</u>** <u>of the following criteria are met:</u> 1. The identified youth meets SEBD Eligibility criteria for CAMHD (See Appendix 7), is registered with a Branch and has an assigned CC; 2. Pre-admission meeting is held with the youth, family/guardian, CC and other relevant treatment members to identify treatment targets to be addressed in the treatment and safety plan and reflected in the realistic discharge criteria along with expectations of family/guardian involvement in the treatment process; 3. <u>One</u> of the following risk to self, other or property must be met: a. There is a risk to self, others, or property; b. Mood, thought or behavioral disorder interfering significantly with activities of daily living (e.g. inability to undertake self-care); c. Suicidal ideation, threats or self-injurious behavior; or d. Risk-taking or other self-endangering behavior; and All of the above behaviors are <u>not</u> so serious as to require 24-hour medical/nursing supervision, but does require structure and supervision for a significant portion of the day and family/community support when not in the program; 4. There is evidence of the child/adolescent's capacity and support for reliable attendance at the partial hospital program

	and there is an adequate social support system available to provide the stability necessary for maintenance in the program; 5. The youth is able to participate in and benefit from the milieu and there is reasonable expectation that treatment will remediate symptoms and/or improve behaviors or there is reasonable evidence that the youth will decompensate or experience relapse if services are not initiated; 6. The CSP identifies this service and measurable objectives and discharge criteria for this service as established in the pre-admission meeting; 7. Documentation of an adequate trial of active treatment at a less restrictive level has been unsuccessful or there is clear and compelling documented clinical evidence that the youth is inappropriate for a trial of less restrictive services; 8. If the youth is diagnosed with a disruptive disorder, the documentation must include the use of one of the evidence-based treatments (MST, FFT, MTFC) before seeking Partial Hospitalization admission, unless there is clear and compelling documented clinical evidence that the youth is inappropriate for an evidence-based treatment at this time; 9. Family/guardian agrees to active involvement in treatment and planning meetings; and 10. Youth agrees to active involvement in treatment.
Initial Authorizations	Initial authorization may be up to fifteen (15) units with review and approval of the Branch Clinical Lead. Unit = one (1) day Level of Care = 27101
Reauthorization	Reauthorization may be up to fifteen (15) units with review and approval of the Branch Clinical Lead. Request for continued stay reviews must be submitted no more than seven (7) calendar days and no less than three (3) calendar days before the end date of the initial authorization or any reauthorizations. Unit = one (1) day Level of Care = 27101 Any request for reauthorization beyond forty (40) units (2 months) must be reviewed and approved by the Branch Utilization Management Team and Clinical Lead.
Continuing Stay Criteria	**All** of the following criteria must be met as determined by clinical review: 1. Youth actively involved in treatment process and at least one of the following criteria must be met: a. Admitting symptoms/behaviors are still present and continue to meet admission criteria; b. Progress in relation to specific symptoms or impairment is clearly evident and can be described in objective terms, but goals of treatment have not yet been achieved, or adjustments in treatment plan to address lack of progress are evident; or

	c. New symptoms have developed and plans have been modified to address these additional symptoms. The symptoms can be safely and effectively addressed, and a less intensive service would not adequately meet the youth/family needs; 2. The documented treatment and safety plan is individualized and appropriate to the individual's changing condition with realistic, measurable and achievable goals, objectives and discharge criteria directed toward stabilization to allow treatment to continue in a less restrictive environment. The treatment plan has been shared with relevant team members; 3. The treatment plan includes a formulated discharge plan that is directly linked to the behaviors and/or symptoms that resulted in admission, and begins to identify appropriate post-partial hospitalization resources; 4. There is documented evidence of active family involvement in treatment as required by the treatment plan at least weekly or there is active documented effort being made to involve them unless it is documented as contraindicated; 5. There is a documented active attempt at coordination of care with other relevant behavioral health providers when appropriate. If coordination is not successful, the reason(s) are documented; and 6. There is reasonable expectation that continued treatment will remediate the symptoms and/or improve behaviors or there is reasonable evidence that the youth will decompensate or experience relapse if services are discontinued.
Discharge Criteria	Youth is no longer in need of or eligible for this service due to **one** (1) of the following criteria: 1. The individual's documented treatment plan goals and objectives have been substantially met; 2. The individual no longer meets admission criteria, or meets criteria for a more intensive level of care; 3. Targeted symptoms/behaviors have abated in severity which no longer requires this level of care and the treatment can now be managed at a less intensive level of care; 4. The youth is no longer eligible for services. As part of discharge, the CC will help coordinate transfer to appropriate treatment services in the least disruptive manner possible; 5. Youth has demonstrated minimal or no progress toward treatment goals for a four (4) week period and appropriate modification of plans has been made and implemented with no significant success, and there is no reasonable expectation of progress at this level of care nor is it required to maintain the current level of function; 6. Youth/family no longer want services and revoke consent with no imminent danger to self or others; or 7. The youth or parent/guardian is not participating in treatment or in following program rules and regulations. The non-participation is of such a degree that treatment at this level of care is rendered ineffective, despite multiple (at least 3)

	documented attempts to address non-participation issues.
Exclusions	Partial Hospitalization is not considered medically necessary and will not be authorized under the following circumstances: 1. Not offered at the same time as Hospital or Community Based Residential programs; 2. Not offered at the same time as any intensive outpatient service (IIH, IILS, MST, FFT) except when clearly documented in Partial Hospitalization's treatment/discharge plan and within two (2) weeks of discharge from Partial Hospital program; 3. No admissions and/or continued stays which are solely for parent/guardian convenience and not related to the care and treatment of the youth; or 4. No admissions that are being sought solely as an alternative to specialized schooling or respite.

Staffing Requirements:
In addition to the staffing requirement listed in the general standards, these staff requirements must be followed. If the standards referenced here differ from those in the general standards, these staffing requirements will supersede the general standards.

1. A multi-disciplinary team of clinical, educational and direct care personnel provides the medical, psychiatric, educational, and recreational services required to provide an intensive therapeutic program.
2. The program director is a licensed mental health professional with clinical/administrative experience in child and adolescent psychiatry.
3. The medical director is a board certified child and adolescent psychiatrist who has overall medical responsibility for the program.
4. The professional staff is comprised of at least the following professionals:
   a. Board certified/eligible child and adolescent psychiatrist(s);
   b. Registered nurse(s) (recommend bachelor's level, certified psychiatric nurses);
   c. Licensed psychologist(s) (consultative);
   d. Credentialed mental health professional(s); and
   e. Activities therapist/ Recreation therapist/Occupational therapist, based on the needs of the population.
5. Adequate care and supervision are provided at all times in accordance with the developmental and clinical needs of the youth served and includes:
   a. One (1) staff per every four (4) youth providing continuous supervision;
   b. Higher staff/youth ratios during periods of greater activity such as shift changes; and
   c. Availability of additional personnel for emergencies or to meet the special needs of youth served at busier or more stressful periods.
6. The program's personnel include those with educational and experiential backgrounds which enable them to participate in the overall treatment program and to meet the emotional and developmental needs of the youth served; and the personal characteristics and temperament suitable for working with youth with special needs.
7. CAMHD expects the Contractor to ensure the educational components of the program, including its teaching staff, meet all CAMHD CAMHPS requirements, even if this component is under a separate contract with the DOE

Clinical Operations

In addition to the clinical operation requirements listed in the general standards, these requirements must be followed. If the standards referenced here differ from those in the general standards, these clinical operation requirements will supersede the general standards.

1. Service is available at least six (6) hours a day, five (5) business days a week.
2. A preadmission meeting is required to obtain youth, family, CC, and other relevant team members' input into symptoms/behavior that are the targets of treatment and reflect in the goals and objectives. A safety plan will be developed that identifies effective youth self-calming interventions that will be incorporated into the youth's treatment/crisis plan. The preadmission meeting also facilitates the development of the youth's discharge plan, including the development of concrete, realistic, measurable discharge criteria and projected timeframe for discharge.
3. Service delivery must be preceded by a thorough assessment of the youth and his/her family which includes preadmission information so that an appropriate and effective treatment plan can be developed. A Preadmission meeting, Intake, Screening, and Assessment are provided to each youth prior to or upon admission.
4. Comprehensive multi-disciplinary assessments are performed within forty-eight (48) hours and include comprehensive DSM-IV assessments on Axes I-V, assessments of patient, family, community strengths/resources, and specific multi-modal treatment recommendations that target the specific factors that precipitated the admission and those that require stabilization in order to return to a less restrictive setting. The assessment also includes comprehensive evaluations of the patient's developmental milestones and course; family dynamics, strengths and capacity to be actively involved in family centered interventions; current and past school, work, or other social role; ability to interact socially (including peer relationships); substance use/abuse; and a summary of all prior psychiatric hospitalizations, medication trials, and other mental health/psychosocial interventions including an assessment of the youth's degree of success and/or failure.
5. Psychological testing will be provided as part of the comprehensive assessment to guide differential diagnosis of mental health disorders or abilities.
6. A treatment plan that identifies targets of treatment that are reflective of the youth's admission behaviors/symptom and the development of realistic goals, objectives, and discharge criteria will be developed as part of the initial assessment process. The treatment plan and safety plan component will be evaluated and revised as necessary as treatment proceeds and will include the youth, family/guardian and other relevant treatment team members.
7. As part the of the treatment planning, a discharge plan will be developed with the family that specifies realistic discharge criteria directly linked to behaviors/symptoms that resulted in the admission, time frame for discharge and any aftercare resources needed to transition the youth to a less restrictive level of treatment.
8. Involvement of parent(s)/guardian(s) is/are essential in the provision of this service and is a necessary tool in enabling the youth to move to less restrictive services. Every effort to include parents in the treatment process must be documented and the use of Telehealth video conferencing or telephone conferencing to facilitate weekly family therapy sessions must be utilized for families who are unable to attend in person.
9. The provider is to follow all applicable professional practice standards and ethical guidelines.
10. The Contractor has established policies and procedures in place for managing crises and effectively and efficiently through the direct interventions of its professional clinical and medical staff. Included in these procedures is the handling of emergency and crisis situations that describe methods for triaging youth who require more intensive interventions.
11. The program provides continuous observation and safe control of behavior (i.e., adequate/appropriate suicidal/homicidal precautions) to protect the patient and others from harm, neglect, and/or serious abuse. These control measures should be used sparingly and under the direction of a child and adolescent psychiatrist. The use of restrictive forms of behavior control must follow JCAHO guidelines.

12. If the program provides services to a mixed population of those in a hospital setting and those who live at home with their families, the program must assure that both the residential and partial hospitalization youth served receive a comprehensive program that meets their needs.
13. Professional staff works closely together to provide integrated care. They meet weekly to review each case.
14. The program has written policies and procedures, which specify its approach to behavior management. These require safe, standardized methods for behavior control and management, which indicate the conditions under which restrictive practices such as seclusion and restraints may be used. They also include the procedures for obtaining informed consent from family or guardians regarding such practices.
15. The organization provides training for its personnel in family-based interventions and other alternative ways of dealing with aggressive or out of control behavior, methods of de-escalating volatile situations and of using non-physical techniques in such situations.
16. To ensure continuity of care, the provider is required to provide discharge summaries as described in the general standards within seven (7) calendar days of discharge. If hospital procedures prevent this timeline from being met, at a minimum the provider must have written discharge follow-up orders which include the youth's diagnosis, current functioning, and any recommended follow-up treatment which is given to the parent/guardian at discharge and sent to the referring CAMHD Branch.
17. When the provider has documented evidence that a youth cannot be maintained in the service without one to one staffing the provider will seek the assistance of the CAMHD Branch where the youth is registered to seek the CAMHD Medical Director approval of one to one (1:1) staffing.
18. Please see Section I General Standards for additional clinical operation requirements:
    - E. Co-Occurring Disorders;
    - G. Referral Process for Services:
        - Referral Acceptance;
    - H. CAMHD Continuity of Care;
    - I. Staffing;
    - J. Supervision;
    - K. Evaluation of Staff Performance;
    - L. Credentialing Requirements;
    - M. Medication Monitoring / Tracking;
    - O. Service Quality;
    - P. Minimum Reporting Requirements;
    - Q. Risk Management:
        - Criminal, Child Abuse, and Background Screening;
        - Safety;
        - Restraints and Seclusion;
        - Sentinel Events and Incidents;
        - Police.

Documentation

1. In addition to the documentation requirements listed in the general standards, these requirements must also be followed. If the standards referenced here differ from those in the general standards, these documentation requirements will supersede the general standards.
2. For youth **not** stepping down from a hospital program, a written admission summary that details the initial diagnosis, mental status, presenting problem, and preliminary recommendations is submitted to the CAMHD Branch within five (5) calendar days of admission.
3. A written treatment plan inclusive of a current safety plan identifying targets of treatment with realistic goals, objective and discharge criteria linked to the admission behavior/symptoms will be

submitted to the CAMHD Branch with ten (10) calendar days of admission. This documentation is required for any reauthorization of partial hospitalization services.

4. Progress notes must document the course of treatment including a description of the interventions implemented, youth's response, and interpretation of the effectiveness of the intervention in addressing treatment plan goals/objectives. The note must include the date of treatment, length of session, type of therapy provided, and specific treatment goal addressed. The note shall be fully dated and signed by the writer and supervisor if needed. The original note must be maintained in the agency's master youth file within 24 hours of service. The following notes are required:
   a. At least weekly observation, assessments and/or treatment progress note from the Psychiatrist;
   b. At least once a week progress notes by the responsible educational/recreational/occupational specialist;
   c. Individual/family/group therapy progress note;
   d. Every nursing contact, including medication administration must be documented; and
   e. Daily progress note for each youth in the program.
5. Please see Section I General Standards for additional documentation requirements:
   - F. Service Planning:
     - Mental Health Treatment Plan including safety, crisis and discharge planning. If any major changes occur in the course of treatment, the all components of the MHTP should be updated to reflect this;
     - Discharge Summary
   - N. Maintenance of Service Records:
     - Progress Notes;
   - P. Minimum Reporting Requirements:
     - Monthly Treatment and Progress Summary.

SECTION III:

APPENDIX

Appendix
CAMHD Documents
(As referenced Standards)

Appendix	Document Name
1.	CASSP Principles
2.	Youth Mental status checklist Form
3.	EPSDT- Elements of EPSDT Screens and Periodicity Schedule
4.	Referral Acceptance Protocol Policy and Procedure 80.614
5.	Referral Acceptance Form
6.	Independent Psychiatrist Consultation Form
7.	Support for Emotional and Behavioral Development (SEBD) Fact Sheet
8.	Therapeutic Foster Home Profile Form
9.	Sentinel Events Policy and Procedure 80.805
10.	72 Hour Sentinel Event Report Form
11.	Sentinel Event Code Definitions
12.	Weekly Census Report on Client Status
13.	Waitlisted Youth Form
14.	Contracted Agency Quarterly Training Report
15.	Child Abuse and Neglect Check Policy and Procedure 80.406
16.	Initial and Re-credentialing of Licensed QMHPs Policy and Procedure 80.308
17.	Grievances and Grievance Appeals Policy and Procedure 80.603
18.	Safety Plan
19.	Initial and Re-credentialing of MHPs and Paraprofessionals P&P 80.308.1
20	CAMHPS Acronym List

Note: The Policies and Procedures in this appendix are current as of April 2012. Providers are responsible for following any future revised policies and procedures as they are made available. Please refer to the DOH website for the most current versions www.hawaii.gov/health/mental-health/camhd/camhd/index.html:

STATE OF HAWAII
Child and Adolescent Service System Program (CASSP) Principles

1. The system of care will be child and family centered and culturally sensitive, with the needs of the child and family determining the types and mix of services provided.

2. Access will be to a comprehensive array of services that addresses the child's physical, emotional, educational, recreational and developmental needs.

3. Family preservation and strengthening along with the promotion of physical and emotional wellbeing shall be the primary focus of the system of care.

4. Services will be provided within the least restrictive, most natural environment that is appropriate to individual needs.

5. Services which require the removal of a child from his/her home will be considered only when all other options have been exhausted, and services aimed at returning the child to his/her family or other permanent placement are an integral consideration at the time of removal.

6. The system of care will include effective mechanisms to ensure that services are delivered in a coordinated and therapeutic manner, and that each child can move throughout the system in accordance with his/her changing needs, regardless of points of entry.

7. Families or surrogate families will be full participants in all aspects of the planning and delivery of services.

8. As children reach maturity, they will be full participants in all aspects of the planning and delivery of services.

9. Early identification of social, emotional, physical and educational needs will be promoted in order to enhance the likelihood of successful early interventions and lessen the need for more intensive and restrictive services.

10. The rights of children will be protected and effective advocacy efforts for children will be promoted.

Developed by the Hawaii Task Force, 1993.
(Adapted from Stroul, Beth A. and Robert M. Friedman, R.M. (1986) *A System of Care for Children & Youth with Severe Emotional Disturbances.* (Revised Edition) Washington, DC: Georgetown University Child Development Center, CASSP Technical Assistance Center.)

Youth Mental Status Exam Checklist Form

General Appearance:

Body Type:
- ☐ age appropriate
- ☐ appears younger than stated age
- ☐ appears older than stated age
- ☐ other: _____

Weight:
- ☐ within normal limits
- ☐ underweight
- ☐ overweight
- ☐ other: _____

Hygiene:
- ☐ well-groomed
- ☐ fair
- ☐ disheveled
- ☐ poor
- ☐ other: _____

Eye Contact:
- ☐ good
- ☐ fair
- ☐ poor
- ☐ other:_____

Comments:_____

Motor:

Fine Motor:
- ☐ advanced
- ☐ normal range
- ☐ mild delays
- ☐ significant delays
- ☐ other:_____

Gross Motor:
- ☐ advanced
- ☐ normal range
- ☐ mild delays
- ☐ significant delays
- ☐ other:_____

Comments:_____

Regulation:

Attention:
- ☐ intact
- ☐ limited
- ☐ severely impaired
- ☐ other:

Activity Level:
- ☐ normal range
- ☐ overactive
- ☐ impulsive
- ☐ agitated
- ☐ lethargic
- ☐ other:_____

Self soothing Capacity:
- ☐ uses developmentally appropriate coping strategies
- ☐ immature coping strategies
- ☐ inconsistent use of appropriate coping strategies
- ☐ limited range of coping strategies
- ☐ other:

Alertness:
- ☐ normal range
- ☐ hyper alert
- ☐ hypo alert
- ☐ confused
- ☐ stuporous
- ☐ other:

Transitions:
- ☐ normal response
- ☐ anxious
- ☐ disorganized
- ☐ uncooperative
- ☐ other:

Affect:
- ☐ normal range
- ☐ constricted
- ☐ blunted
- ☐ flat
- ☐ labile
- ☐ inappropriate
- ☐ other:

Mood:
- ☐ neutral
- ☐ happy
- ☐ sad
- ☐ fearful
- ☐ anxious
- ☐ hostile,
- ☐ angry
- ☐ silly
- ☐ euphoric
- ☐ dysphoric
- ☐ irritable
- ☐ crying
- ☐ other:

Frustration Tolerance and Anger Management Skills:
- ☐ developmentally appropriate
- ☐ emerging ability
- ☐ frequent temper tantrums
- ☐ severe lack of anger management results in aggression or assaultive behaviors

Comments:

Youth Mental Status Exam Checklist Form

Oriented to:
- ☐ person
- ☐ place
- ☐ time

Comments:

Cognition/Thought Processes:

Hallucinations:
- ☐ no current hallucinations
- ☐ auditory
- ☐ visual
- ☐ tactile
- ☐ olfactory
- ☐ reacting to internal stimuli

Delusions:
- ☐ no current delusions
- ☐ persecutory
- ☐ grandiose
- ☐ somatic
- ☐ over-valued ideas

Thought Processes:
- ☐ goal directed
- ☐ concrete
- ☐ logical
- ☐ obsessive
- ☐ unusual fears
- ☐ flight of ideas
- ☐ blocking
- ☐ paucity of ideas
- ☐ illogical
- ☐ other:

Associations:
- ☐ intact
- ☐ loose
- ☐ circumstantial
- ☐ tangential
- ☐ other:

Fund of Knowledge:
- ☐ age appropriate
- ☐ limited
- ☐ impaired
- ☐ other:

Memory-Short Term:
- ☐ intact
- ☐ impaired
- ☐ other:

Memory-Long Term:
- ☐ intact
- ☐ impaired
- ☐ other:

Insight:
- ☐ good
- ☐ fair
- ☐ inconsistent
- ☐ poor
- ☐ other:

Judgment:
- ☐ good
- ☐ fair
- ☐ inconsistent
- ☐ poor
- ☐ other:

Intelligence:
- ☐ average
- ☐ above average
- ☐ borderline
- ☐ below average
- ☐ other:

Comments:

Communication:

Speech:
- ☐ clear
- ☐ atypically slow rate
- ☐ atypically fast rate
- ☐ loud
- ☐ soft
- ☐ poor articulation
- ☐ slurred
- ☐ disfluent
- ☐ monotone
- ☐ paucity
- ☐ unintelligible
- ☐ non-responsive
- ☐ other:

Receptive Language:
- ☐ follows directions easily
- ☐ difficulty comprehending
- ☐ non-responsive
- ☐ other:

Expressive Language:
- ☐ age appropriate use of speech
- ☐ immature use of language
- ☐ primarily uses gestures
- ☐ other:

Comments:

Sleep Patterns:	**Risk Assessment**

Youth Mental Status Exam Checklist Form

☐ normal range
☐ disrupted nighttime sleep
☐ sleeps in the day (not including age appropriate napping)
☐ difficulty falling asleep
☐ difficult to arouse after sleep
☐ frequent night terrors
☐ frequent nightmares
☐ other:
Comments: _____

Eating Patterns:
☐ normal range
☐ very selective
☐ very limited range of foods
☐ not eating enough resulting in weight loss
☐ overeating
☐ binging
☐ purging
☐ refusing to eat
☐ other
Comments:

Unusual Behaviors:
☐ not applicable
☐ compulsions
☐ sexual acting out
☐ traumatic reenactments
☐ head banging
☐ spinning, twirling
☐ hand flapping
☐ finger flicking
☐ rocking
☐ toe walking
☐ staring at lights
☐ spinning objects
☐ repetitive
☐ perseverative
☐ bizarre verbalizations
☐ hair pulling
☐ ruminating
☐ holding breath
☐ other:
Comments:

(Directions: *Use comment section to describe **any** positive findings in this category.)***:**
To Self:
☐ no high risk behaviors
☐ self mutilation
☐ suicidal ideation
☐ suicidal threats
☐ suicidal plans
☐ suicidal intent
☐ suicidal actions
☐ history of self harm
☐ history of psychiatric hospitalization
To Others:
☐ no high risk behaviors
☐ physically aggressive to others
☐ possesses weapons
☐ uses weapons
☐ harms animals
☐ homicidal ideation
☐ threatens to kill others
☐ homicidal plan
☐ homicidal intent
High-Risk Behaviors:
☐ no high-risk behaviors
☐ fire setting
☐ running away
☐ high-risk sexual activity
☐ cruelty to:
☐ breaking curfew
☐ lying
☐ stealing
☐ truancy
☐ other:
Substance Abuse:
☐ not applicable
☐ denies
☐ current
☐ past
Comments:

EPSDT
Elements of EARLY and PERIODIC SCREENING, DIAGNOSIS and TREATMENT (EPSDT) Screens and Periodicity Schedule

EPSDT Description

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program is a federally mandated program under Title XIX of the Social Security Act. This program provides preventive and comprehensive health services for Medicaid eligible individuals under age 21. The primary goal is to offer prevention, early diagnosis and medically necessary treatment of conditions. The program emphasizes the importance of prevention through early screening for medical, dental and behavioral health conditions and timely treatment of conditions that are detected.

