Child and Adolescent Mental Health Performance Standard

State of Hawaii

Department of Health
Child & Adolescent Mental Health Division

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September 23, 2019 Teal Book Updates

1. Clarification on placement of adults in residential treatment p I-6
2. Use of Telehealth to Improve Access p I-11
3. Clarification on comprehensive background screening in the credentialing process p I-24
4. Therapeutic Crisis Home (TCH) CAMHD LOC code added 4102 p II-4
5. Transitional Support Service (TSS) HCPCS code correction from H0036 to T1019 p II-163
6. Credentialing forms removed from the appendices and available for download on the CAMHD website: https://health.hawaii.gov/camhd/credentialing-forms/

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INTRODUCTION

The Hawai'i State Department of Health's (DOH) Child & Adolescent Mental Health Division (CAMHD) provides services and supports through an integrated public-private partnership consisting of contracted community-based agencies, state managed community-based Family Guidance Centers, and a centralized state office to provide administrative, clinical and performance oversight functions. The system of care has developed a comprehensive array of evidence-based services and supports for children and youth with the most challenging emotional and behavioral difficulties, and their families.

The 2018 Edition of the Child and Adolescent Mental Health Performance Standards (CAMHPS) is a manual developed by CAMHD for use in the development and provision of behavioral health services for youth in Hawai'i. It is the fifth such manual issued by the division, and informally named after the color of its cover; in this case it will be known as the "Teal Book." This manual is part of the contractual agreement between CAMHD and its contracted provider agencies for delivering behavioral health services to youth and families in Hawai'i. These standards are designed to describe the array of mental health services available, and to ensure the efficiency and effectiveness of those services. Unless granted a written waiver from CAMHD, all contracted providers agencies, their employees and subcontractors are required to comply with these standards and with their specific contracts which delineate additional requirements for each service. The CAMHPS will be available in electronic form on the CAMHD website, and all updates will be published there: http://health.hawaii.gov/camhd/

Through its seven (7) Family Guidance Centers and the Family Court Liaison Branch, herein after referred to as Centers, the CAMHD provides clinical oversight and case management services to youth and families throughout the state through an assigned Clinical Lead and Care Coordinator. CAMHD also procures needed services from its contracted provider agencies, herein after referred to as Contractors, to meet the treatment needs of youth. CAMHD provides services to youth who meet clinical criteria for serious emotional or behavioral disturbance and who qualify for funding support from the state based on one or more of the following: 1) they have QUEST-Integration insurance; or 2) they have been certified as qualifying for special education services under the Individuals with Disabilities Educational Act (IDEA) and their Individual Educational Plan (IEP) team requests CAMHD services; or 3) they are involved in the Juvenile Justice system and are referred to CAMHD by the Office of Youth Services. Small numbers of other youth may become eligible for CAMHD services based on their qualifying for a particular special program, usually grant-funded.

At its first publication in July 2018, this version of the CAMPS is designed to present all the relevant regulations and standards that apply currently to Contractors. Nonetheless, CAMHD and its Contractors operate in a rapidly changing healthcare environment, and frequent updates to the CAMPS are anticipated. In particular, CAMHD is committed to the development of health information systems in alignment with healthcare policies at the National level. Since these policies can change frequently, Contractors are expected to comply with new billing and documentation practices as they develop. CAMHD expects to introduce many improvements to its information system over the proposed contract period, and Contractors will be expected to cooperate with the implementation of these improvements. There is an exciting and challenging future ahead for CAMHD and its Contractors. Let's go forward together.

SECTION I:

GENERAL PERFORMANCE STANDARDS

SECTION I: GENERAL PERFORMANCE STANDARDS

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.

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 changes that may occur in the future will be posted on the CAMHD website: http://health.hawaii.gov/camhd/. 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 contracted providers to support these components in their respective practices.

1. Commitment to the Hawaii CASSP Principles and the Provision of Inclusive Services

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, Hawai'i communities and stakeholders made minor language revisions to these CASSP principles to effectively address the relevant cultural issues as they presented in Hawai'i. 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"), and Early Intervention Services ("EIS"). A large percentage of the CAMHD population is enrolled in one of the QUEST Integration Health plans and may receive special healthcare services. The CAMHD Care Coordinators (CCs) work with all other child-serving agencies to integrate services and programs across agencies in the best interest of youth and their families.