EPSDT Screen Schedule

Complete EPSDT screens are conducted at the following ages:

- Infancy: By age 1 month, 2, 4, 6, 9 and 12 months
- Early Childhood: At 15, 18 and 24 months and at 3 and 4 years
- Late Childhood: At 5, 6, 8, 10 and 12 years
- Adolescence and Older: At 14, 16, 18 and 20 years

EPSDT covered services include:

1. Regular comprehensive well-child exams from newborn to age 20 years.
   The comprehensive exam includes the following:
   a. An initial or interval history
   b. Measurements
   c. Sensory screening (hearing and vision)
   d. Developmental assessments, including general development and autism, with validated tools
   e. Tuberculosis risk assessment
   f. Lead risk assessment
   g. Psychosocial and behavioral assessment
   h. Alcohol and drug use assessment for adolescents
   i. STI and cervical dysplasia screening as appropriate
   j. Dyslipidemia screening as appropriate
   k. Complete physical exam
   l. Age appropriate surveillance
   m. Age appropriate immunizations
   n. Procedures such as hemoglobin, tuberculosis testing, and lead level as appropriate
   o. Referral to a dental home
   p. Referrals to state or specialty services
   q. Care coordination assistance if needed
   r. Age appropriate anticipatory guidance
   s.

The screenings, assessments, surveillance, and anticipatory guidance under EPSDT are based upon the recommendations of CMS and the most current American Academy of Pediatrics (AAP) and Bright Futures guidelines. This can be found at the following website: **http://brightfutures.aap.org/pdfs/AAP%20Bright%20Futures%20Periodicity%20Sched%20101107.pdf**

CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
POLICY AND PROCEDURE MANUAL

SUBJECT: Referral Acceptance Protocol	**Number:**	**80.614**
	page	1 **of** 6

REFERENCE: Hawaii Revised Statutes, and Hawaii Administrative Rules for Chapter 103F	**APPROVED:**
	Signature on File 8/24/11
	Administrator Eff. Date

PURPOSE

To describe the Child and Adolescent Mental Health Division's (CAMHD) process for youth accessing appropriate intensive mental health services from CAMHD contracted providers, hereinafter identified as Providers. This policy establishes the referral acceptance protocol all Providers must follow.

BACKGROUND

The CAMHD is committed to providing eligible youth and families access to an array of intensive mental health services and service planning delivered by CAMHD staff or Providers in a timely and consistent manner. The CAMHD procures mental health treatment services through the Request for Proposal (RFP) process in accordance with provisions of the Hawaii Revised Statutes, Chapter 103F and its administrative rules. The RFP process results in contractual agreements between the CAMHD and Providers that set forth requirements Providers have agreed to comply with, including referral acceptance requirements.

DEFINITIONS

Branch - CAMHD Family Guidance Center or the Family Court Liaison Branch.

Coordinated Service Plan (CSP) - A written design for service that describes the roles and responsibilities of multiple agencies or programs that provide therapeutic or supportive interventions or activities essential to the youth's and family's treatment.

Mental Health Treatment Team –A team of involved mental health professionals who are responsible for the development, implementation, review, revision and adjustment of the Mental Health Treatment Plan (MHTP), with input from the Branch mental health Care Coordinator (CC) and the youth/family via the CSP meeting.

Mental Health Treatment Plan –Individualized planning for each youth identifying evidence-based treatment interventions that are the most promising options for delivering positive treatment outcomes for a youth's individual goals and objectives. The Plan includes clear descriptions of specific treatment strategies and services and discharge planning.

Rejection – Action taken by a Provider where a youth is not accepted after a referral packet sent by the BRANCH is received and reviewed.

Ejection – Action taken by a Provider whereby a consumer is terminated from a placement in the Provider's treatment program (excluding discharges relating to elopements that last longer than seven days) and the Branch does not agree with the discharge. This includes discharges when the Provider believes the treatment goals have been met but the Branch does not agree.

Referral Packet -The packet of information submitted to a Provider by the Branch when a youth is being referred for services. This packet contains, but is not limited to the following: Application; current or most recent Individualized Educational Plan ((IEP) /CSP (as applicable); current Functional Behavioral Assessment (if applicable); DOE diagnostic packet or re-evaluation information (if applicable); and any recent Admission/Discharge Summaries and/or psychiatric/psychological evaluations from previous out-of-home placements as relevant and TB results (if applicable).

CAMHD Waitlist – A list where youth are placed when the youth has been accepted for placement but CAMHD contracted bed is not available. This list is provided by the out-of- home Providers using a CAMHD form, "*Waitlisted Youth Report*" which is an attachment to the "*Weekly Census Report on Client Status*."

Youth – Children, youth or young adults with emotional and/or behavioral challenges receiving mental health services from the CAMHD.

POLICY

1. The CAMHD provides access to the following services for eligible youth through established referral processes:

   A. Educationally Supportive (ES) services which are available to Individuals with Disabilities Educational Improvement Act (IDEA) eligible children and youth, ages 3-18 (or until 20 years if compensatory education is required). The educationally focused services shall be referred to CAMHD by the youth's Individualized Education Plan (IEP) team.

   B. Support for the Emotional and Behavioral Development (SEBD) Health Plan services which are available to Medicaid/QUEST eligible children and youth, ages 3-21 with a mental health diagnosis and significant functional life impairment.

2. CAMHD Branches shall assign a Care Coordinator (CC) in accordance with *CAMHD Policy & Procedure 80.702, Care Coordination and Policy & Procedure 80.701, Assignment of Branch Mental Health Care Coordinator,* to each youth referred to CAMHD to:

   A. Register the youth into Child and Adolescent Mental Health Management Information System (CAMHMIS);

   B. Facilitate the development of the youth's Coordinated Service Plan (CSP) with the youth, family and all involved parties (DOE, DHS, FC, etc.). The CSP team shall identify the appropriate services and level of care for youth and make appropriate referrals to Providers based on the needs of the youth and in accordance with contractual requirements; and

   C. Make the appropriate referral to a Provider for services.

3. CAMHD shall inform all Providers of the referral of services process and all other relevant requirements as applicable and ensure that these Providers understand and adhere to the referral acceptance protocol. The CAMHD shall inform the Provider that it reserves the right to take any contractual action if a Provider is unable or unwilling to meet the needs of CAMHD youth appropriately referred to them.

PROCEDURE

Referral of Services to Providers:

1. Each Branch will assign a CC to each youth accessing services through CAMHD who will be responsible to register the youth into CAMHMIS in accordance with *CAMHD Policy and Procedure 80.608, Client Registration.*

2. The CC will be responsible to submit complete referral packets to Providers in accordance with the contractual requirements. All referrals will include an explanation of the purpose of treatment, the goals to be achieved via treatment, anticipated duration of the treatment and the discharge/transition criteria in addition to the required assessment documents.

3. Upon receipt of the referral packet, the Provider will forward, within two (2) business days, the ***"Referral Acceptance Form" (See Attachment A)*** to the Branch confirming acceptance and a date for initiation of services or, if all beds are full, an anticipated admission date**.** Although a Provider may require interviews with the youth/family as part of their agency intake process, the Provider is still required to return the referral acceptance form to CAMHD within two (2) business days. CAMHD does not require that youth be interviewed.

4. If the *Branch does not receive the "Acceptance of Referral Form"* within two (2) business days, the Branch CC will contact the Provider to determine the reason for the delay and to provide any necessary assistance.

5. If the youth is accepted but the program beds are at capacity, the CC will ensure that the referred youth is waitlisted by the Provider in the weekly CAMHD ***"Waitlisted Youth Report" (See Attachment B).***

Provider Rejection of Referral

1. Per their contractual agreement with CAMHD Providers are expected to accept all appropriate CAMHD referrals for contracted services. The CC will ensure that Providers follow the referral acceptance protocol that includes a means to justifiably reject a referral should they indicate that a referred youth is not appropriate for their level of care.

2. The Provider must complete the required form to indicate its reasons for the rejection of the referral and submit it to the CC. The CC will report the rejection to the Branch Clinical Director who will contact the Provider's Clinical Director to discuss the rejection reason(s).

   A. If, after such discussion, both Clinical Directors agree the level of care is appropriate, the Provider will give the CC a date for anticipated initiation of services.

   B. If, after such discussion, both Clinical Directors are ***not*** in agreement, the Branch Clinical Director will request that the Provider obtain an independent assessment from a CAMHD approved, Hawaii licensed, qualified child and adolescent psychiatrist, who is independent of CAMHD and the Provider, at the Provider's cost. The Provider must follow CAMHD procedures to determine CAMHD approval of the independent psychiatrist.

   C. If the independent assessment determines that the level of care is ***not*** appropriate, the Branch Chief, the Branch Clinical Director and the youth's treatment team will review the independent psychiatrist's recommendations and determine the appropriate level of care and send out a new referral packet to other applicable Providers. The CAMHD will reimburse the Provider for the cost of the assessment.

   D. If the independent assessment determines that the level of care is appropriate, the Provider will give the Branch a date for anticipated initiation of services. The CAMHD will ***not*** reimburse the Provider for the cost of the assessment.

3. CAMHD CSO must approve the selection of the independent psychiatrist and will describe the guidelines the Provider will follow. The Provider must complete the ***"CAMHD Independent Psychiatrist Consultation Form" (See Attachment C)*** and submit it to the CSO. The CSO will fax its approval or disapproval to the Provider within three (3) business days of the receipt of the form.

4. The MHCC will copy the CSO Resource Management (RM) Supervisor on any rejection letters or rejection indicated on the *"Acceptance of Referral Form".* The CSO RM Supervisor will forward a copy to the CAMHD Performance Monitoring Section and the Provider Relations Liaison.

5. The CAMHD Performance Monitoring Section will ensure that Providers report the number of rejections and ejections to CAMHD on a designated form. The Branches will verify this information by completing the ***"FGC Data Verification Tracking Tool" (See Attachment D).***

Provider Ejection of Accepted Youth

1. Once referrals are accepted the Provider is expected to keep the youth in its program until such time where discharge is appropriate. Providers *may not* eject youth from their program or terminate services to youth. The CC and the Provider are expected to work closely together while the youth is in the Provider's program. The CC will respond to any concerns raised by the Provider by reporting them to the youth's CSP team, the Branch Clinical Director, the Branch Chief, the CSO Practice Development Section, the Resource Management Section and/or the Provider Relations Liaison Specialist as applicable or needed.

2. In accordance with their contractual agreement with CAMHD, Providers *may not* abruptly terminate services or eject a client from the program. If a Provider seeks to terminate services or eject a youth once in the program:

   A. The Provider will be required to complete a full internal review that includes a review documented by a CAMHD approved, Hawaii licensed, qualified child and adolescent psychiatrist, who is independent of CAMHD and the Provider at the Provider's cost. The Provider will be required to report the results of this review to CAMHD and the CSP team prior to any further action being taken.

   B. CAMHD CSO must approve the selection of the independent psychiatrist and will describe the guidelines the Provider will follow. The Provider must complete the "*CAMHD Independent Psychiatrist Consultation Form"* and submit it to the CSO. The CSO will fax its approval or disapproval to the Provider within three (3) business days of the receipt of the form.

CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
POLICY AND PROCEDURE MANUAL

SUBJECT: Referral Acceptance Protocol	**Number:**	**80.614**
	page	6 **of** 6

1. If a Branch receives notification that a Provider wants to eject a youth, the Branch Clinical Director will contact the Provider's Clinical Director to discuss the issue.
2. If, after such discussion, both Clinical Directors agree the level of care continues to be appropriate, the Provider is expected to maintain the consumer in its program.
3. If, after such discussion, both Clinical Directors are ***not*** in agreement, the Branch Clinical Director will request that the Provider obtain an independent assessment, at the agency's cost, from a CAMHD approved, Hawaii licensed, qualified child and adolescent psychiatrist, who is independent of CAMHD and the Provider. The Provider must follow CAMHD procedures to determine CAMHD approval of the independent psychiatrist.
4. If the independent assessment determines that the level of care is *no* longer appropriate, the Branch will initiate appropriate and timely transition services for the youth. If the level of care is being reduced or care is being terminated, the Provider will be requested to maintain the youth for at least ten (10) days per requirements of the appeal process. The CAMHD will reimburse the Provider for the cost of the assessment.
5. If the independent assessment determines that the level of care continues to be appropriate, the Provider is expected to maintain the consumer in its program. The CAMHD will ***not*** reimburse the Provider for the cost of the assessment.
6. The CC will copy the CSO Resource Management (RM) Supervisor on any ejection letters or ejection indicated on the *"Acceptance of Referral Form".* The CSO RM Supervisor will forward a copy to the CAMHD Performance Monitoring Section and the Provider Relations Liaison.

ATTACHMENTS:

A. Referral Acceptance Form

C. Waitlisted Youth Form

D. CAMHD Independent Psychiatrist Consultation Form

E. FGC Quality Indicator Tracking Tool

Referral Acceptance Form

Instructions: Boxes 1 through 12 are to be filled out by the Family Guidance Center (FGC) Care Coordinator (CC).

[1] Youth Name:	[2] Youth Registration Number:	[3] LOC Requested
[4] Family Guidance Center (FGC)	[5] FGC Care Coordinator	
[6] FGC Phone Number	[7] FGC Fax Number	[8] Date Referral Sent to Agency
[9] Name of Provider Agency	[10] Name of Provider Agency Contact Person	
[11] Agency Phone Number	[12] Agency Fax Number	

Instructions: Boxes 13 through 18 are to be filled out by the Provider Agency and returned to the FGC within forty-eight (48) hours of receipt of the referral packet.

[13] Signature of Contact Person	[14] Printed Name of Contact Person
[15] Date Referral Packet Received	[16] Date Referral Accepted
[17] Anticipated Admit Date	[18] Date Waitlisted (for out-of-home providers only and if no bed are available)

Should your agency decide to reject this referral for any reason, please indicate such by completing the following ***required*** steps within two (2) working days of receipt of the referral packet from the FGC:

[1] Indicate by checking the box below if your agency is rejecting the referral.

[2] Have agency Clinical Director print his/her name, and [3] sign form below.

[5] Provide a written justification of the rejection signed by your Clinical Director and attach to this Referral Acceptance Form.

[6] Fax this form and justification to the attention of the **FGC Chief through the above named FGC MHCC within two (2) working days of** receipt of the referral packet**.**

PLEASE NOTE: The above six (6) steps must be completed if the agency rejects a referral. Please contact the FGC MHCC assigned to the referral to discuss any delays in returning this form within the two (2) working days as required.

[19] **REFERRAL REJECTED** ☐

[20] Print Name of Agency Clinical Director _____

[21] Signature of Agency Clinical Director _____

[22] Signed Justification Attached ☐ [23] Date: _____ [24] Fax Referral Form ☐

CAMHD INDEPENDENT PSYCHIATRIST CONSULTATION FORM

Please fill in and submit this form prior to conducting an independent evaluation. Fax it to the Clinical Services Office at 733-9875. CAMHD will fax its approval or disapproval within three (3) business days of the receipt of this form.

Agency Name: _____ Date: _____

Agency Contact: _____ Phone: _____ Fax: _____

Name of Proposed Independent Psychiatrist: _____

Please indicate the qualifications of the psychiatrist as follows:

Yes	No	Psychiatrist licensed as MD or DO in the State of Hawaii.
Yes	No	Current expertise in the Level of Care being disputed (both the level of care and the level of care proposed)
Describe:		
Yes	No	Experience and formal training in Child and Adolescent Psychiatry (prefer psychiatrist boarded in Child Psychiatry)
Describe:		
Yes	No	Does the proposed psychiatrist work for your agency as employee or as a consultant?
Yes	No	Is the psychiatrist employed by the Family Guidance Center providing care coordination for the youth involved?

CAMHD Clinical Director Review:

Agree: Do Not Agree:

Reason
:

Signature
: _____ Date: _____

A7504-D P&P 80.614	Attachment D	01 Feb 2005

Support for Emotional and Behavioral Development (SEBD) Fact Sheet

WHAT IS SEBD Program?

SEBD is an acronym for the Department of Health's (DOH) Child and Adolescent Mental Health Divisions (CAMHD) Support for Emotional and Behavioral Development program.

Formerly known as SED Serious Emotional Disturbance or SEBD Serious Emotional Behavioral Disturbance, CAMHD's SEBD program provides an array of services needed by families to support children and youth with the high-end intensive mental health support.

WHO CAN BE REFERRED?

Children/youth ages 3 through 20
AND
Hawaii Medicaid QUEST or Fee-For-Service (FFS) eligible

WHO CAN MAKE A REFERRAL?

Parents, legal guardians, DOE, DHS, FC, QUEST Plan, DOH, AG, Private Provider or others who submit a referral to ask for help in getting services.

WHAT ARE THE ELIGIBILITY REQUIREMENTS?

Child and Adolescent Functional Assessment Scale (CAFAS) score 80 or above
AND
Eligible DSM-IV Axis I diagnosis

WHAT ARE THE BENEFITS?

A child/youth determined to be SEBD eligible is able to receive appropriate individualized CAMHD intensive mental health services.

REFERRAL FORMS CAN BE FOUND AT:

http://hawaii.gov/health/mental-health/camhd/library/pdf/sebd/f0003.pdf

A7393 – SEBD Referral Process 6 Sep 05

CRITERIA for determination of eligibility for CAMHD Support for Emotional and Behavioral Development (SEBD)

I. **CRITERIA**

Children and youth with serious emotional disturbance are individuals who have a Child and Adolescent Functional Assessment Scale (CAFAS) score of 80 or above and currently, or at anytime during the past year, have had a primary DSM-IV Axis I diagnosis.

II. **EXCLUDED DIAGNOSES**

If the diagnoses listed below are they only DSM-IV diagnoses, the child is ineligible for SEBD services. These diagnoses, however, may and often do co-exist with other DSM-IV diagnoses, which make the youth eligible for SEBD services.

Mental Retardation

317	Mild Mental Retardation
318.0	Moderate Mental Retardation
318.1	Severe Mental Retardation
318.2	Profound Mental Retardation
319	Mental Retardation, Severity Unspecified

Learning Disorders

315.0	Reading Disorder
315.1	Mathematics Disorder
315.2	Disorder of Written Expression
315.9	Learning Disorder NOS

Motor Skills Disorder

315.3	Developmental Coordination Disorder

Communication Disorders

315.31	Expressive Language Disorder
315.32	Mixed Receptive-Expressive Language Disorder
315.39	Phonological Disorder
307.0	Stuttering
307.9	Communication Disorder NOS

Pervasive Developmental Disorders

299.0	Autistic Disorder
299.80	Rett's Disorder
299.10	Childhood Disintegrative Disorder
299.80	Asperger's Disorder
299.80	Pervasive Developmental Disorder NOS

Substance Abuse Disorders

Mental Disorders Due to a General Medical Condition

III. PROVISIONALLY QUALIFIED

Children and youth provisionally qualified as SEBD are defined as those:

- Who have a substance abuse condition and are suspected to suffer from a qualifying condition due to their symptoms and functional limitations. These children and youth have ongoing and recent substance abuse, which prevents the clinician from making a definitive qualifying diagnosis.
- Cases in which the impairment is profound and short-term.
- Whose degrees of impairment falls mainly within the emotional/self-harm domains that show strong evidence of serious disturbance.

Therapeutic Foster Home Profile Form

1. Agency Name:

2. Agency Contact Name & Number: Date:

3. Foster Family Name:

4. Foster Family geographic location:

5. Foster Family preference or exclusions for foster youth (if any including age, gender, diagnosis, etc):

6. Foster Family length of experience as TFH:

7. Foster Family current number, age and sex of foster youth:

8. Foster Family current number, age and sex of biological youth:

9. Foster Family, maximum number of foster youth willing to take:

10. Foster Family strengths:

11. Foster Family weaknesses:

Comments:

CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
POLICY AND PROCEDURE MANUAL

SUBJECT: Sentinel Events	**Number:**	**80.805**
	Page	**5 of 5**

REFERENCE: JCAHO; CARF; COA; 45 C.F.R. §164.502(b)(1); 34 C.F.R. Part 99; HRS 334-5, HRS §350-1.1, HRS §350-1.2, Confidentiality of Records, CAMHD P&P 80.402, "Confidentiality, FAX Transmission."."	**APPROVED:**
	Signature on File 8/24/11
	Administrator Eff. Date

PURPOSE

To establish uniform guidelines for a reporting system that is designed to track and document sentinel events and the follow-up of the events reported by the Child and Adolescent Mental Health Division (CAMHD) Branches and contracted provider agencies (Provider).

DEFINITIONS

Sentinel Event - An occurrence involving serious physical or psychological harm to anyone or the risk thereof, as defined under the categories of sentinel event codes and definitions. A sentinel event includes 1) any inappropriate sexual contact between youth, or credible allegation thereof; 2) any inappropriate, intentional physical contact between youth that could reasonably be expected to result in bodily harm, or credible allegation thereof; 3) any physical or sexual mistreatment of a youth by staff, or credible allegation thereof; 4) any accidental injury to the youth or medical condition requiring attention by a medical professional or transfer to a medical facility for emergency treatment or admission; 5) medication errors and drug reactions; 6) any fire, spill of hazardous materials, or other environmental emergency requiring the removal of youth from a facility; or 7) any incident of elopement by a youth.

Critical Events - Events involving serious injury or death, suicidal attempts, sexual misconduct, allegations of staff abuse or misconduct.

Incident - An occurrence that is a safety issue that is minor in nature and does not require major medical or staff intervention and is not identified as a reportable event as defined in the sentinel event codes and definitions. Incidents as defined here should be recorded and tracked internally, but do not need to be reported to CAMHD Sentinel Events Specialist (SES).

Root Cause Analysis - A process for identifying the basic or causal factors that underlie variation in performance, including the occurrence or possible occurrence of a sentinel event. A root cause analysis focuses primarily on systems and processes, not individual performance. It progresses from special causes in clinical processes to common causes in organizational processes and identifies potential improvements in processes or systems that would tend to decrease the likelihood of such events in the future, or determines, after analysis, that no such improvement opportunities exist.

The product of the root cause analysis is an ***action plan*** that identifies the strategies that the organization intends to implement to reduce the risk of similar events occurring

in the future. The plan should address responsibility for implementation, oversight, pilot testing as appropriate, time lines, and strategies for measuring the effectiveness of the actions.

Individually Identifiable Health Information - Information that is a subset of protected health information, including demographic information collected from an individual, and: (1) Is created or received by a health care provider, health plan, employer, or health care clearinghouse; and (2) Relates to the past, present, or future physical or mental health condition of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual, and that identifies the individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

Protected Health Information - Individually identifiable health information that is transmitted by electronic media or maintained in electronic form/medium. Protected health information excludes individually identifiable health information in: (1) Education record covered by the Family Educational Rights and Privacy Act (FERPA) as amended by 20 U.S.C. 1232g; (2) Records described at 20 U.S.C. 1232g(a)(4)(B)(iv); and (3) Employment records held by a covered entity in its role as employer. CAMHD client clinical records, and those of its contracted providers, are considered "educational records" that come under FERPA authority. However, for the purpose of reporting a sentinel event, individually identifiable health information will be exchanged following HIPAA guidelines for handling PHI.

Minimum Necessary applies. When using or disclosing protected health information or *when requesting protected health information from another covered entity, a covered* entity must make reasonable efforts to limit protected health information to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request.

POLICY

1. Providers shall document and report all sentinel events to the CAMHD Performance Management Office's Sentinel Events Specialist (SES), and to the applicable Branch where youth is registered. All events that occur during the period a youth is receiving services must be reported, including events not witnessed directly by the Provider's staff.
2. Providers are required to track and analyze the occurrence of both sentinel events and incidents as part of their quality improvement program to identify areas of need for changes in general operations, program, staffing, training, or supervision. Results of these analyses shall be reported in the Providers' *Quarterly Quality Improvement Report* to CAMHD.
3. The CAMHD sentinel events reporting system shall allow for clinical and administrative oversight as well as provision of data utilized towards preventive interventions.

CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
POLICY AND PROCEDURE MANUAL

SUBJECT: Sentinel Events	Number:	80.805
	Page	5 of 5

4. The Provider shall immediately establish a safe and therapeutic environment following any event in which the safety of youth, family, community members, or staff, is compromised.
5. The Provider will review the sentinel event to determine:
   A. Triggers that caused the event to occur; and
   B. Root causes of the sentinel event.
6. The Provider will complete:
   A. A detailed assessment and analysis of the sentinel event, including the identification of triggers and root causes; and
   B. A time-limited plan or strategy that allows the primary agency or party with oversight authority to adopt and implement a corrective course of action that reduces the probability of similar events reoccurring with any youth.

PROCEDURE

1. When a sentinel event occurs the Provider shall verbally notify the SES, the youth's legal guardian, and the youth's assigned Care Coordinator (CC) within twenty-four (24) hours of the occurrence of the sentinel event by phone.

2. Providers shall submit in writing all sentinel events using CAMHD's standard *72 Hour Sentinel Event Report* form *(See Attachments A and B)* by a confidential fax to the SES, and CC within ***seventy-two (72) business hours*** of the sentinel event by fax (733-9357). Fax transmissions that contain protected health information about consumers shall follow protocol pursuant to *CAMHD P&P 80.402, "Confidentiality, FAX Transmission."* The documentation shall include:
   A. Youth's name, date of birth ,
   B. A written description of the event,
   C. Review and identification of precipitating events,
   D. Immediate actions taken ,
   E. Analysis of actions on the part of staff that may have reduced the severity of the occurrence, and
   F. Action that will be or have been taken in the attempt to prevent future similar occurrences.
3. In cases of critical events involving serious injury or death, suicidal attempts, sexual misconduct, allegations of staff abuse or misconduct, the Provider shall report such event by telephone to SES ***within two (2) hours*** of event occurrence.
4. The SES shall immediately notify the Supervisor of critical safety/risk management concerns. Critical events involving serious injury or death, suicidal attempts, or rape, may require immediate on-site investigations conducted by the Performance Management Reviewers; or at the very least, immediate information, guidance, and requests of the Provider are conducted in writing or by telephone.

CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
POLICY AND PROCEDURE MANUAL

SUBJECT: Sentinel Events	Number:	80.805
	Page	5 of 5

5. The Performance Management Office will conduct an investigation of critical events within thirty (30) calendar days for the following critical sentinel events:

   A. Suicide,
   B. Homicide,
   C. Accidental death,
   D. Serious physical injury requiring hospitalization, and
   E. Rape.

6. The CAMHD Performance Manager shall convene a team of CAMHD professionals and others to conduct a root cause analysis of a critical event. Providers will participate in the root cause analysis and provide all relevant information requested by the team as appropriate.

   A. Members of the team shall include at the minimum:

      1) A licensed clinical mental health professional,
      2) A quality assurance specialist,
      3) An administrator, and
      4) Other representatives to assure all parties involved participate in the Root Cause Analysis.

   B. The Performance Manager will prepare a formal written report of the investigation and its findings, including the root cause analysis and the Provider's Action Plan for review by the CAMHD Administrator and by the CAMHD Safety and Risk Management Committee (SARM).
   C. The Performance Manager will prepare a final written report of the findings and recommendations that will be distributed to all applicable CAMHD sections, including Branches. Performance Management reviewers shall follow-through and monitor required documents and adequacy of corrective action from the agency.

7. The Provider's Clinical Director or qualified mental health professional (QMHP) designee shall review and provide comments to each *72 Hour Sentinel Event Report* to ensure legibility, accuracy, completeness, and clinical/administrative adequacy prior to signing and releasing to CAMHD.

8. Providers shall maintain a systematic log of their sentinel events on a manual or electronic database to generate reports to conduct their internal reviews and analyses. Aggregate analyses, findings and actions taken to reduce frequency of occurrences shall be a part of the agency's overall Quarterly Quality Improvement Report submitted to CAMHD. Further, comparisons shall be made of each ensuing quarter against previous quarters' findings.

9. The SES shall maintain a log of all sentinel notifications to determine whether further information is necessary in instances where immediate action by the Provider and CAMHD is warranted.

CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
POLICY AND PROCEDURE MANUAL

SUBJECT: Sentinel Events	Number:	80.805
	Page	5 of 5

10. The SES shall track the timeliness and adequacy of Providers' *72-Hour Sentinel Event Reports.* The SES shall consult with or inform the appropriate Performance Management Office or Clinical Services Office clinician as necessary.
11. The SES shall maintain an electronic database of all sentinels reported by Providers or Branches. Various reports are aggregated from data fields sorted by Provider with comparisons among all Providers of like services on a quarterly basis. CAMHD's SARM Committee, and the Performance Improvement Steering Committee (PISC) shall review these reports. Additionally, such reports are also incorporated into CAMHD's quarterly report to Med-QUEST Division.
12. The SES shall generate full detailed reports for Performance Management reviewers in preparation for the Provider agencies' case-based reviews.
13. The Performance Management Reviewers shall conduct desk reviews or on-site reviews of Providers' system of tracking and analyses in full detail of incidents whenever special investigations, regular provider agency case-based reviews, or licensing reviews are conducted.

ATTACHMENTS

A. 72-Hour Sentinel Event Report Form
B. Sentinel Event Code Definitions

Child & Adolescent Mental Health Division
State of Hawaii Department of Health
72-HOUR SENTINEL EVENT REPORT

Internal Use Only

Log Number	Level

Under CAMHD guidelines, a sentinel event is an occurrence involving serious physical and/or psychological harm or the risk thereof. A separate form is required for each singular event.

Fax the completed form to the CAMHD Sentinel Events Specialist at 733-9357 and to the youth's FGC Care Coordinator at the appropriate Family Guidance Center fax number *within three business days of the event occurrence*. A 24-hour verbal report is also required to the case Care Coordinator as well as to the CAMHD Sentinel Events Specialist at 733-9356. Pages 1 - 3 are to be completed by staff witnesses involved. Page 4 is to be completed by the Clinical Director or designated Qualified Mental Health Professional.

Agency: _____ Program Name:_____ Provider ID#:_____
Street Address (residential facilities only)**: _____ Phone:_____**

Island:_____ Reported By: _____ Date Reported:_____ Time Reported _____am/pm
Level of Service (check one):
☐ Hospital-Based Residential ☐ Community Based Residential ☐ Community Based Residential-High Risk
☐ Intensive In-Home ☐ Multi-Systemic Therapy ☐ Functional Family
☐ Therapeutic Foster Home ☐ Multidimensional Treatment Foster Care
☐ Therapeutic Group Home ☐ Independent Living Program
☐ Community Based Residential ☐ Community Based Residential-High Risk ☐ Crisis Residential
☐ Other:_____

Care Coordinator:_____ Family Guidance Center:_____
Youth's Last Name:_____ Youth's First Name:_____
CAMHD CR#:_____ DOB:_____ Event Date:_____ Time:_____ am/pm

☐ Check here if event occurred when client was not under direct care of program or staff (e.g., family outing, in school, etc.)

☐ Care Coordinator Notified of Event
Date:_____ Time:_____ am/pm

☐ Personal Notification of Parent or Legal Guardian
Date:_____ Time:_____ am/pm

☐ Youth's Therapist Notified of Event
Date:_____ Time:_____ am/pm

☐ Probation Officer Notified of Event (If Applicable)
Date:_____ Time:_____ am/pm

DESCRIPTION OF EVENT

A. Where did this event happen? (*State actual location of event.*)

B. What happened? *(Summarize what occurred, attach additional sheet, if necessary)*

C. What happened before this event? *(List precipitating factors AND/OR antecedents that occurred prior to this event happening, Identify any of the youth's triggers that may have occurred prior to the even happening.)*

D. Who was involved in this event? *(List the names and titles of participants engaged in this event. Submit separate report for other CAMHD youth involved.)*

E. How did this event end? *(Describe the status of the youth and staff involved in this event.)*

F. What type of follow-up has been planned for the staff and/or youth witnesses affected by this event?

EVENT CODES - Check all event codes that apply. Please use the Sentinel Event Code Definitions found in the Interagency Performance Standards and Practice Guidelines (IPSPG) for an explanation of each event code type. An ASTERISK (*) indicates reporting is required only for CAMHD out of home placements. If NOS/Other is checked please indicate what OTHER is.

YOUTH EVENTS

Person Directed – youth is the perpetrator

1 ☐ Sexually Inappropriate Behavior – *consensual, while in CAMHD out-of-home placement**

2 ☐ Sexually Inappropriate Behavior – *non-consensual*

3 ☐ Physical Assault I

4 ☐ Physical Assault II – *homicidal intent or potentially fatal*

5 ☐ Homicide

6 ☐ Sexual Assault I

7 ☐ Sexual Assault II – *penetration through coercion or threat of force*

8 ☐ NOS/Other: _____

Substance Use

9 ☐ Alcohol, Illicit Drugs, or Other Irregular use of Chemicals - *while in CAMHD out-of-home placement**

10 ☐ Accidental Overdose *(intentional is coded as a self injury)*

11 ☐ NOS/Other: _____

Property Directed

12 ☐ Theft – *replacement value greater than $250*

13 ☐ Destruction/Assault of Property – *requiring crisis or authority intervention*

14 ☐ Possession of Weapons or Hazardous Items

15 ☐ NOS/Other: _____

Intentional Self-Inflicted Injury

16 ☐ Refusal of Life Preserving Medical Treatment

17 ☐ Suicidal Ideation

18 ☐ Suicidal Threat – *verbal or gestural*

19 ☐ Non-Lethal Injury

20 ☐ Potentially Lethal Injury or Hospitalization

21 ☐ Suicide

22 ☐ NOS/Other: _____

Escape or Avoidance Behavior

23 ☐ Runaway – *while in family or non-CAMHD placement and gone for 24-hours or more*

24 ☐ Elopement - *while in CAMHD out-of-home placement and gone for 1 hour or more**

25 ☐ NOS/Other: _____

Aberrant Behavior

26 ☐ Aberrant Behavior - *active psychosis*

27 ☐ NOS/Other: _____

ALLEGATIONS MADE ONLY BY YOUTH WITH NO WITNESSES

28 ☐ Abuse of Youth by Staff – I*ndicate type of abuse*

☐ VERBAL Abuse

☐ PHYSICAL Abuse

☐ SEXUAL Abuse

29 ☐ *Abuse of Youth by Non-Agency Individual* – Indicate type of abuse

☐ PHYSICAL Abuse

☐ SEXUAL Abuse

30 ☐ NOS/Other: _____

INSTITUTIONAL EVENTS

Person Directed – Youth is the Victim

31 ☐ Youth Assaulted or Injured by Peer – *medical attention needed*

32 ☐ Youth Sexually Assaulted by Peer

33 ☐ Youth Assaulted or Injured by Non-Agency Adult

34 ☐ Youth Sexually Assaulted by Non-Agency Adult

35 ☐ NOS/Other: _____

Interventions

36 ☐ Restraint – PHYSICAL HOLD OR ESCORT
Start Time: _____ End Time: _____

37 ☐ Restraint – MECHANICAL OR CHAIR (Please Circle)
Start Time: _____ End Time: _____

38 ☐ Restraint – CHEMICAL
Name of Med: _____

39 ☐ Medication Used for Control
Name of Med: _____

40 ☐ Psychiatric Hospitalization (changed to psychiatric)

41 ☐ Seclusion
Start Time: _____ End Time: _____

42 ☐ Police Called – Criminal Charges Filed or Arrest

43 ☐ NOS/Other: _____

Youth Injury

44 ☐ Staff Medication Error

45 ☐ Youth Injured – *requiring immediate medical attention*

46 ☐ Youth Injured – *requiring hospitalization*

47 ☐ Death of Youth

48 ☐ NOS/Other: _____

Staff Injury

49 ☐ Staff Injured – *requiring medical attention*

50 ☐ Staff Injured During Seclusion or Restraint

51 ☐ NOS/Other: _____

Allegations CORROBORATED by a person other than youth

52 ☐ Abuse of Youth by Staff – *Indicate type of abuse*

☐ VERBAL Abuse

☐ PHYSICAL Abuse

☐ SEXUAL Abuse

53 ☐ *Abuse of Youth by Non-Agency Individual* – Indicate type of abuse

☐ PHYSICAL Abuse

☐ SEXUAL Abuse

54 ☐ NOS/Other: _____

FOLLOW-UP, ANALYSIS AND ACTION PLAN

This section to be completed by the Clinical Director or designated Qualified Mental Health Professional

G. Why do you think this event happened? **(Please describe what may have contributed to this event – intrinsic to the youth and external to the staff, environment, and/or program.)**

H. What have you learned about the youth, staff, and program? What changes will be made to the youth's treatment plan and crisis plan, program, or physical structure to address what you have learned?

I. *What interventions or strategies below are planned or have been implemented? For each box checked, provide a description in the Narrative portion below.*

- 01 ☐ Repeat Occurrence – Heighten Monitoring
- 02 ☐ Multiple Repeat Occurrence – Address in Treatment Plan
- 03 ☐ 1:1 Monitoring by Staff, duration:_____
- 04 ☐ Schedule Treatment Team Meeting
- 05 ☐ Assessment Scheduled
- 06 ☐ Room Change
- 07 ☐ Detained at Correctional Facility
- 08 ☐ Appointment with Primary Care Physician
- 09 ☐ Appointment with Psychiatrist
- 010 ☐ Consult with Doctor Regarding Medication
- 011 ☐ Consult Program RN
- 012 ☐ Medical Attention Provided
- 013 ☐ Admin Review of Policy and Procedures
- 014 ☐ Programmatic Changes Made
- 015 ☐ Staff Training Scheduled
- 016 ☐ Police Report Made
- 017 ☐ CPS Report Made
- 018 ☐ Debriefing

Narrative:

Clinical Director Print Name:_____ Date:_____

*If designee, indicate position and discipline title:_____

Phone:_____ e-mail address:_____

Signature:_____

SENTINEL EVENT CODE DEFINITIONS

Child Events

Child events generally occur due to choices made by the child and often involve target behaviors. These events are divided into 7 subcategories:

- Person Directed,
- Self-Injury,
- Substance Use,
- Property Directed,
- Aberrant Behavior
- Escape/Avoidance Behaviors, and
- Allegations Made by the Child (this category describes events reported by the child without witnesses or corroboration from another individual).

Person Directed Definitions – Client is the Perpetrator

1.	Sexually Inappropriate Behavior – consensual, while in CAMHD out-of-home placement	Inappropriate sexual behavior or non-penetrating sexual acts. Others involved must be willing participants or observers. Does not include acts with participants/observers who are 3 or more years younger. *This code only needs to be reported for clients in a Child and Adolescent Mental Health Division out of home placement.*
2.	Sexually Inappropriate Behavior –non-consensual	Inappropriate sexual behavior involving other non-consenting individuals. Includes events involving physical contact and events without any contact. e.g., exposure, verbally inappropriate behavior, sexually suggestive gestures, standing too close in an elevator, inappropriate hugging, etc.
3.	Physical Assault I	A violent physical attack or attempt to inflict offensive physical contact or bodily harm that puts the person in immediate danger of such harm or contact. Does not include incidents that fall under Assault II category.
4.	Physical Assault II – homicidal intent or potentially fatal	A violent physical attack or attempt to inflict offensive physical contact or bodily harm that puts the person in immediate danger of such harm or contact. Act must include homicidal intent or be potentially fatal.
5.	Homicide	Killing of one person by another.
6	Sexual Assault I	Act of engaging in sexual penetration with another person who is less than 14 years old.
7.	Sexual Assault II – penetration through coercion by threat of force	Act of engaging in non-consensual penetration with another through coercion or threat of force.
8.	NOS/Other	Other person directed events not described by above definitions.

Substance Use – Self Administered or Non-professionally Administered

9.	Alcohol or Other Irregular use of Chemicals - while in CAMHD out-of-home placement	Possession or use of alcohol, drugs, or other illicit or poisonous natural or synthesized substances. Includes consumption of legal substances in way not intended for use (sniffing glue, etc.).
10.	Accidental Overdose (intentional overdose coded as self injury)	Consumption of alcohol, drugs, tobacco, or other illicit or poisonous natural or synthesized substances requiring medical attention.
11.	NOS/Other	Other substance abuse events not described by above definitions.

Property Directed

12.	Theft	Any type of stealing or theft of an item with a replacement value greater than $50.
13.	Destruction/Assault of Property	Destruction of personal possessions, physical structures, furnishings, or other such property requiring crisis or authority intervention (police called, charges pressed, etc.).
14.	Possession of Weapons or Hazardous Items	Possession of a prohibited item or weapon with the potential to inflict serious harm to persons or property.
15.	NOS/Other	Other property directed events not described by above definitions.

Intentional Self-Inflicted Injury

16.	Refusal of Life-Preserving Medical Treatment	Refusal to receive recommended, life-preserving medical treatment other than medication.
		Second consecutive refusal by youth to take medication as prescribed. Do not combine multiple days on one report, each day must be reported separately.
17.	Suicidal Ideation	Expression of thoughts to harm self (verbal, gestures, drawings, letters, etc.).
18.	Suicidal Threat – verbal or gestural	Immediate serious threat with a plan to harm.
19.	Non-Lethal Injury	Self-inflicted, non-lethal, injury without the potential to end one's life.
		Self-inflicted, non-lethal, injury without the potential to end one's life which requires immediate medical attention.
20.	Potentially Lethal Injury or Hospitalization	Self-inflicted injury with the intention or potential to end one's life requiring hospitalization - or - requiring immediate care and attention of a qualified physician, and which, if not treated immediately, would jeopardize or impair the health of the child.
21.	Suicide	Intentionally ending own life.
22.	NOS/Other	Other self-injury events not described by above definitions.

Escape or Avoidance Behavior

25.	Runaway - while residing in family home or other non-CAMHD placement	Removing self from supervision for 24-hours without permission while residing with natural family, DHS foster home, or other placement not contracted through Child and Adolescent Mental Health Division.
26.	Elopement - while residing in CAMHD Out-Of-Home placement	Removing self from supervision without permission for an hour or more while residing in a Child and Adolescent Mental Health Division out-of-home placement, such as therapeutic foster home, group home, etc. Only report incidents of truancy where the youth is not present at the expected time.
27.	NOS/Other	Other escape or avoidance behavior events not described by above definitions.

Aberrant Behavior

28.	Aberrant Behavior	Severe behavior involving dissociated behavior or possible psychosis that does not fit into another event category.
29.	NOS/Other	Other aberrant behavior not described by above definition.

Allegations – Made Only by Client

Allegations that are only made by the client with no witnesses or others involved who can corroborate the allegation.