CAMHD works closely with our other state agencies through the Hawaii Interagency State Youth Network of Care (HISYNC) group. HISYNC meets monthly and brings together leaders from all the state child-serving agencies including: ADAD, EIS, the Department of Education's (DOE) School Based Behavioral Health (SBBH) and Community Children's Council (CCC), Child Welfare Services (CWS), Office of Youth Services (OYS), Med QUEST Division, Family Court/Juvenile probation, and Ohana Services, the Parent Partner service provider for CAMHD. HISYNC meetings provide opportunities for these groups to share and compare data about service system outcomes, and to discuss policy changes that could improve the system. There are several active HILYNC (Hawaii Interagency Local Youth Network of Care) groups that bring the same agencies together on a local/regional level. Contracted providers who experience difficulties collaborating with one of these state child-serving agencies are encouraged to raise

their concerns with CAMHD leaders for discussion at HISYNC, and to attend their local HILYNC meetings.

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 interventions should stem from careful consideration of the most current research. The following resources offer up to date summaries of the youth mental health treatment literature: (a) the evidence-based child and adolescent psychosocial intervention matrix from the American Academy of Pediatrics (click on "The Blue Menu" link here:http://helpyourkeiki.com/how-can-i-learn-more-about-mental-health-concerns/) and (b) the practices derived from the evidence base, organized by problem area (scroll to the "See What Works" sections within the specific links for the "Common Problems" page: http://helpyourkeiki.com/common-problems/).

In addition, agencies are encouraged to make data-based decisions throughout the entire treatment process. This might include gathering and evaluating CAMHD or agency-collected data on client outcomes and functioning to further inform clinical decisions and the design of appropriate interventions.

a. Definition of Evidence-Based Practice

CAMHD has required contracted providers 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 evidence-based child and adolescent psychosocial intervention matrix from the American Academy of Pediatrics (click on "The Blue Menu" link here: http://helpyourkeiki.com/how-can-i-learn-more-about-mental-health-concerns/) and Practice Element Profiles in the latest CAMHD Biennial Report: http://helpyourkeiki.com/wp-content/uploads/2013/08/2009-Biennial-Report.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., Treatment Progress Summary progress 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. Examples of this evidence-base include data on the client-level dashboard that will be provided within the client's electronic health record via a CAMHD portal when it becomes available.

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. Examples of this evidence-base include data found on the provider-level dashboard that will be provided within the client's electronic health record via a CAMHD portal when it becomes available.

iv. Causal Mechanism Evidence

Memory, judgment, and the professional knowledge of team members regarding the various causal mechanisms associated with the developmental psychopathology and treatment trajectory associated with a youth can be used to guide treatment. 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 and Functional Family Therapy. The term "evidence" can and should take on many forms and exists within a broader culture of data-based decision making. CAMHD is committed to developing resources to support families in becoming informed consumers of mental health services. As a result, CAMHD encourages providers to direct clients and families to the Help you Keiki website (http://helpyourkeiki.com/) to learn more about evidence-based practices.

4. Commitment to Ethical Service Delivery

The CAMHD is committed to providing services in an ethically upstanding manner, consistent with the ethics codes of the American Psychological Association, National Association of Social Workers, American Psychiatric Association, and those of other national organizations relating to

the provision of mental health services. The CAMHD employees and contracted providers are expected to provide services in a non-discriminatory manner, consistently maintain appropriate professional boundaries, regularly seek informed consent, and respect the youths' and families' rights, prioritizing the benefits to the client of any therapeutic intervention over personal or professional gain.

Any sexual contact between contracted provider agency staff members and CAMHD youth is strictly forbidden, and any incident of this kind can be grounds for immediate termination of a provider's contract. Contracted providers are expected to supervise all agency staff closely and to be attuned to the risks of boundary violations by staff.

The CAMHD maintains commitment to serving all eligible youth, regardless of race, ethnicity, national origin, religion, culture, sex, sexual orientation, gender identity and expression, and disability. The CAMHD and its contracted providers continually strive to provide eligible youth and families with services sensitive to and nurturing of each individual youth's and family's identity, language and culture. Services are to be provided in a youth and family centered culturally appropriate manner, and inclusive of the youth's preferred name and pronoun (See Appendix 2 – Non-discrimination policy)

5. Commitment to Quality Improvement

The CAMHD is committed to ongoing evaluation of performance, compliant billing practices, and the use of data to improve contracted provider and CAMHD system development. Its quality improvement 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 performance data across all aspects of service delivery and care. CAMHD uses this information to determine how well the system is performing for youth, how well contracted providers are serving the 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, outcome and satisfaction data, and examinations of practice and quality of services.

Additionally, CAMHD is committed to the development of a health information system which is in alignment with healthcare policies at the National level. Since these policies can change frequently, contracted providers are expected to comply with new billing and documentation practices as they develop. Developments are aimed at the long-range goal of a centralized electronic health record, efficient and immediate information sharing, real time data for a variety of indicators (i.e. census, utilization, sentinel events, demographics, credentialing, etc.) and efficient billing of services that is compliant with national requirements. CAMHD expects to introduce many improvements to its information system over the proposed contract period, and contracted providers will be expected to cooperate with the implementation of these improvements.