28.	Abuse of Client by Staff – Please indicate type of abuse: Verbal Physical Sexual	Client alleges staff member of reporting agency of abuse. Please indicate type of abuse being alleged.
.		Client alleges physical abuse from staff member of reporting agency. Includes hair pulling, pushing, or inappropriate methods of restraint (like grabbing shirt).
29.	Abuse of Client by Non-Agency Individual – Please indicate type of abuse: Physical Sexual	Client alleges abuse from individual that is not a staff member of reporting agency. Please indicate type of abuse being alleged.
.		Client alleges sexual abuse from staff member of reporting agency.
.		Client alleges sexual abuse from individual that is not a staff member of reporting agency.
30.	NOS/Other	Other allegations made by the child not described by above definitions.

Institutional Events

Institutional events are events that happen to the child or occur as a consequence of child behavior. These events generally occur due to choices made by individuals other than the child. These events are divided into 5 subcategories:

- Person Directed,
- Treatment Interventions,
- Client-Injury,
- Staff Injury, and
- Allegations made by person other than the child (this category does not include events only reported by the child without corroboration from another individual).

Person Directed – Client is the Victim

31.	Client Assaulted or Injured by Peer – medical attention needed	Physical mistreatment by peer(s) requiring medical attention or hospitalization.
32.	Client Sexually Assaulted by Peer	Client sexually assaulted or mistreated by peer(s).
33.	Client Assaulted or Injured by Non-Agency Adult	Physical mistreatment by adult not employed by reporting agency.
.		Physical mistreatment by adult not employed by reporting agency - requiring medical attention or hospitalization.
34.	Client Sexually Assaulted by Non-Agency Adult	Client sexually assaulted or mistreated by adult not employed by reporting agency.
35.	NOS/Other	Other person directed events not described by above definitions.

Interventions

36.	Restraint - physical hold or escort Start time: End time:	Involves the application of physical force without the use of any device, for the purpose of restricting freedom of movement. Brief 'personal holds' without undue force for the purpose of comforting, or holding an individual's hand or arm for safe escort to another area is not considered a restraint. Physical escorts in which the youth is willfully cooperating with the guide is not considered restraint until such a time as the youth no longer intends to follow or be escorted (e.g., youth struggles with staff). Excludes physical separation of two individuals by placing body between them to prevent physical altercation. There are no distinguishing time limits.
37.	Restraint - mechanical Start time: End time:	Involves the use of any restraining device attached or adjacent to the youth's body (e.g., four point bed restraints) that restricts a youth's movement. There are no distinguishing time limits.
38.	Restraint - chemical Name of medication:	Involves the incidental use of medications and drugs to control acute unsafe behavior through temporary sedation or other related pharmacological action. Does not include PRN. Please specify the type of medication administered.

39.	Medication used for Control Name of medication:	Any medication given urgently for emotional or behavioral control such as NOW or STAT orders. Please specify the type of medication administered. * For in-home services, it is only necessary to report those events requiring crisis intervention.
40	Psychiatric Hospitalization	Acute and emergent admission to the hospital for psychiatric reasons.
41.	Seclusion Start Time: End Time:	The involuntary confinement of a youth in a locked and/or secure room to ensure the safety of the child or others. Any such isolation in a secure environment from which the youth is not potentially free to leave is considered seclusion (e.g., having a staff member block the exit from the unlocked seclusion room).
42.	Police Called – Criminal Charges Filed or Client is Arrested	Police called and charges filed - or - Child is arrested. Excludes instances of calling the police when used as a planned treatment intervention previously decided by treatment team and written into the individual treatment plan.
43.	NOS/Other	Other interventions not described by above definitions.

Client Injury

This section refers to those events where the reason for occurrence is other than an assault against the client. Events that involve the assault of a client should be coded as Person Directed Institutional Events.

		Any error in making medication available to client by a non-agency individual. This includes dispensing errors made while child is on pass.
44.	Staff Medication Error	Any error in making medication available to client by an agency individual/staff. Includes forgetting medication, giving wrong medication, and discovering medication count is different from medication log.
45.	Client Injured - requiring immediate medical attention	Injury to client, not intentionally self-inflicted, and requiring immediate medical attention
46.	Client Injured - requiring hospitalization	Injury to client, not intentionally self-inflicted, with the potential to end one's life requiring hospitalization for non-psychiatric reasons - or - requiring immediate care and attention of a qualified physician, and which, if not treated immediately, would jeopardize or impair the health of the child.
47.	Death of Client	Death from any cause.
48.	NOS - non-injury related (i.e. seizure)	Other significant events requiring medical attention not classified by above categories, including non-injury related events (e.g., medical complications).

Staff Injury

49.	Staff Injured - medical	Program related or youth caused injury to staff requiring medical

	attention required	attention. Does not include injuries that occur during a seclusion or restraint.
50.	Staff Injured During Seclusion or Restraint	Injury to staff that occurs during a seclusion or restraint intervention.
9.		Injury to staff that occurs during a seclusion or restraint requiring medical attention.
51.	NOS/Other	Other staff injury events not described by above definitions.

Allegations – Corroborated by a Person Other than Client

Allegations made by the client and there are witnesses or others involved who can corroborate the allegation. Allegations made by others concerning the client also fall under this category.

52.	Abuse of Client by Staff – Please indicate type of abuse: Verbal Physical Sexual	Alleged abuse from staff member of reporting agency. Please indicate type of abuse being alleged.
.		Alleged inappropriate physical abuse from staff member of reporting agency. Includes hair pulling, pushing, or inappropriate methods of restraint (like grabbing shirt).
53.	Abuse of Client by Non-Agency Individual – Please indicate type of abuse: Physical Sexual	Alleged abuse from individual that is not a staff member of reporting agency.
.		Alleged sexual abuse from staff member of reporting agency.
		Alleged sexual abuse from individual that is not a staff member of reporting agency.
54.	NOS/Other	Other allegations made by person other than child not described by above definitions.

Weekly Census Report on Patient Status (Admitted / Pending / Screening)

Facility: _____ **Ward:** _____ (Unit) *Use **Separate** sheet for each unit*

For: Month _____ Day _____ Year _____ Prepared By: _____

*Due **before** close of business day each Monday*

No of Beds currently available	Age	Gender	Sub LOC	*Specialty*	General Location	Other

For **All** patients, fill in all appropriate columns

Family Guidance Center abbreviations are**:**

CO	Central Oahu	**HNL**	Honolulu, Oahu	**LO**	Leeward Oahu	**WO**	Windward Oahu
FCLB	Family Court Liaison Branch	**H**	Hawaii	**M**	Maui	**K**	Kauiai

WAIT LIST	
***Yes** ☐	**No** ☐
** If Yes, Enter details below*	

A	B	C	D	E	F	G	H	I	J	K
Date of Admission	Patient Name LN, FN	Gender M or F	Sub Loc	Referring Agency (FGC)	Projected Date of Discharge	Actual Date of Discharge	Wait Listed Date	Projected Date of Admission	Screen Date	Comments

FAX to Romel Mendoza at Clinical Services Office: (808) 733-9875 rev. 2/16/01

WAITLISTED YOUTH

Facility: _____ **Program:** _____ **For:** Month _____ Day _____ Year _____

Use Separate sheet for each program

*Due **before** close of business day each Monday*

Prepared By: _____

Contact # _____

CO	Central Oahu	**HNL**	Honolulu, Oahu	**LO**	Leeward Oahu	**WO**	Windward Oahu
H	Hawaii	**M**	Maui	**K**	Kauai		

Note : All columns must be completed as appropriate

Client's Name LN, FN	FGC	Gender M or F	D.O.B	Diagnosis	Current Placement	Date Waitlisted	Projected Date of Admission	Sub Level of Care Needed	Other Agencies Involved	Waitlisted Region

Agency Name:

State Training Proportion of Total Trng. Cost [%]

CONTRACTED AGENCY QUARTERLY TRAINING REPORT (TRAINER & TRAINEE COSTS)

Staff Name (Last, First)	Position Title		Professional Degree (Ph.D., MSW, etc)		Social Security or Position ID#			
Training Title/Topic and a Brief Description:	Trng. Purpose Categ*****	Training Dates	Training Modality*	Training Hours	Hourly Trng Cost**	Salary Cost***	Other Costs****	Total Trng. Cost
						$ -		$ -
						$ -		$ -
						$ -		$ -
						$ -		$ -
						$ -		$ -
Total Training Hours/Cost for Staff				0		$ -	$ -	$ -

Staff Name (Last, First)	Position Title		Professional Degree (Ph.D., MSW, etc.)		Social Security or Position ID#			
Training Title/Topic and a Brief Description:	Trng. Purpose Categ*****	Training Dates	Training Modality*	Training Hours	Hourly Trng Cost**	Salary Cost***	Other Costs****	Total Trng. Cost
						$ -		$ -
						$ -		$ -
						$ -		$ -
						$ -		$ -
						$ -		$ -
Total Training Hours/Cost for Staff				0		$ -	$ -	$ -

INSTRUCTION: 1)Read Attachment before filling out form;

2) Use this form to list all training attended or conducted by staff. **IV-E Training Form 05**

CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
POLICY AND PROCEDURE MANUAL

SUBJECT: Child Abuse and Neglect Check	**Number:**	**80.406**
	Page	**1 of 4**

REFERENCE: Hawaii Revised Statutes 350; Hawaii Administrative Rules, Chapter 920.1-11-13	**APPROVED:**
	Signature on File 08/26/2011
	Administrator Eff. Date

PURPOSE

To establish procedures for child abuse and neglect clearances for the Child and Adolescent Mental Health Division (CAMHD) to ensure the safety of youths served by CAMHD employees or the employees and/or subcontractors of the CAMHD contracted agencies.

DEFINITIONS

"Confirmed" means a report of child abuse or neglect that has been investigated by the Department of Human (DHS) where there has been a determination by the DHS that physical, sexual, or psychological harm, physical neglect, threatened harm occurred, and a perpetrator of the harm or threat has been identified.

"Child abuse or neglect" means the acts or omissions of any person who, or legal entity which, is in any manner or degree related to the child, is residing with the child, or is otherwise responsible for the child's care, that have resulted in the physical or psychological health or welfare of the child, who is under the age of eighteen, to be harmed, or to be subject to any reasonably foreseeable, substantial risk of being harmed.

POLICY

1. The CAMHD shall deny, revoke or not renew an individual provider's credentials and/or privileges, or certification to provide services to CAMHD youth if the individual has been confirmed as a perpetrator of harm or substantial risk of harm to a minor in a prior Child Abuse or Neglect (CAN) case involving any of the following:

   A. Sexual abuse of all levels of harm at any time;

   B. High or severe physical or psychological abuse at any time as defined by the DHS;

   C. High or severe neglect (includes medical neglect, failure to thrive) at any time as defined by the DHS;

   D. Involuntary termination of parental rights of a child due to neglect or abuse;

   E. Moderate physical or psychological abuse within the last five (5) years, which may include repeated episodes of minor bruising, verbal humiliations and degradations, unexplained medical injuries which may or may not require medical assistance, and any other instance as defined by the DHS; or

F. Moderate neglect within the last five (5) years, which may include: repeated episodes of impulsive and careless behaviors, failure to provide a safe and healthy

2. The CAMHD may deny, revoke or not renew an individual provider's credentials and/or privileges, or certification to provide services if the provider has been confirmed as a perpetrator in a CAN case ***not listed above*** if this could pose a risk to the health, safety or well-being of children under CAMHD's care.

PROCEDURE

1. CAMHD and its contracted agencies will request, via a valid and signed informed consent to release information, a review of the DHS's ***Child Protective Services System (CPSS)*** registry for every direct service personnel according to procedure identified in CAMHD's Credentialing policies and procedures.

2. CAMHD's designated staff will review the DHS's ***CPSS*** registry for confirmed cases of CAN based on staff information provided by the contracted agency.

3. Designated CAMHD staff will consult with the DHS staff or DHS contracted agency, whenever the DHS's *CPSS* information is not available or is incomplete to determine cleared or confirmed cases of CAN.

4. Based on *CPSS* review and corroboration with the DHS staff or DHS contracted agency, CAMHD's Credentialing Specialist or designee will inform the contracted agencies of those personnel that have been cleared.

5. Contract agencies will arrange for a copy of DHS' CAN report through the affected staff; interview the staff member, and request a letter from the staff that provides background information, follow-up actions taken, and any testimony self or otherwise, on his or her behalf.

6. The applicable contracted agency's or CAMHD's clinical supervisor or administrator of the specified staff will conduct a thorough assessment to determine the current level of risk involved, and subsequent course of action as future risk deterrents.

7. A written report of the risk assessment shall be sent to CAMHD's Credentialing Committee, with all supporting documents as necessary defining findings and justifying the course of action taken. Reports shall evidence assessments that consider at minimum, the following:

   A. Type of harm,

   B. When the harm occurred,

   C. The circumstances surrounding the harm,

D. The frequency or pattern of occurrences,

E. Whether treatment or rehabilitation took place,

F. Degree of access to children and whether employment would pose a risk to children, and

G. Special conditions of continued employment, including degree and frequency of individual supervision.

8. The Credentialing Committee will:

A. Review agency's report of findings and actions;

B. Determine the relevancy and adequacy of all available information relative to actions taken regarding the employee;

C. If necessary, request additional information such as psychological evaluations, substance abuse assessments, ***etc***., with any costs incurred, the responsibility of the provider;

D. Recommend to the CAMHD Executive Management Team a course of action to be taken by CAMHD against an agency/provider if the seriousness of risk is established; and

E. Determine whether consideration may be given to the individual who shows more than a single evidence of being rehabilitated, which may include:

1. Letters from a counselor or therapist indicating successful completion of treatment and a statement that the counselor believes the individual does not pose a risk to children;

2. Successful completion of past services that are relevant to the report of abuse or neglect;

3. Statements from individuals who are credible and reliable who can document and verify a sustained change in the individual's behavior that is relevant to the individuals employment; or

4. Positive conduct in the community or in employment.

9. The Credentialing Committee will inform the agency in writing, under CAMHD Administrator's approval and signature, of CAMHD's decision, basis for the decision, and recommendations that may include:

A. Support of the individual's employment with evidence of rehabilitation;

B. Letters of support from past employers or community advocates that validates safety of the children;

C. Employee personnel record review via consent from the employer and employee; and

D. Re-evaluation of the employee in six (6) months, with a report of findings and actions submitted to CAMHD's Credentialing Committee.

ATTACHMENT: None

CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
POLICY AND PROCEDURE MANUAL

SUBJECT: Initial and Re-Credentialing of Licensed Qualified Mental Health Professionals	**Number:**	**80.308**
	Page:	**1 of 15**

REFERENCE: HRS; HI QUEST; QARI; HI State; Licensing Boards; CMSS; CAMHD QAIP; NCQA Standards for Credentialing & Re-credentialing: 42CFR; §438.12, § 438.200, § 438.204, § 438.206, § 438.214, §438.224; HSAG Audit Tool; HAR, Title 11, Department of Health, Chapter 98, Special Treatment Facilities	**APPROVED:** *Signature on File* 8/23/11 Administrator Eff. Date

PURPOSE

The purpose of this policy is to assure that qualified mental health professionals through established minimum qualifications render services to CAMHD youth.

DEFINITIONS

See Glossary of Credentialing Terms **(See Attachment A)**

POLICY

1. The CAMHD ensures a systematic credentialing process of assessing the qualifications of CAMHD and CAMHD contracted Provider Agencies' licensed, Qualified Mental Health Professionals (QMHP), direct care personnel and clinical supervisors. This process ensures that any Hawaii licensed practitioner providing mental health services to youth served by the CAMHD, who either:

   A. Is an independent contractor with CAMHD; or

   B. Is employed with CAMHD; or

   C. Is employed or subcontracted by a CAMHD contracted Provider Agency, hereafter referred to as the Provider Agency; and

   is credentialed *prior* to providing direct mental health services to youth.

2. The CAMHD Credentialing Committee, hereinafter referred to as the "Committee" meets monthly to make determination on all credentialing/re-credentialing applications. The Committee makes such determinations in accordance with this policy and the policy and procedures set forth in CAMHD P&P 80.508, "Credentialing Committee."

3. The CAMHD reserves the right to make the final determination about which practitioners may participate in its network and provide services to CAMHD registered youth. Practitioners shall meet all applicable standards to participate in the CAMHD's provider network.

   The CAMHD *will not pay* for services rendered if the provider is NOT credentialed.

4. The CAMHD credentials the following licensed practitioners as a QMHP:
   - Medical Doctor

94REVISION HISTORY: 8/13/02, 3/17/03, 7/15/03, 8/25/0*
Initial Effective Date: 2/15/02
Biannual Review Date:

File Ref: A6799

- Licensed Clinical Social Worker (LCSW)
- Licensed Marriage and Family Therapist (LMFT)
- Licensed Psychologist (Ph.D. or Psy.D.);
- Advanced Practice Registered Nurse (APRN); and
- Osteopathic Doctor (D.O.)

5. The licensed practitioners who do not need to be credentialed/re-credentialed by CAMHD include:

   - Practitioners who practice exclusively within the inpatient setting and who do not provide mental health care for CAMHD youth who are admitted to a hospital or another inpatient setting. These practitioners need to be credentialed by the hospital or the inpatient setting they provide services.
   - Practitioners who do not provide care for CAMHD youth in a treatment setting (consultants).

6. The CAMHD will delegate to the Hospital-based Residential Programs the credentialing of QMHPs only.

7. **Applications.** The CAMHD Credentialing Section reviews all credentialing and re-credentialing applications. All applications shall include all required documents and verifications that will be presented to the Committee for review and approval. *(See **Attachment B, CAMHD Licensed Provider Initial Credentialing Application Form)*** A completed application shall include or meet the following requirements:

   A. All blanks on the application form are filled in and necessary additional explanations provided;

   B. All requested attachments and information have been submitted;

   C. Verification of the information is complete and done through primary sources when required; and

   D. All information necessary to properly evaluate the applicant's qualifications has been received and is consistent with the information provided in the application.

8. **Primary Source Verifications.** The CAMHD delegates primary source verification to the Provider Agencies for their employees and/or subcontractors. The CAMHD delegates the primary source verification to a contracted credentialing verification service for CAMHD employees. Required primary source verifications are outlined in ***Attachment C, CAMHD Licensed Provider Checklist (LPC)***, and include verification timeline requirements, and methods of accepted primary source verification.

   A. Practitioners shall be primary source verified with the State of Hawaii Department of Commerce and Consumer Affairs (DCCA), Professional and Vocational Licensing Division at http://pvl.ehawaii.gov/pvlsearch/app to verify Hawaii licensure.

B. The credentials of practitioners shall be evaluated against pre-determined criteria in conjunction with the National Committee of Quality Assurance (NCQA) and state licensing requirements.

C. Practitioners will be notified in writing via regular mail of any information obtained during the credentialing process that varies substantially from the information provided to the CAMHD and/or the Provider Agency.

9. **Timeframes.** To prevent the Committee from considering a provider whose credentials may have changed since they were verified, primary source verification should be no more than one hundred eighty (180) days old (unless otherwise stated) at the time of the credentialing committee decision.

A. **Written verifications.** The one hundred eighty (180) days time limit begins with the date that the credentials were verified (the date on the letter or the signature date) and not when CAMHD or the Provider Agency received the information. Written documentation shall be complete using indelible ink.

B. **Oral verifications.** Oral verifications require a written statement to the CAMHD stating the verification date, the name of the primary source person who verified the information, the name and dated signature of the CAMHD or Provider Agency staff that conducted the query.

C. **Internet website verifications.** Internet verifications require the dated signature of the CAMHD or Provider Agency staff that conducted the query on all printed pages. Electronic signatures are allowed provided the signatures are password protected. The Provider Agencies and other agencies designated as primary source verifiers shall send a written report to the CAMHD of their electronic signature password protection policies.

10. **Credentialing Cycle.** Once a practitioner is credentialed, he/she is able to carry the full credential status for two (2)-years with the specified agency he/she is credentialed under. Upon approval, the Credentialing Section shall submit the practitioner's credentialing information to the CAMHD's Management Information System (MIS) Section for entry into the information/billing system.

A. The credentialing cycle begins with the date of the initial Committee decision to approve the credentialing application and ends two (2) years later. For example, if the Committee approved the practitioner's credentialing application on December 1, 2011, the practitioner's credentialing period would begin on December 1, 2011 and end on December 1, 2013.

B. Practitioners are considered credentialed/re-credentialed upon notification from the Credentialing Section after the Committee has rendered its decision.

11. **Confidentiality Policy**. The CAMHD holds all practitioner data and information obtained through the credentialing/re-credentialing process in strict confidence.

12. **Non-discrimination Policy.** The Committee does not make credentialing/re-credentialing decisions based solely on the applicant's race, ethnic/national identity, gender, age, sexual orientation, or the types of procedures or patients the practitioner (e.g., Medicaid) specializes in.

13. **Practitioner Rights.** The CAMHD shall provide all contracted agencies and CAMHD employees of their practitioner rights in the credentialing/re-credentialing process. Rights include but are not limited to:

    A. A review of submitted information in support of their credentialing/re-credentialing applications;

    B. The right to correct erroneous information; and

    C. The right to appeal any credentialing/re-credentialing decisions that limit, suspend or terminate a practitioner's credentialing/re-credentialing status.

PROCEDURES

1. **Credentialing Section Responsibilities:** The Credentialing Section staff, under the oversight of the Performance Manager, will:

    A. Inform the Provider Agencies of CAMHD's credentialing policies and procedures, providing them with a copy of each of CAMHD credentialing policies and procedures. The Provider Agencies are required to have similar policies and procedures to follow within their own agencies that comply with the CAMHD's credentialing policies and procedures.

    B. Provide training to the Provider Agencies on the credentialing/re-credentialing operational processes and requirements.

    C. Perform the following prior to the Committee's review of credentialing/re-credentialing applications:

        1. Receive and process all credentialing/re-credentialing applications prior to Committee review;

        2. Process all applications and conduct preliminary reviews of each practitioner's credentials in accordance with the LPC to ensure all primary source verifications being submitted meet the CAMHD's established criteria;

        3. Maintain and have available for review by the Committee the practitioner files that meet established criteria prior to the scheduled Committee meetings;

        4. Present a list of the names of all practitioners who meet the established criteria to the Committee for review and final approval;

        5. Present to the Committee all applicant files that do not meet all established criteria with all documentation necessary for the Committee to review and render appropriate determinations; and

6. Provide the CAMHD's MIS Section with a list of credentialed practitioners following approval from the Credentialing Committee.

II. Credentialing/Re-credentialing Documents and Primary Source Verification Requirements. The Credentialing Section staff will ensure that all credentialing/re-credentialing documentation and verification requirements are met. Primary source verification should be no more than one hundred eighty (180) days old (unless otherwise stated) at the time of the Committee's decision. Staff will use the LPC that outlines the CAMHD required primary source verifications, verification timeline requirements, and methods of accepted primary source verification. All boxes of the LPC must be checked off with verifying documents attached. The LPC includes the following criteria items:

A. Attestation: ***(See Attachment D, Attestation Letter)***. The Provider Agency or CAMHD's designated primary source verification agency representative shall complete the "*CAMHD Attestation Letter*" and submit the signed original letter to the Credentialing Section.

B. Background Verification Application. The *Background Verification Form for Qualified Mental Health Professionals* (Application Form). Applicants ***shall complete all areas*** of the application form including:

1. Identifying Information
2. Educational Information
3. Health status: In the event an applicant answers "Yes", a letter of explanation must accompany the application. The Committee shall review the letter of explanation and weigh the implications of any health conditions stated as it pertains to the applicant's ability to perform the functions of the position for which the provider is being credentialed. The Committee may consider approval of the applicant with or without restrictions.
4. Restrictive Actions: In the event an applicant answers "Yes", a letter of explanation must accompany the application. The explanation shall be for each occurrence with dates, parties involved, circumstances surrounding the situation and the outcomes. The CAMHD shall review the application and letter of explanation from applicant with restrictive actions and a letter of support from the agency addressing the specific restrictive action. Restrictive actions include any of the following below:

   a. Loss, denial, limitation of privileges or disciplinary activity
   b. Voluntary relinquishing of privileges or license
   c. Denial of certification
   d. Malpractice issues
   e. Criminal convictions
   f. Illegal Drug Use

g. History of loss or limitation of privileges or disciplinary activity

5. Relevant Work/Volunteer/Intern Experience
6. Release of Information Authorizations: Dated signature required
7. Affirmation: Dated signature required
8. Release and Immunity: Dated signature required
9. Provider Rights
10. Attestation as to the correctness and completeness of the application. The applicant must sign and date the attestation statement in the application.

C. Resume: The CAMHD does not require primary source verification of relevant work history to be submitted as part of the credentialing/re-credentialing requirement but defers employment verification activities as part of the intra agency human resource functions performed by the CAMHD or Provider Agencies in the case of CAMHD personnel.

For the work history requirement, a minimum of five (5) years of relevant work history must be obtained through the practitioner's resume. If it is obtained from the resume, the resume must state *a date of preparation* so that the Committee is able to determine the one hundred eighty (180)-day time limit for this criterion. The applicant must submit a written explanation of any gaps over six (6) months.

D. Education: The CAMHD or the Provider Agency must verify only the highest level of credentials attained. If a physician is board certified, verification of that board certification fully meets this element because specialty boards verify education and training. For practitioners who are not board certified, verification of completion of residency fully meets this requirement. For those who have not completed a residency program, verification of graduation from medical school meets this standard. Old verifications would be acceptable provided it verifies the education that is applicable to the licensure for which the applicant is being credentialed.

1. Education and training including board certification if the practitioner states on the application that he/she is board certified.
2. Education Verification Requirements for Different Specialties:

a. *For Board Certified Physicians:*

Verification of board certification fully meets education verification requirements because medical boards already verify education and training. Separate verification of education and residency training is not required for board certified medical doctors**.**

b. *For Non-Board Certified Physicians:*

Verification requirements of the completion of residency training or graduation from medical school can be met by the one of the following:

- Confirmation from the medical school
- Entry in the American Medical Association (AMA) Physician Master FileEntry in the American Osteopathic Association (AOA) Physician Master File
- Confirmation from the Educational Commission for Foreign Medical Graduates (ECMFG) for international medical graduates after 1986

c. *Non-Physician Behavioral Healthcare Professionals*

Confirmation from the university specifically stating name of applicant, degree and date conferred. Written verifications must be received directly from the university attended. Telephone verifications are acceptable provided the name of the person verifying the information; the date of verification and the person's name at the primary source is identified in a memo.

E. Board certification, if designated by the practitioner on the application. ***Verification Time Limit:*** *Any NCQA recognized source is valid up to one (1) year but if it is a document source (e.g. American Board of Medical Specialties (ABMS) Compendium), verification must also be based on the most current edition*

If an applicant states in their application form that they are board-certified, the board certification must be queried. Acceptable methods of verification include any of the following:

1. *Physicians*

   Completion of one of these:

   - Entry in the ABMS Compendium.
   - Entry in the American Osteopathic Association (AOA) Physician Master File.
   - Entry in the AOA Directory of Osteopathic Physicians.
   - Entry in the American Medical Association (AMA) Master File.
   - Confirmation from the specialty board

2. *Non-Physician Behavioral Healthcare Professionals*

   Confirmation from the specialty board

3. *Foreign Trained Physicians*

   Foreign trained physicians that graduated and obtained licensed after 1986 must submit a copy of their ECFMG certificate.

F. State of Hawaii License Verification. ***Verification time limit: 180 days***

Applicant shall possess a current license to practice in the State of Hawaii.

The Provider Agency shall confirm that the applicant holds a valid, current State of Hawaii license to practice. The license must be primary source verified with the State of Hawaii Department of Commerce and Consumer Affairs, Professional and Vocational Licensing Division at http://pvl.ehawaii.gov/pvlsearch/app. A copy of the license shall be printed and the person conducting the query shall date and sign all pages of the printout results.

G. Controlled Substance – State and Federal. ***Verification time limit: Certificate must be effective at the time of the credentialing/re-credentialing committee decision.*** If the applicant is a medical doctor, a copy of the current Drug Enforcement Agency (DEA) and state Narcotics Enforcement Division (NED) certificate must be present at the time of credentialing/re-credentialing approval.

A practitioner with a pending DEA application may be credentialed provided that another practitioner with a valid DEA certificate write all prescriptions requiring a DEA number for the practitioner until the practitioner has a valid DEA certificate. The name of the practitioner with the valid DEA number shall be noted clearly on the credentialing/re-credentialing file of the provider without a DEA number.

H. Malpractice Insurance: ***Verification time limit: Coverage must be effective at the time of the credentialing/re-credentialing decision.***

The Provider Agency shall obtain a letter confirming current malpractice coverage from the insurer. The letter shall state the name of the provider, policy number, dates of coverage, and 1 million / 3 million aggregate of coverage. Copies of face sheets from the practitioner will not satisfy this requirement unless it has been received from the insurer. History of professional liability claims that resulted in settlements or judgments paid by or on behalf of the practitioner. *Verification time limit: 180 days*
The Provider Agency shall obtain written confirmation of malpractice settlements from the current malpractice carrier and for all malpractice carriers in the past seven (7) years. These years may include residency years. In some instances, practitioners may have been covered by a hospital insurance policy during residency. In these cases, CAMHD or its Agency does not need to obtain confirmation from the carrier**.**

I. National Practitioner Data Bank Query. ***Verification time limit: 180 days***

The National Practitioner Data Bank (NPDB) shall be queried for previous malpractice claims history and/or state licensure sanctions. The CAMHD, Provider Agencies or their primary source verification contractor must become registered users of the NPDB to be able to request verifications. The query results must indicate "no records" query result. In the event that there is a record on file, the applicant must provide a letter of explanation of the record including a printout of the results from the NPDB. The committee will review the implications of the record as it pertains to the applicant's ability to provide quality services to CAMHD youth.

J. National Provider Identification: ***Verification time limit: 180 days***

The National Provider Identifier (NPI) is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered health care providers. Covered health care providers and all health plans and health care clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty. The NPI shall be used in lieu of legacy provider identifiers in the HIPAA standards transactions. As outlined in the Federal Regulation, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), covered providers must also share their NPI with other providers, health plans, clearinghouses, and any entity that may need it for billing purposes.
The CAMHD requires an NPI for all QMHPs and MHPs, and all paraprofessionals providing and billing for Intensive In-Home Therapy services.

K. State of Hawaii License Sanctions and Complaints History. ***Verification time limit: 180 days***

The practitioner's license limitations and restrictions must be primary source verified with the State of Hawaii Department of Commerce and Consumer Affairs, Professional and Vocational Licensing Division at http://pvl.ehawaii.gov/pvlsearch/app. The results of the complaints history query shall be printed and the person conducting the query shall date and sign all the pages of the printout results.

L. Medicare/Medicaid Sanctions. ***Verification time limit: 180 days***

The Office of the Inspector General at http://exclusions.oig.hhs.gov/search.html must be queried for the existence of any Medicare/Medicaid sanctions against the applicant. The results of the sanctions query should be printed and the person conducting the query shall date and sign all pages of the printout results. The query results must indicate "no records" query result. In the event that there is a record on file, the applicant shall provide a letter of explanation of the record. The committee will review the implications of the record as it pertains to the applicant's ability to provide quality services to CAMHD youth.

M. Other State License Verification. ***Verification time limit: 180 days***
The Provider Agency shall query an applicant that possesses a current or expired license in another state.
For active licenses, the Provider Agency shall confirm that the applicant's license is valid and current in the state reported. This query must be primary-source-verified with that

state's licensing board. The person conducting the query must date and sign all the pages of the printout results.

If the license has expired, the Provider Agency shall query the prior complaints history on such license. (See below.)

State sanctions, restrictions on licensure and/or limitation on scope of practice – for both active and expired out of state licenses:

The practitioner's license limitations and restrictions must be primary source verified with the other state's licensing board. The person conducting the query shall date and sign all the pages of the complaints history printout results.

N. Letters of Good Standing from Hospitals with Current Privileges. ***Verification time limit: 180 days.***

CAMHD must obtain a letter from any and all hospitals with which the practitioner has current privileges.

O. Hawaii Justice Center Data Bank Verification: ***Verification time limit: 180 days***

The CAMHD or Provider Agency shall query the Hawaii Justice Center Data Bank for any criminal record. The query results must indicate "no records found". In the event that a record is found within the past ten (10) years, the applicant shall provide a written explanation of the record. Rehabilitative or self-improvement programs attended to help improve whatever issues there may be at the time of offense shall be listed. In addition, the Provider Agency shall also submit to CAMHD a written supervision plan that outlines the position and overall function of the applicant, supervision structure, and any other mechanisms in place to prevent similar offenses from occurring while the applicant is employed with the Provider Agency or around CAMHD youth.

P. Child and Abuse Neglect (CAN) Verification. ***Verification time limit: 180 days***

The Department of Human Services Child Protective Services Database must be queried for child abuse and neglect records. The ***" CAMHD CAN Request Form" (See Attachment E)*** and ***"CAMHD CAN Authorization Form" (See Attachment F) s***hall be completed. The query results must indicate "no records found". In the event that a positive CAN record is found, the Provider Agency shall notify the CAMHD Credentialing Section of the record within twenty-four hours (24) by telephone and provide the hardcopy of the positive CAN record within three (3) business days by fax. The applicant through the Provider Agency shall submit a letter of explanation regarding the positive CAN results to the Credentialing Committee.

Once the applicant is credentialed and a CAN report is received with positive results, the Provider Agency shall suspend the practitioner from providing direct care services to CAMHD youth until the Committee has made a decision.

Q. Central Database Check for Sentinel Events, Grievance, and Medicare/Medicaid Exclusion. ***Verification time limit: 180 days.***

The CAMHD Credentialing Section shall check its central database to determine if the provider applicant has had previous reports pertaining to Sentinel Events or Grievances or has been excluded from participating in Medicare programs.

2. **Credentialing Committee Decisions.** The Committee shall review the complete application packets presented by the Credentialing Section prior to rendering any determinations. The CAMHD has the right to make the final determination about which practitioners participate within its network.

3. **Notification of Credentialing Adverse Determinations.** The Provider Agency or CAMHD practitioner will be informed in writing of any adverse credentialing/re-credentialing decision(s) from the Chair of the Credentialing Committee.

   A. The decision letter shall be sent to the Provider Agency within fifteen (15) calendar days of the decision. The letter will include the reconsideration and appeal process.

   B. Upon receipt of an appeal, the CAMHD has thirty (30) calendar days from the date of receipt of the letter of explanation to review documents and render a decision.

   C. The practitioner has the option to request a hearing and/or be represented by another person of the practitioner's choice.

4. **Practitioner Suspension of Participation**. The Committee has the authority to suspend a practitioner's participation in providing services to CAMHD youth. When there is immediate risk to a youth, the CAMHD shall suspend a practitioner's credentials while an investigation is conducted by the CAMHD.

   A. The suspension process is initiated when a report is made or an investigation occurs in cases where it is determined that potential risks or harm may exist to CAMHD youth and presented to the Committee for review and decision. These preliminary investigative reports to the Committee may be from any of the following:

   - Sentinel Events Unit
   - Grievance Office
   - Performance Monitoring
   - Facility Certification Unit
   - Possible abuse as indicated in the Child Abuse and Neglect Screening (CANS) Check Results

B. The Credentialing Section or Performance Management Office shall notify the Provider Agency verbally of the practitioner suspension within twenty-four (24) hours of the identified risk. The Provider Agency shall be notified in writing within seven (7) calendar days of the decision to suspend the practitioner's credentials. During the suspension of credentials, the practitioner may not work directly with CAMHD youth.

5. **Practitioner Restriction or Limitation of Participation.** The Committee has the authority to restrict or limit a practitioner's participation in the CAMHD Provider Network. Restriction or limitation may be considered in any of the following cases:

   A. Previous Grievance, Sentinel Events, or Performance Monitoring report(s) involving any of the events while previously employed with another Provider Agency.

   B. Previous criminal record within the past ten (10) years.

   C. Reported prior termination due to poor performance.

   D. Prior malpractice claims within the past ten (10) years.

   E. Positive CAN check results within the past ten (10) years.

   F. Prior drug abuse record within the past ten (10) years.

6. **Practitioner Termination.** The Committee has the authority to terminate a practitioner's participation in the CAMHD Provider Network. Termination may be considered in any of the following cases:

   - Loss of License
   - Exclusion from the Medicare/Medicaid program
   - Misrepresentation of credentials and/or other pertinent information (i.e. restrictive action questions)
   - Involvement in a malpractice claim that involves client safety
   - Criminal indictment of any type
   - Failure to adhere to what is established in the practitioner suspension, restriction or limitation of participation investigations (as described previously in the policy)
   - Findings of fraud and abuse in billing

7. **Practitioner Reinstatement.** If a CAMHD or Provider Agency practitioner is voluntarily or involuntarily terminated by the CAMHD or the Provider Agency and the practitioner wishes to be reinstated:

   A. In the case of voluntary termination the practitioner must again be initially credentialed if the break in service is *thirty (30) calendar days* or more.

B. In the case of involuntary termination, after all requests for consideration and Grievance & Appeals has been exhausted and Credentialing not approved, the practitioner shall wait one (1) year from the date of termination before submitting a new application for initial credentialing.

C. The CAMHD and/or the Provider Agency shall re-verify credential factors that are no longer within the credentialing/re-credentialing time limits.

D. The Committee shall review all credentials and make the final determination prior to the practitioner's re-entry into the organization. A decision letter shall be processed to the applicant within fifteen (15) calendar days of its decision. The decision letter includes the reconsideration and appeal process stated in the *"Request for Reconsideration & Appeal Process"* section of this policy.

8. **Practitioner Agency Transfer.** Credentialing approval is specific to the Provider Agency making the application for credentialing and is non-transferable. Practitioners wanting to be credentialed at multiple agencies shall submit initial credentialing packet to the Credentialing Section to process for each of the multiple agency.

9. **Initial Credentialing Site Visits.**

A. Onsite visits shall be conducted on an annual basis for all practitioner sites. These sites shall include treatment offices located within the CAMHD including Family Guidance Centers, or the Provider Agency Administrative Office, community treatment offices, residential facilities, and any other locations as reported by the practitioner applicant.

B. The *CAMHD Treatment Office Site Visit Tool* shall be used for these treatment office site visits. ***(See Attachment G, CAMHD Treatment Office Site Visit Tool).*** A designated Performance Management staff shall conduct the reviews. The reviews shall include the following:

1. Treatment Office Evaluation

   A minimum score of 90% for the office site section is required. For practitioners providing services in a special treatment facility (STF) or therapeutic group home (TGH), the license to operate issued to the agency by the Office of Health Care Administration (OHCA) will be accepted as verification that the facility is in compliant with all state laws pertaining to the type of service.

2. Treatment Record-keeping Practices

   A minimum score of 90% for the office site section is required.

3. Availability of Emergency Equipment

   A minimum score of 90% for the office site section is required.

C. Relocations and Additional Sites

When notified upon any agency's application to open a new site, the CAMHD Credentialing Specialist or designated CAMHD staff shall conduct a readiness site visit. Instances when CAMHD shall visit new sites include, but are not limited to when a practitioner opens an additional office or moves to offices from one location to another.

10. **Follow-up Actions for Initial Onsite Visit Findings/Deficiencies**

A. Reporting of Initial Onsite Audit Deficiencies and Corrective Action Activities

1. If the provider scores lower than the minimum score allowed on any of the criteria in the "Treatment Office Visit Tool" during the initial visit, a request for a corrective action plan from the practitioner shall be made during the exit interview.

2. A written notification of the request for the corrective action shall be sent to the practitioner through the Provider Agency via regular mail or electronic mail.

B. Credentialing/re-credentialing of the practitioner shall be deferred until all deficiencies in the onsite visit are addressed and a score higher than the minimum scored required is obtained.

C. Corrective action plans or other required documents shall be submitted to the CAMHD Credentialing Specialist no later than thirty (30) days from the date of onsite visit. The CAMHD shall review the corrective action plan and submitted documents. All primary source verifications in the deferred file would have to be within acceptable timelines at the time of review and approval by the Committee.

D. Follow-up Onsite Visit. The CAMHD reserves the right to conduct a follow up onsite visit prior to approving the practitioner to ensure that initial deficiencies noted are now within acceptable thresholds.

11. **Ongoing Monitoring of Sanctions and Complaints**

A. State sanctions or limitations on licensure. On a yearly basis, the Provider Agency shall verify the status of practitioner's State of Hawaii licensure, sanctions, or limitations with the State of Hawaii Department of Commerce and Consumer Affairs, Professional and Vocational Licensing Division at http://pvl.ehawaii.gov/pvlsearch/app.

B. In addition, the CAMHD compiles all listing of Medicaid suspended or terminated practitioner letters from the Med-Quest Division. In the event that the name being reported by Medicaid is a current member of the CAMHD provider network, the issue shall be brought to the Committee within **twenty-four (**24**)** hours of receipt to conduct an emergency meeting to formalize the suspension or termination of the practitioner from the network.

C. The decision letter shall be issued within fifteen (15) calendar days and include the reconsideration and appeal process stated in the *"Request for Reconsideration & Appeal Process"* section of this policy.

12. **Notification to Authorities**

The CAMHD reserves the right to rescind the full credentialing/re-credentialing status of any practitioner that does not comply with State Ethics Standards, CAMHD standards, and State and Federal laws range of actions.

A. If the CAMHD discovers any misrepresentation of credentials or other illegal activities, the Committee shall review and make appropriate decisions. Results of the review may warrant reporting the practitioner's name and situation to the CAMHD Compliance Committee, Professional Activities Review Committee (PARC), and/or any other appropriate authority for investigation, with a copy to the Provider Relations Liaison. If warranted, the CAMHD shall refer the licensed practitioner's name to the designated Medicaid Investigator. The CAMHD reserves the right to retain, suspend, or terminate any practitioner that has misrepresented his or her credentials.

F. The CAMHD Fraud and Abuse Program describe the CAMHD's procedures for reporting serious quality deficiencies that could result in a provider's suspension or termination to the Medicaid Fraud Investigator as well as other appropriate authorities.

13. **Credentialing Reports**

A. The Provider Agencies are required to submit electronic quarterly reports of their current credentialed licensed staff in the format required by CAMHD.

B. If a practitioner is terminated, the Provider Agency is required to submit the terminated practitioner's name and termination code immediately to the CAMHD Credentialing Section via email.

ATTACHMENTS:

A. CAMHD Glossary of Credentialing Terms, Rev. July 15, 2009

B. CAMHD Licensed Provider Initial Credentialing Application Form, Rev. July 15, 2009

C. CAMHD Licensed Provider Initial Credentialing Checklist, Rev. May 19, 2011

D. CAMHD Attestation Letter, Rev. July 15, 2009

E. CAMHD Child Abuse and Neglect Disclosure Statement, Rev. 3/2006

F. CAMHD Child Abuse and Neglect Consent to Release Information, Rev. 02/2006

G. CAMHD Treatment Office Site Visit Tool; Rev. July 15, 2009

CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
POLICY AND PROCEDURE MANUAL

SUBJECT: Grievances and Grievance Appeals	**Number:**	**80.603**
	Page	**1 of 21**

REFERENCE: Hawaii Administrative Rule§11-175-34; Title 45 C.F.R.§164.502(b), 164.530; 42 C.F.R. §§438.210(d)(2)(i), 438. 406(a)(1), 438.408(c)(2); HRS §334; HRS 622 (Part V), Medical Records; HRS [Chapter 92F]	**APPROVED:**
	Signature on File 25 Aug 2011
	Administrator Eff. Date

PURPOSE

To manage a systematic process for registering, tracking, resolving, and reporting grievances and grievance appeals filed by youth, families, providers, Child and Adolescent Mental Health Division (CAMHD) personnel, or other concerned parties.

DEFINITION

Aggrieved Party **–** The person who is filing a grievance or on whose behalf the grievance or grievance appeal is being filed.

Third Party Representative ("TPR") – A person who, in a representative capacity and with written consent, files a grievance on behalf of the aggrieved party.

BRANCH – A CAMHD Family Guidance Center or Family Court Liaison Branch.

Youth – Youth with emotional and/or behavioral challenges receiving intensive mental health services from CAMHD. For the purposes of this policy the definition of "consumer" may include the youth's parent(s), legal guardian or designated third party representative.

Default Determination – An alternative determination made by the GO is cases where a party to a grievance fails to respond to an inquiry by the GO or fails to produce requested documents by the given response date, or within a reasonable time thereafter.

HIPAA Complaint – Any assertion, whether written or oral, that an unauthorized disclosure of protected health information was made in violation of HIPAA regulations by CAMHD.

Grievance - Any oral or written communication, made by or on the behalf of a consumer, provider, and others that expresses dissatisfaction with any aspect of the CAMHD operations, activities, behavior, or providers and its sub-contractor(s), except in matters regarding the termination of a contract or a non-extension of a contract that is eligible for extension. Such appeals are addressed in another policy.

Grievance Review –A Med-Quest review process of a denied, unresolved, or unfavorable findings and conclusions, made on behalf of a Med-Quest youth at the CAMHD grievance level. The Grievance Review process is not open to grievances that merely involve a Med-Quest youth (e.g., provider reimbursement for services to a Med-Quest youth, etc.).

Grievance Appeal **–** A written request made by, or on behalf of a non-Med-QUEST consumer or provider for review by the Grievance and Appeals Committee of an adverse

grievance grievance decision; or for review by the Appeals Board of an adverse Grievance and Appeals Committee decision.

Grievance Management System (GMS) - The designated system that has the responsibility to address and resolve a grievance or an appeal of an action. The Grievance Office (GO), the CAMHD Privacy Coordinator, Claims Review Section, and the Branch's Quality Assurance Specialist are the primary GMS. As a grievance may actually be an appeal of an action, the CAMHD Clinical Services Office (CSO) is also considered a GMS.

POLICY

1. CAMHD shall insure that all consumers and providers are informed of, understand, and make effective use of the grievance and appeal processes outlined in this document. The CAMHD shall inform all consumers and providers of the two portals through which they can access the CAMHD's grievance system and how he/she/they can receive assistance in communicating the grievance.
2. The GMS shall make provisions to allow the aggrieved party to be represented by another person – a Third Party Representative ("TPR").
3. All concerns brought to the CAMHD's attention by anyone shall be addressed, investigated, and resolved in timely fashion as can reasonably be expected, by all parties with a vested interest in the issues at hand. Where there is the possibility that the thirty (30) day timeline (along with the fifteen (15) day extension) will not be met because of a party's inaction or inability (e.g., a pending court proceeding, due process hearing, etc.), a default determination will be made against the party that does not reply or provide requested documents to the GO by the stated response date. A default determination does not resolve any substantive issue where the fact(s) remain in dispute. However, if a grievance involves a particular staff's conduct (e.g. abuse, assault, questionable billing, etc.) the staff's name will be forwarded to the CAMHD's Credentialing Committee for review and possible restriction on providing services for their current, or any future provider, until the issue is resolved.
4. All CAMHD personnel shall cooperate fully with any investigation and resolution of grievances.
5. All corrective measures, deemed warranted, shall be executed in a timely manner.
6. When using or disclosing protected health information or when requesting protected health information from another covered entity, CAMHD must make reasonable efforts to limit protected health information to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request. 45 C.F.R. §164.502(b). To determine minimum necessary, refer to *P&P 80.407, "Release of and Access to Confidential Information about Consumers."*

7. Pursuant to HRS §92F(1) and (3), the CAMHD shall recognize an aggrieved party's request to keep their identity anonymous

PROCEDURE

1. **GENERAL**

   A. Upon receipt of a call from a consumer, provider or subcontractor, the Branch or GO staff will interview the person making the call, while at the same time, using the *"CAMHD Discernment Tool*," ***(See Attachment A)*** assess the type of call, e.g., inquiry, grievance, grievance appeal, or HIPAA complaint.

   B. The BRANCH or GO staff shall also determine if the person at issue is a Med-QUEST enrollee (through monthly Med-Quest log to be provided by CAMHD's Quest Plan Coordinator).

      1) If the issue is determined to be a grievance, the grievance must be filed with CAMHD within thirty (30) calendar days of the date of the occurrence.

      2) Grievances may be filed with CAMHD in the event of dissatisfaction or disagreement with:

         a. Availability of mental health services (may be discerned as an action);
         b. Delivery of services;
         c. Quality of services;
         d. Individual staff;
         e. Provider agency and its sub-contractors;
         f. Payment/Billing;
         g. Any aspect of the performance of Branch staff; or
         h. Performance of CAMHD Central Administration Offices or staff.

   C. All referrals to the CAMHD shall include the name, address and phone number of the aggrieved party, the nature of the grievance, and documentation of actions taken prior to the referral.

   D. All expressions of dissatisfaction, regardless of the degree of perceived seriousness, relating to quality of care, availability and delivery of mental health or support services performed by the CAMHD personnel or the CAMHD contracted providers, shall be investigated and responded to by either the BRANCH's Quality Assurance Specialists ("QAS") or the Grievance Office ("GO").

E. Grievances concerning billing, nonpayment or delay in reimbursement will be referred to, investigated and responded to by the CAMHD Claims Review Section.

F. Should the aggrieved party wish to be represented by a TPR, the GO or the QAS must first obtain the aggrieved party's signed written consent [***See Attachment B***], or, in the alternative, a signed and dated written consent drafted by the aggrieved party identifying the TPR stating that they are allowing the TPR to represent them. If possible, consent should be obtained directly from the aggrieved party through a face-to-face meeting. However, if this is not possible, the consent must be mailed to the aggrieved party with a return date. A self-addressed envelope and postage should be included with the consent. Once the written consent is obtained, the designated TPR will represent the aggrieved party throughout the grievance process (including all subsequent appeals), unless the consent is withdrawn. The 30-day timeline does not begin until the GMS has received the written consent form. If a TPR also has a grievance against the same adverse party [independent of that of the aggrieved party and consolidated into one (1) grievance], should the aggrieved party withdraw the consent, the GMS is still obligated to resolve the TPR's issue(s)/grievance.

G. HIPAA Complaints, whether from a consumer, provider, or BRANCH, concerning unauthorized disclosure of protected health information (PHI) in violation of HIPAA regulations, will be initially processed through the GO (e.g., logged into database as a complaint, etc.). The complaint will then be forwarded to the CAMHD Privacy Coordinator for acknowledgement and resolution within HIPAA established Timelines. *See P&P 80.603.1, "Individual Right to File Complaints About Compliance with Privacy Policy and Procedures."*

H. If the call is determined to be an inquiry, the BRANCH staff will address the inquiry and forward the information the GO via the CAMHD Monthly Grievance Information Log.

I. If an inquiry is later determined to be a grievance, the GO will contact the caller to confirm if the caller wants to pursue the inquiry as a grievance. If the caller chooses to pursue a grievance, the thirty (30) day grievance resolution timeline begins as of the day that the GO contacted the caller.

2. **GRIEVANCE MANAGEMENT**

There are two (2) portals through which a consumer, provider, or its sub-contractor can access the CAMHD's grievance system. The aggrieved party can either call a BRANCH or call the GO directly. Once staff has determined the type of call, the call will be forwarded to the appropriate GMS. With the exception of grievances that involve QAS

investigation of sensitive issues, the QAS has the option to resolve or forward a grievance to the GO (i.e., grievance about administration, etc.). The grievance should be resolved by the GMS that received the call. ***(See Attachment C)***

J. BRANCH Portal: Upon the BRANCH receipt of a call by the consumer or provider, the BRANCH GMS will:

1) Register the call.
   a. The BRANCH staff taking the call will record caller's name (if different from the aggrieved party, and the aggrieved person's name) and the phone number and address of the aggrieved.
   b. The BRANCH staff will document the name of the assigned Mental Health Care Coordinator (MHCC) and the date of the call.
2) Document substance of the call.
   a. Give consumers any reasonable assistance in completing forms, framing the issues, and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capabilities.
   b. The BRANCH staff taking the call will attempt to obtain the general nature of the call. The staff taking the call will note what they perceive as the issue and forward that information to the appropriate GMS.
3) Complete weekly *"CAMHD Grievance Intake Form"* ***(See Attachment D)***, and submit to the GO. Discern whether the call is an inquiry, grievance, or an appeal of an action, and link to that GMS.
   a. Using the *"CAMHD Discerning Tool,"* the BRANCH staff will ask the caller a series of questions that will give a preliminary determination of whether the call is an inquiry, an appeal, or a grievance. Once the nature of the call is determined, the BRANCH staff will:
      i. Forward the call to the QAS (if it is a grievance); and
      ii. Upon receipt of a grievance, BRANCH personnel will complete the *"Grievances Intake Form."*
      iii. Resolve the call (if the call is a simple inquiry); or
      iv. Forward the call to CSO (if the call is an appeal of an action).
      v. If the BRANCH QAS determines that a grievance involves an administrator of the BRANCH, the QAS has the option

to forward the grievance directly to the GO. Should the QAS choose to forward the grievance to the GO, this must be accomplished immediately (within twenty-four (24) hours of receipt of the grievance), in order for the GO to meet the prescribed timelines. If the QAS chooses to retain the grievance, the timelines listed in the "Timelines" section applies and must be adhered to.

vi. Should a grievance be retained by the QAS, the QAS must send a *"Letter of Acknowledgement"* acknowledging the receipt of the grievance and reiterating the grievance issues to the aggrieved party within five (5) days from receipt of the grievance. ***(See Attachment E).***

A letter of acknowledgement must also be sent to the TPR, if necessary.

4) If the call is determined to be a grievance, investigate the substance including all necessary facts to support the reasons for the grievance along with the specific date(s) and time(s). In all investigations of grievances, the BRANCH staff will fully assist and cooperate with the GO and provide all requested documentation and information.

a. Clinical issues:
   i. Obtain issues from the aggrieved party;
   ii. Ask the caller what they expect the outcome to be, e.g., just to inform CAMHD, investigate, etc.; and
   iii. Interview MHCC and provider.

b. All pertinent documentation:
   i. Request all necessary documents in CAMHD's possession from MHCC or QAS (i.e., IEP, CSP, MHTP);
   ii. Request other necessary documents not in CAMHD's possession (written statements, impressions, etc.), from providers, teachers, etc.; and
   iii. Consult the CAMHD CASSP Principles and IPSPG.
   iv. Clinical, administrative, or other consultation:
      1. BRANCH Clinical Director;
      2. Mental Health Supervisor and Branch Chief; and/or
      3. CAMHD Medical Director (CSO).

5) Make a determination based upon the information obtained from the investigation, within thirty (30) calendar days from receipt of the call, conclude the investigation and make a determination on the issue.

6) Manage clinically urgent grievances.
   a. All clinically urgent grievances, such as abuse, must be addressed by the staff that makes the discovery. That staff is obligated to make all appropriate referral(s), e.g., sentinel events, police, CPS, etc.
   b. Should misconduct, attributed to a provider, be determined as the result of a grievance investigation, the investigating body will also report this information to CAMHD's Credentialing Unit.
7) Follow timelines. Pursuant to 42 CFR §438.406 and 45 CFR §160.306(b)(3), it is necessary to follow the timelines for each step of a grievance:
   a. *HIPAA Timelines*:
      i. One hundred eighty (180) days for aggrieved party to file from the day they knew, or should have known of the breach; and
      ii. Thirty (30) days to address and mitigate.
   b. *Expedited Appeals*:
      i. Immediate verbal acknowledgement;
      ii. Two (2) days written acknowledgement; and
      iii. Three (3) Business days resolution. If denied, timeframe shifts to regular appeals process.
   c. *Med-Quest Grievances*:
      i. Five (5) days to acknowledge;
      ii. Thirty (30) days to investigate and make a determination, Fourteen (14) days extension for cause;
      iii. Thirty (30) days to file for a Grievance Review (from day of receipt of determination); and
      iv. Thirty (30) days for Med-Quest to conclude the Grievance Review.
   d. *Non-Med-Quest Grievances*:
      i. Five (5) days to acknowledge;
      ii. Thirty (30) days to investigate and make determination, Fourteen (14) days extension for cause; and
      iii. Thirty (30) days for Grievance Appeals.
   e. All timeframe references to days are "calendar" days, except where business days are mentioned. The aggrieved party or CAMHD can request an extension (if CAMHD can show how the delay is in the recipient's interest).

8) Notify consumers of disposition and appeal rights (emphasize importance/clarity of response). On, or before the thirty (30) day investigation period ends and a determination has been made by the QAS, a letter of determination shall be drafted. The content of the letter should:
   a. Summarize the issue(s) of the grievance;
   b. Explain the decision, the decision making process and logic; and
   c. Conclude with a paragraph stating the Aggrieved Party's right to file for a Med-Quest Grievance Review.
9) The QAS will then forward copies of the determination letters accordingly:
   a. The original to the Aggrieved Party;
   b. The TPR, if necessary;
   c. One copy to the GO; and
   d. One copy to file.
10) Data tracking/Reporting. The QAS will :
   i. Complete the grievance intake form and log the grievance;
   ii. Forward the log and intake form (each Monday of the following week) to the GO. The GO will enter the grievance into the database.
   iii. Report all negative grievances in the log and fax to the GO, regardless if the form contains no data.
   iv. Fax the "*CAMHD Weekly Information Log*" ***(See Attachment F)*** for grievances, grievance appeals, and HIPAA complaints, generated the previous week to the GO by 4:00 p.m. each Monday. If the Weekly Information Log contains a consumer's protected health information (PHI), proper faxing protocol must be followed pursuant to *P&P 80.402, "Confidentiality, FAX Transmission."*
   v.

B. Grievance Office (GO) Portal: Grievances concerning fiscal matters by the GO are forwarded to the designated Claims Review personnel for investigation and response. The Claims Reviews staff is responsible for inputting case information in the Grievance Tracking Database System, and for following the procedures in this manual to initiate and complete the investigation.
1) For cases that are referred to the GO for investigation, the GO will assist the aggrieved party in determining the substantive issue(s) of the case and provide the aggrieved party with a written acknowledgement within five (5) workdays from receipt of the grievance. All information will be

recorded in the Grievance Tracking Database System. Investigations will begin within seven (7) workdays from the date the complaint is filed.

2) The investigative and resolution portion of the complaint process will not exceed thirty (30) calendar days. It will begin with a discussion with the Mental Health Care Coordinator regarding the child's history if the nature of the complaint is specific to a child.

3) Extensions are permitted only if exceptional circumstances exist with respect to a particular grievance. Any extension cannot exceed 15 calendar days. The investigating party will maintain documentation on extensions, including the rationale for the extension and the new date for issuance of findings. Exceptional circumstances may include but are not limited to:

   a. The need to review documents or information that will not be available until after the thirty (30) day time limit;
   b. Unusually complex issues or extraordinarily high volume of documents;
   c. Extensive number of issues; or
   d. Temporary unavailability of individuals with information critical to the complaint.

   In the event a fourteen (14) day extension is needed, a notice will be mailed to the aggrieved party three (3) days prior to the expiration of the thirty (30) day timeframe and will set forth the reason for the requested extension along with the revised deadline date.

4) In resolving grievances, the investigating party will follow the CAMHD "Interagency Performance Standards and Practice Guidelines" and all applicable laws. Other Central Administration or BRANCH staff may be consulted or asked to assist in this fact-finding process. On-site reviews by Clinical Services and Performance Management may be requested as necessary.

5) Response: The investigating party (BRANCH, GO, or Claims Review Section) will respond to the aggrieved party in writing. The "*Letter of Resolution"* ***(See Attachment G)*** must include the following information:

   a. Name and address of the aggrieved party;
   b. Date of notification and date when grievance was originally filed with the GO;
   c. Name of the staff investigator;
   d. Findings;
   e. Corrective action plan, if needed; and

f. A concluding paragraph (for Med-QUEST consumers only) that states*: "This letter is the CAMHD GO's decision. If you do not agree, you may ask for a Grievance Review. Submit a written request for a Grievance Review with the Med-QUEST Office within thirty (30) calendar days of this notice. If you choose not to pursue a Grievance Review with the Med-QUEST Division, the GO's decision is the final resolution of your grievance. You can write in care of: Med-QUEST Division, Health Coverage Management Branch, 601 Kamokila Blvd., #506, Kapolei, Hawaii, 96707."* or

g. For non-Med-QUEST consumers, the concluding paragraph must state: *"This letter represents the CAMHD GO's decision. If you do not agree, you may file an appeal within thirty (30) calendar days of this notice. Please call or write the CAMHD Grievance Office to file the appeal. If you choose not to appeal, this is the final resolution of your grievance. The CAMHD Grievance Committee will hear your appeal. Please send your written request together with any supporting documentation to the Grievance Office, 3627 Kilauea Ave., Room 101, Honolulu, Hawaii 96816. Should you have any questions you can contact the GO at (808) 733-9352;*" and

h. In grievances involving direct service providers and delegated activities contractors, a copy of the Resolution letter should be provided to the Credentialing Unit or other CAMHD administrative section as applicable (**i.e.**, performance monitoring unit).

6) Calls To The GO: Upon the GO receipt of a call by the consumer, third party representative, or provider, the GO GMS will:

a. Register the call.

b. Record:

i. Callers name (if different from the aggrieved party, and the aggrieved person's name), phone number and address of the aggrieved party;

ii. The consumer's client record (CR) number and/or Med-Quest ID number;

iii. The assigned MHCC; and

iv. The date of the call.

c. Log call into the GO Database.

d. Document substance of the call.
The GO staff taking the call will attempt to obtain the general nature of the call and note what they perceive as the issue and either resolve the grievance within prescribed timelines, or forward that information to the appropriate GMS.

e. Discern whether the call is an inquiry, grievance, or an appeal of an action, and link to that GMS. Using the Discerning Tool, the GO staff will ask the caller a series of questions that will give a preliminary determination of whether the call is an inquiry, a grievance, or an appeal of an action. Once the nature of the call is determined, the GO will:
   i. Resolve the call (if the call is a simple inquiry);
   ii. Address the grievance as noted above;
   iii. Should a grievance be retained by the GO, the GO must send a letter of acknowledgement to her aggrieved party (and TPR, if necessary) within five (5) days from receipt of the grievance.
   iv. Forward the call to CSO if: 1) the call is an appeal of an action, or 2) notwithstanding the timeframes set fourth in *P&P 80.604, "Denial of Services, Appeals, & Med-Quest Hearing Process,"* the action had been implemented without (i) the consumer receiving proper notice, and/or (ii) appeal rights (unless such a procedural error results in a grievance); or
   v. Forward the complaint to the CAMHD Privacy Coordinator (if the call is a HIPAA issue).

f. If the call is determined to be a grievance, investigate the substance of the grievance including:
   i. Obtain clinical issues from the aggrieved party;
   ii. Ask the caller what they expect the outcome to be, e.g., just to inform CAMHD, investigate, etc.; and
      - Interview MHCC and provider.
   iii. Obtain all pertinent documentation:
      - Request all necessary documents in CAMHD's possession from MHCC or QAS (i.e., IEP, CSP, MHTP, etc.);

-
- Request other necessary documents not in CAMHD's possession (written statements, impressions, etc.), from providers, teachers, etc.; and
- Consult the CAMHD CASSP Principles and IPSPG.

iv. Seek clinical, administrative, or other consultation from:

- **BRANCH Clinical Director;**
- **MHS and Branch Chief; and/or**
- **CAMHD Medical Director (CSO).**

g. Make a determination based upon the information obtained from the investigation, within thirty (30) calendar days from receipt of the call, the GO will conclude the investigation and make a determination on the issue(s).

h. Managing clinically urgent grievances.

i. The staff that makes the discovery must address all clinically urgent grievances, such as abuse. That staff is obligated to make all appropriate referral(s), e.g., sentinel events, police, CPS, etc.

ii. Should misconduct, attributed to a provider, be determined as the result of a grievance investigation, the investigating body will also report this information to CAMHD's Credentialing Unit.

1) Pursuant to 42 CFR §438.406 and 45 CFR §160.306(b)(3), it is necessary to follow the timelines for each step of a grievance:

a. *HIPAA Timelines*:

i. One hundred and eighty (180) days for aggrieved party to file from the day they knew, or should have known of the breach; and

ii. Thirty (30) days to address and mitigate.

b. *Expedited Appeals*:

i. Immediate verbal acknowledgement;

ii. Two (2)-day written acknowledgement; and

iii. Three (3) Business Day resolution. If denied, timeframe shifts to regular appeals process.

c. *Med-Quest Grievances*:

i. Five (5) days to acknowledge;

ii. Thirty (30) days to investigate and make a determination, fourteen (14) days extension for cause;
iii. Thirty (30) days to file for a Grievance Review (from day of receipt of determination); and
iv. Thirty (30) days for Med-Quest to conclude the Grievance Review.

d. *Non-Med-Quest Grievances*:
i. Five (5) days to acknowledge;
ii. Thirty (30) days to investigate and make determination, Fourteen (14) days extension for cause; and
iii. Thirty (30) days for Grievance Appeals.

All timeframe references to days are "calendar" days, except where business days are mentioned. The aggrieved party or CAMHD can request an extension (if CAMHD can show how the delay is in the recipient's interest).

2) Notify consumers of disposition and appeal rights (emphasize importance/ clarity of response).

Once the GO staff has made a determination, a letter of determination shall be drafted. The content of the letter should: 1) Summarize the issue(s) of the grievance; 2) Explain the decision, the decision making process and logic; and 3) Conclude with a paragraph stating the Aggrieved Party's right to file for a Med-Quest Grievance Review (Med-QUEST case), or to file for a first-level appeal (Non-Med-QUEST cases). The GO will then forward copies of the determination letters accordingly:

a. The original to the Aggrieved Party;
b. The TPR, if necessary;
c. One copy to the Supervisor of Performance Management;
d. One copy to the Med-QUEST plan liaison (Med-Quest case);
e. One copy to file.

3) Data tracking/Reporting.

a. The GO staff will receive and track the intake form from the QAS and log and enter the data into the GO database;
b. The GO staff will enter the grievance and its resolution into the Grievance database; and
c. The GO will generate all tracking and trending reports/analysis and submits the reports to the appropriate committees, i.e., Performance Information Steering Committee Report and Med-Quest Division Report.

3. **ACTIONS**

A. If the BRANCH staff determines that the nature of the call is regarding an action, the call is immediately referred to the QAS.

B. The QAS will (within twenty-four (24) hours of receipt of call) forward the Aggrieved Party to the Clinical Services Office (CSO).

C. Appeals, along with applicable Timelines, are addressed pursuant to P&P 80.604, "Denial of Services, Appeals, and the State Fair Hearing Process."

D. If the GO determines that the nature of the call is in regard to an action, the GO will immediately forward the call, along with all pertinent information the GO receives, to CSO for resolution.

E. If the GO or QAS receives a written grievance (from a parent or 3rd party representative) that is determined to be an action, the GO will immediately forward all necessary information to CSO and the appropriate BRANCH's MHCC and CD. The thirty (30) day resolution timeline begins when the GO has made the determination that the grievance is an action.

4. **OTHER CENTRAL ADMINISTRATION OFFICE (CAO) DUTIES**

A. DOE: The GO may assist the Complaints Resolution Office of the Department of Education to investigate mental health related complaints about youth filed with the DOE. The investigation will follow DOE complaint procedures.

B. Files: All grievances files will be maintained in a secured file marked with the grievance case number and the name of the aggrieved party.

C. QAS Training on the Grievances Process: The CAO will train all QAS on the grievance process in order to assure consistent application of the process and procedures at the BRANCH level. The training will occur annually, at new employee orientation for the QAS, and when changes in the grievances process warrants re-training. The training will also explain the function and procedural process of grievances and appeals at the GO level. Training will include, but is not limited to:

1) Logging all grievances received at the BRANCH level, whether resolved by the QAS or referred to the GO;
2) The completion and submission of weekly reports to the GO for the purpose of tracking and trending;
3) The role of the BRANCHs and the GO in the grievance process; and
4) The exchange of critical case information between the GO and QAS.

5. **GRIEVANCE REVIEW (Med-QUEST)**

A. Consumers, families or providers who disagree with the findings and decisions at the grievance level may file for a "Grievance Review" with the Med-QUEST Division. Grievances reviews must be filed within thirty (30) calendar days of the date stated on the GO's findings and decisions letter.

B. All requests for a grievance review must be submitted to the Med-QUEST Division. Aggrieved parties who wish to pursue a grievance review must submit a written request to:

1) Med-QUEST Division

Health Coverage Management Branch
601 Kamokila Blvd., #506
Kapolei, Hawaii 96707
(808) 692-8093 or 692-8096

2) The Med-QUEST Plan Liaison must review the grievance and contact the recipient with a determination within thirty (30) calendar days from the day he/she received the request for a grievance review.

C. The grievance review determination made by the Med-QUEST staff is final.

6. **GRIEVANCE (Non-Med-QUEST)**

The procedure and applicable Timelines for non-Med-QUEST grievances will be the same as Med-QUEST grievances. However, the appeal rights for non-Med-QUEST consumers will be handled according to internal CAMHD appeals protocol exclusive of Med-QUEST Division. Non-Med-Quest grievances must be filed with the GO within thirty (30) days of its occurrence or thirty (30) days from the time the aggrieved party knew, or should have known, of the grievance.

A. Investigation of the grievance will be initiated within seven (7) workdays from the date the grievance is filed. The grievance process will not exceed thirty (30) calendar days. Extensions are permitted only if exceptional circumstances exist with respect to a particular grievance. Any extension will be for a specified duration of time, not to exceed fourteen (14) days. The investigating party will maintain documentation on extensions, including the rationale for the extension and the new date for issuance of findings. Exceptional circumstances may include but are not limited to:

1) The need to review documents or information that will not be available until after the thirty (30) calendar day time limit;
2) Unusually complex issues or extraordinarily high volumes of documents;
3) Extensive number of issues;

4) Temporary unavailability of individuals with information critical to the grievance; and
5) Scheduling conflicts of the Grievance and Appeals Committee.

B. Investigation Process (Non-Med-QUEST)

1) The GO will receive written grievances, forwarding those that are fiscally related to the CAMHD Fiscal Section. Information related to all grievances shall be reviewed to insure all areas of the complaint processes have been exhausted prior to opening the grievance. Further fact-finding shall be conducted of any significant new information brought forth by the written grievance.
2) The GO or the CAMHD Fiscal Section, as applicable, will notify the grieving party in writing of the receipt of the grievance. Either the GO or the CAMHD Fiscal Section as applicable shall enter case information into the shared Grievance Tracking Database System.
3) The GO shall prepare non-fiscal grievance reports for the Grievance and Appeals Committee's review, including any applicable new fact-finding information; the Claims Review Section will do the same for fiscal-related grievances.
4) All grievances pursuant to 42 CFR §438.400(b) (6), shall be addressed by the GO following the established guidelines and timelines defined by Med-Quest.

C. The Grievance and Appeals Committee (Non-Med-QUEST)

1) Grievance appeals are presented to the CAMHD Grievance and Appeals Committee at the next regularly scheduled meeting following the conclusion of the investigation. The committee will consist of a quorum of the following CAMHD staff: Clinical Director, Performance Management Supervisor, Provider Relations Specialist, BRANCH Representative, and Fiscal Representative. The committee membership will also include a family resource representative.
2) The committee will render a decision upon hearing and reviewing the grievance report. This determination will be reported in writing to the grieving party within ten (10) working days of the decision. The party responsible for presenting the grievance at the committee meeting will prepare the response. The written response to the grieving party must include the following information:
   a. Name and address of the aggrieved party;

b. Findings of the Grievance and Appeals Committee;
c. Corrective action plan;
d. Agreement (as to monetary disputes), if applicable; and
e. For all adverse decisions to a grievance, a concluding paragraph that notifies the grieving party of their right to file a second-level appeal to the CAMHD Appeals Board, how to file the appeal, the timeline to filing, and the address of the GO.
f. In the matter of fiscal grievances, CAMHD reserves the exclusive right to determine whether or not to engage in a settlement process.
g. The grievance files will be maintained in a file marked with the grievance case number and the name of the grieving party. These files will be controlled as sensitive material and will be maintained on premises by the GO Office in a secure file cabinet.

D. Settlement Process (Non-Med-QUEST)

1) The Grievance and Appeals Committee will consider the following factors in determining whether a settlement shall be offered based on the following factors:

a. Whether denial of the grievance will have a significant impact on the agency's ability to continue providing services to CAMHD identified youth. The existence of a significant impact will be determined by looking at the following:
i. The amount requested/being appealed.
ii. The percentage of the appealed amount to the total amount the grieving party has billed CAMHD encompassing the preceding year to date.

b. Acceptable alternative documentation as proof of the provision of services consisting of:
i. Clear evidence that the services in question were provided.The seriousness of the billing deficiency in relation to the compliance with the contractual documentation requirements, per level of care at issue.

c. The lack of evidence of a pattern of fraud and/or abuse.

d. The impact on CAMHD's ability to provide services to CAMHD youth.

2) Following a compilation of documentation related to all of the above factors, the Claims Review Section will present a written summary

3) accompanied with a recommendation for offer of settlement for the Grievance and Appeals Committee's consideration and decision.

4) It is within the CAMHD's sole discretion to determine the amount offered to a grieving party.

5) The Grievance and Appeals Committee's decision stands in the event a settlement is not offered.

6) Following a decision to offer a settlement, the Claims Review Section will send a written response to the grieving party that includes the following information:

   a. Name and address of the grieving party;
   b. Findings of the Grievance and Appeals Committee;
   c. Corrective action plan, if needed; and
   d. Agreement (as to monetary disputes), if needed.

E. APPEALS (Non-Med-QUEST)

1) The aggrieved party may file a written appeal (2nd level appeal) with the GO if they disagree with the determination of the Grievance and Appeals Committee. The appeal of the Grievance and Appeals Committee's decision must be filed within thirty (30) calendar days of the date stated on the determination letter. It must include:

   a. The reasons the complainant believes the Grievance and Appeals Committee's decision was in error;
   b. All necessary facts and documents to support the reasons for appeal;
   c. Any new information that was previously unavailable together with the reasons why the new information was not previously available; and
   d. If applicable, a description of any extenuating circumstances.

2) The Grievance Office may dismiss a request for appeal if the request for appeal does not meet the foregoing requirements, for good cause, or where the request for appeal is frivolous and without merit. Any dismissal of a request for appeal shall be in writing and state the reasons for dismissal.

3) The GO or the Claims Review Section as applicable, upon receipt of the written appeal, will review the information to ensure all areas of the grievance process have been exhausted prior to opening the appeal. The applicable office will enter all pertinent information into the Grievance Tracking Database system and the appealing party notified in writing of the receipt of the appeal.

4) The appealing party has the right to submit documentation in support of the appeal or appear in person before the CAMHD Appeals Board. The GO or the Fiscal Section as applicable will inform the appealing party of the appeal date as soon as one can be scheduled.

5) A synopsis of the case on appeal will be prepared by the GO (non-fiscal cases), or the Claims Review Section (fiscal cases). The GO will coordinate the forwarding of the synopsis to the CAMHD Appeals Board for briefing purposes.

6) Pursuant to HAR §11-175-34(c), the appeals process will not exceed thirty (30) calendar days from receipt of the appeal. Extensions are permitted only if exceptional circumstances exist with respect to a particular appeal. Any extension will be for a specific amount of time. The GO or the Claims Review Section, as applicable, will maintain documentation on the extension, including the rationale for the extension and the new date for issuance of findings. Exceptional circumstances may include but are not limited to:

   a. The need to review documents or information that will not be available until after the thirty (30) day time limit.
   b. Unusually complex issues or extraordinarily high volume of documents;
   c. Extensive number of issues; or
   d. Temporary unavailability of individuals with information critical to the appeal; and
   e. Scheduling conflicts of the CAMHD Appeals Board.

7) If CAMHD extends the timelines, it must – for any extension not requested by the consumer, give the consumer written notice of the reason for the delay.

   a. The CAMHD Appeals Board consists of the Deputy Director for Behavioral Health, the CAMHD Chief and the Medical Director.
   b. After the consumer files an appeal and before the CAMHD Appeals Board hears the case, the GO and the Claims Review Section may engage in efforts at settlement with the appealing party. The procedures for settlement outlined in the "Settlement Process Section," will be followed.
   c. The CAMHD Appeals Board, after hearing and reviewing the appeal, will render a decision. This decision will be reported in writing to the appealing party within ten (10) working days of the

decision. The decision of the CAMHD Appeals Board will be the final response from the CAMHD.

d. Appeal files will be maintained in a file marked with the appeal case number and name of the appealing party. These files will be controlled as sensitive material and will be maintained on premises in a secure file cabinet.

F. **DISMISSAL (Non-Med-QUEST)**

The CAMHD has the discretion to dismiss a grievance or appeal at any time upon written request from the initiating party or when the aggrieved party has failed to pursue or present their case, after reasonable notice by the CAMHD, after one (1) year of the initiation of the grievance or appeal. Upon a showing of good cause, the aggrieved party can request a reinstatement of their case.

G. REQUEST FOR PRODUCTION (Response and Documents)

Should the party upon whom the request is served (non-moving party) fail to respond to the GO's inquiry within the stated time, or fail to produce any requested documents, the GO will find against that party. Prior to the resolution deadline, and upon a showing of good cause, the non-moving party can request to have their response and/or documents admitted.

H. CREDENTIALING (Provider Misconduct)

Pursuant to an investigation, and upon a final determination, the GO will notify the Credentialing Section of any acts of misconduct of a CAMHD contracted provider. The GO will also notify the Credentialing Section of any ongoing investigation(s) regarding an allegation of provider misconduct. This information will consist of the provider's name, affiliation, the nature of the allegation, along with the GO's determination. The GO will also respond to requests for information for the purpose of Credentialing clearance reviews and for provider/staff in the process of re-credentialing.

I. CONFIDENTIALITY/HANDLING

Access to records will be limited to those staff members directly involved in the investigation of the grievance or appeal as well as managerial staff on a need to know basis. When not in use, records will be stored in a locked drawer or cabinet. Records will not be left unattended or unsecured in the workplace or in a position or location easily accessible to non-staff members.

J. RECORD RETENTION

All records of persons served by CAMHD will be maintained in a protected and confidential manner for time periods consistent with applicable laws.

1) Records pertinent to minors shall be maintained for a period of twenty-five (25) years from the date of majority.

2) The CAMHD will maintain records of all grievances and appeals for two years on site (current and last calendar year), with the remaining years being maintained in secure storage.

K. **REQUEST FOR GRIEVANCE RECORDS**

1) Should the GO/QAS receive a request for access to any grievance documents, the GO/QAS will inform the requesting party any information contained in a CAMHD record may be subject to access by the public at the conclusion of the investigation and upon a requesting party's completion of a "*Request to Access a Government Record*" Form through OIP ***(See Attachment H)***. HRS §92F-12(b) (2).

2) The GO/QAS must complete and attach a "*Notice to Requestor*" Form ***(See Attachment I)*** to GO's written response to anyone requesting access to information regarding the filed grievance. The response, if requested by the aggrieved party, will bar any identifying references to the aggrieved party and the *Notice to Requestor* will set forth, *inter alia*:

   a. Timeframe of the response;
   b. Any costs for the production of documents;
   c. Exceptions that would either (i) deny the request in its entirety, (ii) grant the request in full, or (iii) only as to certain parts; and
   d. Citation(s) to the appropriate statute and a brief explanation.

3) Should an aggrieved party request anonymity, the GO/QAS will:

   a. Advise the aggrieved party that the release of any identifying information contained in a government record under HRS §92F-12(b) (2) may be an exception under §92F-13(1), (3). Identifying information of a complainant in an individual's own personal record under HRS § 92F-21 may be an exception under HRS § 92F-22(2), where the source who furnished information did so under "[A]n express or implied promise of confidentiality;

   b. Advise the aggrieved party that to ensure his/her anonymity he/she should not disclose his/her name, address, phone number or other identifying information to the GO or QAS;

   c. Assign a "Doe" name to the aggrieved party along with the five (5) digit grievance sequence number assigned by the GO database (i.e., "Mr./Ms. Doe 00335") for reference; and

   d. Advise the aggrieved party to do the following to allow for sharing of information necessary to address the grievance filed. The aggrieved party should be instructed to do the following:

i. Pick-up CAMHD's acknowledgement letter, indicating the receipt of the grievance, within three (3) days of the aggrieved party's initial call at the GO or QAS. The letter may be picked up from the CAMHD;

ii. Contact the GO ten (10) days after the initial contact [in the event that the GO requires additional information from the aggrieved party];

iii. Contact the GO three (3) days prior to end of the thirty (30) day resolution timeline in order for the GO to notify aggrieved party of any resolution or need to do an extension of fourteen (14)-days; and

iv. Arrange to pick-up the CAMHD's final determination letter at the CAMHD.

ATTACHMENTS:

A. CAMHD Discernment Tool
B. CAMHD Grievance Flow Chart
C. CAMHD Grievance Intake Form
D. CAMHD Sample Letter of Acknowledgement
E. CAMHD Weekly Grievance Information Log
F. CAMHD Letter of Resolution
G. Request to Access a Government Record (OIP)
H. Notice to Requestor (OIP)

SAFETY PLAN

Youth's name: _____ Date:_____

PROBLEM BEHAVIORS: These are behaviors I sometimes show, especially when I'm stressed:

☐ Losing control	☐ Assaulting people	☐ Feeling suicidal	☐ Running away	☐ Using other drugs
☐ Injuring myself	☐ Attempting suicide	☐ Threatening others	☐ Using alcohol	☐ Feeling unsafe
☐ Other (please describe:				

_____

TRIGGERS: When these things happen, I am more likely to feel unsafe and upset:

☐ Not being listened to	☐ Feeling pressured	☐ Being touched	☐ Lack of privacy	☐ People yelling
☐ Loud noises	☐ Feeling lonely	☐ Arguments	☐ Not having control	☐ Being isolated
☐ Darkness	☐ Being stared at	☐ Being teased	☐ Particular time of day: _____	☐ Particular time of year: _____
☐ Contact with family	☐ Particular person: _____	☐ Other (please describe): _____		

WARNING SIGNS: These are things other people may notice me doing if I begin to lose control:

☐ Sweating	☐ Breathing hard	☐ Racing heart	☐ Clenching teeth	☐ Clenching fists
☐ Red faced	☐ Wringing hands	☐ Loud voice	☐ Sleeping a lot	☐ Sleeping less
☐ Acting hyper	☐ Swearing	☐ Bouncing legs	☐ Rocking	☐ Can't sit still
☐ Being Rude	☐ Pacing	☐ Crying	☐ Squatting	☐ Hurting things
☐ Eating more	☐ Eating less	☐ Not taking care of myself	☐ Isolating/avoiding people	☐ Laughing loudly/giddy
☐ Singing inappropriately	☐ Other (please describe):			

_____

INTERVENTIONS: These are things that might help me calm down and keep myself safe when I'm feeling upset:
(Check off what you know works; star things you might like to try in the future)

☐ Time out in my room	☐ Listening to music	☐ Reading a book	☐ Sitting with staff	☐ Pacing
☐ Talking with friends	☐ Talking with an adult	☐ Coloring	☐ Molding clay	☐ Humor
☐ Exercising	☐ A cold cloth on face	☐ Writing in a journal	☐ Punching a pillow	☐ Hugging a stuffed animal
☐ Taking a hot shower	☐ Taking a cold shower	☐ Playing cards	☐ Video Games	☐ Lying down
☐ Ripping paper	☐ Screaming into pillow	☐ Holding ice in my hand	☐ Getting a hug	☐ Using the gym
☐ Bouncing a ball	☐ Male staff support	☐ Female staff support	☐ Deep breathing	☐ Speaking w/ my therapist
☐ Drawing	☐ Being read a story	☐ Making a collage	☐ Crying	☐ Snapping bubble wrap
☐ Being around others	☐ Doing chores/jobs	☐ Cold water on hands	☐ Drinking hot herb tea	☐ Using a rocking chair
☐ Calling family (who?) _____	☐ Other (please describe): _____			

THINGS THAT MAKE IT WORSE: These are things that do NOT help me calm down or stay safe:

- ☐ Being alone
- ☐ Being around people
- ☐ Humor
- ☐ Not being listened to
- ☐ Peers teasing
- ☐ Being disrespected
- ☐ Loud tone of voice
- ☐ Being ignored
- ☐ Having staff support
- ☐ Talking to an adult
- ☐ Being reminded of the rules
- ☐ Being touched
- ☐ Other (please describe): _____

CRISIS PLAN:

1) I will try to notice the following warning signs and triggers:

2) I'd like staff/my family to notice the following warning signs:

3) When I notice these triggers or warning signs, I will take action to prevent a crisis from developing by doing the following:

4) When staff/my family notice that I'm getting upset, I'd like them to help me prevent a crisis by doing the following:

Youth signature_____ Date: _____

Parent signature: _____ Date: _____

CHILD AND ADOLESCENT MENTAL HEALTH DIVISION POLICY AND PROCEDURE MANUAL

SUBJECT: Initial and Re-Credentialing of Mental Health Professionals and Paraprofessionals	**Number:**	**80.308.1**
	Page:	1of 12

REFERENCE: HRS; HI QUEST; QARI; HI State; Licensing Boards; CMSS; CAMHD QAIP; NCQA Standards for Credentialing & Re-credentialing: 42CFR; §438.12, § 438.200, § 438.204, § 438.206, § 438.214, §438.224; HSAG Audit Tool; HAR, Title 11, Department of Health, Chapter 98, Special Treatment Facilities	**APPROVED:** ***Signature on File*** 8/23/11 Administrator Eff. Date

PURPOSE

The purpose of this policy is to assure that qualified mental health professionals through established minimum qualifications render services to CAMHD youth.

DEFINITIONS

See Glossary of Credentialing Terms *(See Attachment A)*

POLICY

1. The CAMHD ensures a systematic credentialing process of assessing the qualifications of CAMHD and CAMHD contracted Provider Agencies' mental health professional (MHP) and Paraprofessionals (PARA) This process ensures that any practitioner providing mental health services to youth served by the CAMHD, who either:

   A. Is an independent contractor with CAMHD;

   B. Is employed with CAMHD; or

   C. Is employed or subcontracted by CAMHD contracted Provider Agencies, hereafter referred to as the Provider Agency; and

   is credentialed *prior* to providing direct mental health services to youth.

2. The CAMHD Credentialing Committee, hereinafter referred to as the "Committee" meets monthly to make determinations on all credentialing/re-credentialing applications. The Committee makes such determinations in accordance with this policy and the policy and procedures set forth in CAMHD P&P 80.508, "Credentialing Committee".

3. The CAMHD reserves the right to make the final determination about which practitioners may participate in its network and provide services to CAMHD registered youth. Practitioners shall meet all applicable standards to participate in the CAMHD's provider network.

   CAMHD *will not pay* for services rendered if the provider is NOT credentialed.

4. The CAMHD credentials the following unlicensed practitioners as an MHP:

   - Unlicensed, Board Ineligible Psychiatrist;
   - Psychiatric Resident;
   - Unlicensed Psychologist (PhD or PsyD);

- Registered Public Nurse, Licensed Masters;
- Unlicensed Masters: Psychology, or Social Work, Marriage & Family Therapist, or Certified Counselor;
- Licensed Masters Social Work;
- Masters Degree with approval from the Credentialing Committee

The CAMHD credentials the following unlicensed practitioners as a PARA:

- Certified Substance Abuse Counselor (CSAC);
- Registered Public Nurse (RPN) Bachelors, Associates or Diploma Licensed;
- Licensed Practical Nurse (LPN)
- Bachelors Degree: Psychology, Social Work, Counseling or Other;
- Associates: Psychology or Other;
- High School Graduate or Equivalent

6. **Applications.** The CAMHD Credentialing section reviews all credentialing and re-credentialing applications. All applications shall include all required documents and verifications that will be presented to the Committee for review and approval. ***(See Attachment B, CAMHD Unlicensed Mental Health Care Professionals and Paraprofessionals Initial and Re-credentialing Application Form*)** A completed application shall include or meet the following requirements:

   A. All blanks on the application form are filled in and necessary additional explanations provided;

   B. All requested attachments and information have been submitted;

   C. Verification of the information is complete and was done through primary sources when required; and

   D. All information necessary to properly evaluate the applicant's qualifications has been received and is consistent with the information provided in the application.

7. **Primary Source Verifications.** The CAMHD delegates primary source verification to the Provider Agencies for their employees and/or subcontractors. The CAMHD delegates the primary source verification to a contracted credentialing verification service for CAMHD employees. Required primary source verifications are outlined in ***Attachment C, CAMHD Unlicensed Mental Health Professionals and Paraprofessionals Provider Checklist (MHP & PARA PC),*** and include verification timeline requirements, and methods of accepted primary source verification.

   A. Practitioners shall be primary source verified with the State of Hawaii Department of Commerce and Consumer Affairs (DCCA), Professional and Vocational Licensing Division at http://pvl.ehawaii.gov/pvlsearch/app to verify Hawaii licensure.

B. The credentials of applicants shall be evaluated against pre-determined criteria in conjunction with the National Committee of Quality Assurance (NCQA) and state licensing requirements.

C. Practitioners will be notified in writing via regular mail of any information obtained during the credentialing process that varies substantially from the information provided to the CAMHD and/or the Provider Agency.

8. **Timeframes.** To prevent the Committee from considering a provider whose credentials may have changed since they were verified, primary source verification should be no more than one hundred eighty (180) days old (unless otherwise stated) at the time of the credentialing committee decision.

A. **Written verifications.** The one hundred eighty (180) days time limit begins with the date that the credentials were verified (the date on the letter or the signature date) and not when CAMHD or the Provider Agency received the information. Written documentation shall be completed using indelible ink.

B. **Oral verifications.** Oral verifications require a written statement to CAMHD stating the verification date, the name of the primary source person who verified the information, the name and dated signature of the CAMHD or Provider Agency staff that conducted the query.

C. **Internet website verifications.** Internet verifications require the dated signature of the CAMHD or Provider Agency staff that conducted the query on all printed pages. Electronic signatures are allowed provided the signatures are password protected. The Provider Agencies and other agencies designated as primary source verifiers must send a written report to CAMHD of their electronic signature password protection policies.

9. **Credentialing Cycle.** Once a practitioner is credentialed, he/she is able to carry his/her full credential status for two (2)-years with the specified agency he/she is credentialed under. Upon approval, the practitioner's credentialing information is submitted to CAMHD's Management Information Section (MIS) by the Credentialing Section for entry into the information system.

A. The credentialing cycle begins with the date of the initial Committee decision to approve the credentialing application and ends two (2) years later. For example, if the Committee approved the practitioner's credentialing application on December 1, 2011, the practitioner's credentialing period would begin on December 1, 2011 and end on December 1, 2013.

B. Practitioners are considered credentialed/recredentialed upon notification from the Credentialing Section after the Committee has rendered its decision.

10. **Confidentiality Policy**. The CAMHD holds all practitioner data and information that is obtained through the credentialing/recredentialing process in strict confidence.

11. **Non-discrimination Policy.** The Committee does not make credentialing/recredentialing decisions based solely on the applicant's race, ethnic/national identity, gender, age, sexual orientation, or the types of procedures or patients the practitioner (e.g., Medicaid) specializes in.

12. **Practitioner Rights.** The CAMHD shall provide all contracted agencies and CAMHD employees of their practitioner rights in the credentialing/re-credentialing process. Rights include but are not limited to:

A. A review of submitted information in support of their credentialing/re-credentialing applications;

B. The right to correct erroneous information; and

C. The right to appeal any credentialing/re-credentialing decisions that limit, suspend or terminate a practitioner's credentialing/re-credentialing status.

PROCEDURES

1. **Credentialing Section Responsibilities:** The Credentialing Section staff, under the oversight of the Performance Manager, will:

D. Inform the Provider Agencies of CAMHD's credentialing policies and procedures, providing them with a copy of each of CAMHD credentialing policies and procedures. The Provider Agencies are required to have similar policies and procedures to follow within their own agencies that comply with the CAMHD's credentialing policies and procedures.

E. Provide training to the Provider Agencies on the credentialing/re-credentialing operational processes and requirements.

F. Perform the following prior to the Committee's review of credentialing/re-credentialing applications.

1. Receive and process all credentialing/re-credentialing applications prior to Committee review.

2. Process all applications and conduct preliminary reviews of each practitioner's credentials in accordance with the MHP & PARA LPC to ensure all primary source verifications being submitted meet CAMHD's established criteria.

3. Maintain and have available for review by the Committee the practitioner files that meet established criteria prior to the scheduled Committee meetings.

4. Present a list of the names of all practitioners who meet the established criteria to the Committee for review and final approval.

5. Present to the Committee all applicant files that do not meet all established criteria with all documentation necessary for the Committee to review and render appropriate determinations.

6. Provide CAMHD's MIS Section with a list of credentialed practitioners following approval from the Credentialing Committee.

2. **Credentialing/Re-credentialing Documents and Primary Source Verification Requirements.** The Credentialing Section staff will ensure that all credentialing/re-credentialing documentation

and verification requirements are met. Primary source verification should be no more than one hundred eighty (180) days old (unless otherwise stated) at the time of the Committee's decision. Staff will use the MHP & PARA LPC that outlines the CAMHD required primary source verifications, verification timeline requirements, and methods of accepted primary source verification. All boxes of the MHP & PARA LPC must be checked off with verifying documents attached. The MHP & PARA LPC includes the following criteria items:

A. Attestation: ***(See Attachment D, Attestation Letter)***. The Provider Agency or CAMHD designated primary source verification agency representative shall complete the "*CAMHD Attestation Letter*" and submit the signed original letter to the Credentialing Section.

B. Background Verification Application. The *Background Verification Form for Mental Health Professionals and Paraprofessionals* (Application Form). Applicants ***shall complete all areas*** of the application form including:

1. Identifying Information
2. Educational Information
3. Health status: In the event an applicant answers "Yes", a letter of explanation must accompany the application. The Committee shall review the letter of explanation and weigh the implications of any health conditions stated as it pertains to the applicant's ability to perform the functions of the position for which the provider is being credentialed. The Committee may consider approval of the applicant with or without restrictions.
4. Restrictive Actions: In the event an applicant answers "Yes", a letter of explanation must accompany the application. The explanation shall be for each occurrence with dates, parties involved, circumstances surrounding the situation and the outcomes. The CAMHD shall review the applications of those with restrictive actions. Restrictive actions include any of the following below:
    a. Loss, denial, limitation of privileges or disciplinary activity
    b. Voluntary relinquishing of privileges or license
    c. Denial of certification
    d. Malpractice issues
    e. Criminal convictions
    f. Illegal Drug Use
    g. History of loss or limitation of privileges or disciplinary activity
5. Relevant Work/Volunteer/Intern Experience
6. Release of Information Authorizations: Dated signature required
7. Affirmation: Dated signature required
8. Release and Immunity: Dated signature required
9. Provider Rights
10. Attestation as to the correctness and completeness of the application. The applicant must sign and date the attestation statement in the application.

C. Resume: The CAMHD does not require primary source verification of relevant work history to be submitted as part of the credentialing/recredentialing requirement but defers employment verification activities as part of the intra agency human resource functions performed by Provider Agencies or CAMHD in the case of CAMHD personnel.

For the work history requirement, a minimum of five (5) years of relevant work history must be obtained through the practitioner's resume. If it is obtained from the resume, the resume must state *a date of preparation* so that the Committee is able to determine the one hundred eighty (180)-day time limit for this criterion. The applicant must submit a written explanation of any gaps over six (6) months.

~~D.~~ Education: CAMHD or the Provider Agency must verify education that is applicable to the position that the applicant is applying for.

E. State of Hawaii License Verification. ***Verification time limit: 180 days***

Applicant shall possess a current license to practice in the State of Hawaii.
The Provider Agency shall confirm that the applicant holds a valid, current State of Hawaii license to practice. The license must be primary source verified with the State of Hawaii Department of Commerce and Consumer Affairs, Professional and Vocational Licensing Division at http://pvl.ehawaii.gov/pvlsearch/app. A copy of the license shall be printed and the person conducting the query shall date and sign all pages of the printout results.

F. National Provider Identification: ***Verification time limit: 180 days***

The National Provider Identifier (NPI) is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered health care providers. Covered health care providers and all health plans and health care clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty. The NPI shall be used in lieu of legacy provider identifiers in the HIPAA standards transactions. As outlined in the Federal Regulation, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), covered providers must also share their NPI with other providers, health plans, clearinghouses, and any entity that may need it for billing purposes.
The CAMHD requires an NPI for all QMHPs and MHPs, and all paraprofessionals providing and billing for Intensive In-Home Therapy services.

G. State of Hawaii License Sanctions and Complaints History. ***Verification time Limit - One hundred eighty (180)-days.***

The practitioner's license limitations and restrictions must be primary source verified with the State of Hawaii Department of Commerce and Consumer Affairs, Professional and

Vocational Licensing Division at http://pvl.ehawaii.gov/pvlsearch/app. The results of the complaints history query shall be printed and the person conducting the query shall date and sign all pages of the printout results**.**

H. Medicare/Medicaid Sanctions. ***Verification time limit: 180 days***

The Office of the Inspector General at http://exclusions.oig.hhs.gov/search.html must be queried for the existence of any Medicare/Medicaid sanctions against the applicant. The results should be printed and the person conducting the query shall initial all pages of the printout results. The query results must indicate "no records" query result. In the event that there is a record on file, the applicant shall provide a letter of explanation of the record. The committee will review the implications of the record as it pertains to the applicant's ability to provide quality services to CAMHD youth.

I. Hawaii Justice Center Data Bank Verification: ***Verification time limit: 180 days***

The Hawaii Justice Center Data Bank must be queried for any criminal record. The query results must indicate "no records found". In the event that a record is found within the past ten (10) years, the applicant shall provide a written explanation of the record. Rehabilitative or self-improvement programs attended to help improve whatever issues there may be at the time of offense shall be listed. In addition, the Provider Agency shall also submit to CAMHD a written supervision plan that outlines the position and overall function of the applicant, supervision structure, and any other mechanisms in place to prevent similar offenses from occurring while the applicant is employed with the Provider Agency or around CAMHD youth.

J. Child and Abuse Neglect (CAN) Verification. ***Verification time limit: 180 days***

The Department of Human Services Child Protective Services Database must be queried for child abuse and neglect records. The ***" CAMHD CAN Request Form" (See Attachment E)*** and ***"CAMHD CAN Authorization Form" (See Attachment F)*** shall be completed. The query results must indicate "no records found". In the event that a positive CAN record is found, the Provider Agency shall notify the CAMHD Credentialing Section of the record within twenty-four hours (24) by telephone and provide the hardcopy of the positive CAN record within three (3) business days by fax.
The applicant through the Provider Agency shall submit a letter of explanation regarding the positive CAN results to the Credentialing Committee.

Once the applicant is credentialed and a CAN report is received with positive results, the Provider Agency must suspend the practitioner from providing direct care services to CAMHD youth until the Credentialing Committee has made a decision.

K. Central Database Check for Sentinel Events, Grievance, and Medicare/Medicaid Exclusion. ***Verification time limit: 180 days.***

The CAMHD Credentialing Section shall check its central database to determine if the provider applicant has had previous reports pertaining to Sentinel Events or Grievances or has been excluded from participating in Medicare programs.

3. **Credentialing Committee Decisions.** The Committee shall review the complete application packets presented by the Credentialing Section prior to rendering any determinations. The CAMHD has the right to make the final determination about which practitioners participate within its network.

4. **Notification of Credentialing Adverse Determinations.** The Provider Agency or CAMHD practitioner will be informed in writing of any adverse credentialing/re-credentialing decision(s) from the Chair of the Credentialing Committee.

   A. The decision letter shall be sent to the Provider Agency within fifteen (15) calendar days of the decision. The letter will include the reconsideration and appeal process.

   B. Upon receipt of an appeal, the CAMHD has thirty (30) calendar days from the date of receipt of the letter of explanation to review documents and render a decision.

   C. The practitioner has the option to request a hearing and/or be represented by another person the practitioner's choice.

5. **Practitioner Suspension of Participation**. The Committee has the authority to suspend a practitioner's participation in providing services to CAMHD youth. When there is immediate risk to a youth, the CAMHD shall suspend a practitioner's credentials while an investigation is conducted by the CAMHD.

   A. The suspension process is initiated when a report is made or an investigation occurs in cases where it is determined that potential risks or harm may exist to CAMHD youth and presented to the Committee for review and decision. These preliminary investigative reports to the Committee may be from any of the following:

      - Sentinel Events Unit
      - Grievance Office
      - Performance Monitoring
      - Facility Certification Unit
      - Possible abuse as indicated in the Child Abuse and Neglect Screening (CANS) Check Results

   B. The Credentialing Section or Performance Management Office shall notify the Provider Agency verbally of the practitioner suspension within twenty-four (24) hours of the identified risk. The Provider Agency shall be notified in writing within seven (7) calendar days of the decision to suspend the practitioner's credentials. During the suspension of credentials, the practitioner may not work directly with CAMHD youth.

6. **Practitioner Restriction or Limitation of Participation.** The Committee has the authority to restrict or limit a practitioner's participation in the CAMHD Provider Network. Restriction or limitation may be considered in any of the following cases:

   A. Previous Grievance, Sentinel Events, or Performance Monitoring report(s) involving any of the events while previously employed with another CAMHD Provider agency.

   B. Previous criminal record within the past ten (10) years.

   C. Reported prior termination due to poor performance.

   D. Positive CAN Check results within the past ten (10) years.

   E. Prior drug abuse record within the past ten (10) years.

7. **Practitioner Termination.** The Committee has the authority to terminate a practitioner's participation in the CAMHD Provider Network. Termination may be considered in any of the following cases:

   - Loss of License
   - Exclusion from the Medicare/Medicaid program
   - Misrepresentation of credentials and/or other pertinent information (i.e. restrictive action questions)
   - Involvement in a malpractice claim that involves client safety
   - Criminal indictment of any type
   - Failure to adhere to what is established in the practitioner suspension, restriction or limitation of participation investigations (as previously in this policy).
   - Findings of fraud and abuse in billing

8. **Practitioner Reinstatement.** If a CAMHD or Provider Agency practitioner is voluntarily or involuntarily terminated by the CAMHD or the Provider Agency and the practitioner wishes to be reinstated:

   A. In the case of voluntary termination the practitioner must again be initially credentialed if the break in service is *thirty (30) calendar days* or more.

   B. In the case of involuntary termination, after all requests for consideration and Grievance & Appeals has been exhausted and Credentialing not approved, the practitioner shall wait one (1) year from the date of termination before submitting a new application for initial credentialing.

   C. The CAMHD and/or the Provider Agency shall re-verify credential factors that are no longer within the credentialing/recredentialing time limits.

   D. The Committee shall review all credentials and make the final determination prior to the practitioner's re-entry into the organization. A decision letter shall be processed to the applicant within fifteen (15) calendar days of its decision. The decision letter includes the

reconsideration and appeal process stated in the *"Request for Reconsideration & Appeal Process"* section of this policy.

9. **Practitioner Agency Transfer.** Credentialing approval is specific to the Provider Agency making the application for credentialing and is non-transferable. Practitioners wanting to be credentialed at multiple agencies shall submit initial credentialing packet to the Credentialing Section to process for each of the multiple agency.

10. **Initial Credentialing Site Visits.**

A. Onsite visits shall be conducted on an annual basis for all practitioner sites. These sites shall include treatment offices located within CAMHD including Family Guidance Centers, or Provider Agency Administrative Office, community treatment offices, residential facilities, and any other locations as reported by the practitioner applicant.

B. The *CAMHD Treatment Office Site Visit Tool* shall be used for these treatment office site visits. ***(See Attachment G, CAMHD Treatment Office Site Visit Tool).*** A designated Performance Management staff shall conduct the reviews. The reviews shall include the following:

1. Treatment Office Evaluation

   A minimum score of 90% for the office site section is required. For practitioners providing services in a special treatment facility (STF) or therapeutic group home (TGH), the license to operate issued to the agency by the Office of Health Care Administration (OHCA) will be accepted as verification that the facility is in compliant with all state laws pertaining to the type of service.

2. Treatment Record-keeping Practices

   A minimum score of 90% for the office site section is required.

3. Availability of Emergency Equipment

   A minimum score of 90% for the office site section is required.

C. Relocations and Additional Sites

When notified upon any agency's application to open a new site, the CAMHD Credentialing Specialist or designated CAMHD staff shall conduct a readiness site visit. Instances when CAMHD shall visit new sites include, but are not limited to when a practitioner opens an additional office or moves to offices from one location to another.

11. **Follow-up Actions for Initial Onsite Visit Findings/Deficiencies**

A. Reporting of Initial Onsite Audit Deficiencies and Corrective Action Activities

1. If the provider scores lower than the minimum score allowed on any of the criteria in the "Treatment Office Visit Tool" during the initial visit, a request for a corrective action plan from the practitioner shall be made during the exit interview.

2. A written notification of the request for the corrective action shall also be sent to the practitioner through the Provider Agency via regular mail or electronic mail.

B. Credentialing/recredentialing of the practitioner shall be deferred until all deficiencies in the onsite visit are addressed and a score higher than the minimum scored required is obtained.

C. Corrective action plans or other required documents shall be submitted to the CAMHD Credentialing Specialist no later than thirty (30) days from the date of onsite visit. The CAMHD shall review the corrective action plan and submitted documents. All primary source verifications in the deferred file would have to be within acceptable timelines at the time of review and approval by the Committee.

D. Follow-up Onsite Visit. CAMHD reserves the right to conduct a follow up onsite visit prior to approving the practitioner to ensure that initial deficiencies noted are now within acceptable thresholds.

12. **Ongoing Monitoring of Sanctions and Complaints**

A. State sanctions or limitations on licensure. On a yearly basis the status of practitioner's State of Hawaii licensure, sanctions, or limitations thereof are verified with the State of Hawaii Department of Commerce and Consumer Affairs, Professional and Vocational Licensing Division at http://pvl.ehawaii.gov/pvlsearch/app.

B. In addition, the CAMHD compiles all listing of Medicaid suspended or terminated practitioner letters from the Med-Quest Division. In the event that the name being reported by Medicaid is a current member of the CAMHD provider network, the issue shall be brought to the Committee within **twenty-four (**24**)** hours of receipt to conduct an emergency meeting to formalize the suspension or termination of the practitioner from the network.

C. The decision letter shall be issued within fifteen (15) calendar days and include the reconsideration and appeal process stated in the *"Request for Reconsideration & Appeal Process"* section of this policy.

13. **Notification to Authorities**

The CAMHD reserves the right to rescind the full credentialing/re-credentialing status of any practitioner that does not comply with State Ethics Standards, CAMHD standards, and State and Federal laws range of actions.

A. If the CAMHD discovers any misrepresentation of credentials or other illegal activities, the Committee shall review and make appropriate decisions. Results of the review may warrant reporting the practitioner's name and situation to the CAMHD Compliance Committee, Professional Activities Review Committee (PARC), and/or any other appropriate authority for investigation, with a copy to the Provider Relations Liaison. If warranted, licensed practitioner's name shall refer the practitioner's name to the designated

Medicaid Investigator. The CAMHD reserves the right to retain, suspend, or terminate any practitioner that has misrepresented his or her credentials.

B. The CAMHD Fraud and Abuse Program describe the CAMHD's procedure for reporting serious quality deficiencies that could result in a provider's suspension or termination to the Medicaid Fraud Investigator as well as other appropriate authorities.

14. **Credentialing Reports**

A. The Provider Agencies are required to submit electronic quarterly reports of their current credentialed licensed staff in the format required by CAMHD.

B. If a practitioner is terminated, the Provider Agency is required to submit the terminated practitioner's name and termination code immediately to the CAMHD Credentialing Section via email.

ATTACHMENTS:

A. CAMHD Glossary of Credentialing Terms – July 15, 2009

B. CAMHD Unlicensed Mental Health Care Professionals and Paraprofessionals Initial and Re-credentialing Application Form, Rev. July 15, 2009

C. CAMHD Unlicensed Mental Health Care Professionals and Paraprofessionals Initial and Recredentialing Checklist, Rev. May 19, 2011

D. CAMHD Attestation Letter, July 15, 2009

E. CAMHD Child Abuse and Neglect Disclosure Statement, Rev. 3/2006

F. CAMHD Child Abuse and Neglect Consent to Release Information, Rev. 02/2006

G. CAMHD Treatment Office Site Visit Tool; Rev. July 15, 2009

CAMHPS Acronym List

ABPN	American Board of Psychiatry and Neurology
ACGME	Accreditation Council on Graduate Medical Education
ADAD	Alcohol and Drug Abuse Division
APRN	Advanced Practice Registered Nurse
ASEBA	Achenbach System of Empirically Based Assessment
BASC	Behavioral Assessment System for Children
CAFAS	Child and Adolescent Functional Assessment Scale
CAMHD	Child and Adolescent Mental Health Division
CAMHPS	Child and Adolescent Mental Health Performance Standards
CARF	Council on Accreditation of Rehabilitation Facilities
CASSP	Child and Adolescent Service System Program
CC	Care Coordinator
CCC	Community Children's Councils
CMS	Center for Medicare and Medicaid Services
COA	Council on Accreditation
CPR	Cardiac Pulmonary Resuscitation
CSAC	Certified Substance Abuse Counselor
CSO	Clinical Services Office
CSP	Coordinated Service Plan
DDD	Developmental Disabilities Division
DOE	Department of Education
DSM	Diagnostic Statistical Manual
EBA	Emotional Behavioral Assessment
EBS	Evidence-Based Services
EIS	Early Intervention Services
EPSDT	Early Periodic Screening , Diagnosis, and Treatment
ES	Educationally Supportive
FBA	Functional Behavioral Assessment
HAR	Hawai'i Administrative Rules
HIPAA	Health Insurance Portability and Accountability Act
IDEA	Individuals with Disabilities Education Act
IEP	Individualized Educational Program
IPSPG	Interagency Performance Standards and Practice Guidelines
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
LCSW	Licensed Clinical Social Worker
LMFT	Licensed Marriage and Family Therapist
LMHC	Licensed Mental Health Counselor
LSW	Licensed Social Worker
MHP	Mental Health Professional
MHTP	Mental Health Treatment Plan
MTPS	Monthly Treatment and Progress Summary
OHCA	Office of Health Care Assurance
OTC	Over-the-counter
PARC	Professional Activities Review Committee
PECFAS	Preschool and Early Childhood Functional Assessment Scale
PRN	Pro re nata "as needed"
QA	Quality Assurance
QMHP	Qualified Mental Health Professional
RN	Registered Nurse
SBBH	School-Based Behavioral Health
SEBD	Support for Emotional and Behavioral Development
SUDS	Subjective Units of Distress Scale
TB	Tuberculosis Test
UR	Utilization Review