6. Commitment to Information System Performance

CAMHD is committed to the development of health information systems as tools to improve youth services. These systems are developed in alignment with healthcare policies at the National level. Since these policies can change frequently, contracted providers are expected to comply with new federal and state-required billing and documentation practices as they develop. CAMHD system developments are aimed at the long-range goal of a paperless care system, a centralized electronic health record, efficient and immediate secure information sharing, availability of real time data for a variety of indicators (i.e. census, utilization, sentinel events,

demographics, credentialing etc.), and efficient billing of services in compliance with national requirements and standards. CAMHD expects to introduce many improvements to information systems over the proposed contract period, and contracted providers will be expected to cooperate with the scheduled implementation of these improvements. Providers will be expected to adjust the schedules, systems, and formats by which they send administrative, clinical, and billing documentation to CAMHD with these system changes. These systems changes are to reach the goal of near-real time availability of information for decision-making by those providing services to specific youth and managing the CAMHD systems of care as a whole.

7. Commitment to Continuity of Care

The CAMHD believes 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 restrictive levels of care as their changing clinical needs dictate. At any level of care, treatment should be individualized and should take into consideration the youth's stage of readiness to change and participate in treatment.

CAMHD's commitment to treating youth in the least restrictive environment includes utilizing out-of-home locations that are near their family if they can't be appropriately treated in their family home. Nonetheless, there are a few specialized situations that warrant sending youth to specialized treatment facilities out-of-state. These situations are utilized only when CAMHD cannot provide for the youth's needs in Hawai'i, and only with careful consideration by the treatment team and approval by the CAMHD Medical Director. Out-of-state treatment is utilized only until the youth can be safely returned to Hawaii to continue their treatment at or near their family home.

CAMHD does not place young adults (those over 18 years old) in out-of-home or out-of-state residential programs. Youth up to 17 years of age may be placed in an out-of-home residential program in Hawai'i. If the youth turns 18 during the course of treatment, the young adult must exit that residential program before their 19th birthday. Likewise, youth up to 17 years of age may be considered for out-of-state placement. If the youth's anticipated course of treatment extends into their 18 year of life, out-of-state placement is not an option.

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 Family Guidance Center 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.

8. Commitment to Providing Medically Necessary Services

CAMHD as a Medicaid Provider may only authorize treatment that is Medically Necessary and will use this definition of Medical Necessity to guide its 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 youth'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 level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide; and
   v. Be furnished in a manner not primarily intended for the convenience of the youth, the youth'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.

9. Commitment to Clinical Excellence and Co-management of Care

To ensure clinically appropriate, effective and efficient treatment is provided, CAMHD maintains clinical oversight of each youth served. Upon enrollment at a Family Guidance Center (FGC), each youth is assigned a "team" of mental health professionals which consists of a Care Coordinator (CC) and a Clinical Lead (CL), moving forward referred to as the FGC Team. The FGC Team works together with families, contracted providers and other stakeholders to promote wellness and assure the highest quality care for the youth they serve.

a. Clinical Lead

Within each Family Guidance Center, either a Clinical Psychologist or a Child Psychiatrist serves as the Clinical Lead (CL) on a youth's FGC Team. Clinical Leads are responsible for providing clinical case formulation, treatment direction and service authorization via collaboration and consultation with the youth's assigned Care Coordinator and contracted service provider over the course of a youth's care.

Clinical Leads begin a youth's care by determining their eligibility into CAMHD. Frequently, Clinical Lead's will perform a youth's Initial Mental Health Evaluation (IMHE) and use those findings to make their eligibility determination. Other times, a Clinical Lead will review an evaluation written by a non-CAMHD clinician and perform a functional assessment to determine eligibility.

The Clinical Lead documents the broad direction of treatment for each assigned youth using a Clinical Management Plan (CMP). The CMP is initially based on the Initial Mental Health Evaluation (IMHE) and is updated to reflect changes in the direction of treatment over time. The CMP outlines the major areas of focus for the proposed treatment and serves as the clinical insert to the youth's Coordinated Service Plan (CSP). Service providers are expected to utilize ideas from the CMP in developing their Mental Health Treatment Plans (MHTP).

The Clinical Lead's co-management of a youth's care is ongoing throughout treatment with CAMHD. Co-management includes direct communication between the Clinical Lead and

contracted service provider and/or their supervisor to obtain information about the status of the youth in treatment, as well as consult and collaborate to develop individualized and clinically indicated treatment and crisis plans. In addition, Clinical Leads and Care Coordinators work together to understand all the systems and issues impacting a youth's therapeutic progress to facilitate proactive and effective treatment planning for the youth they serve. To accomplish this, on a regular basis, the Clinical Lead reviews each youth's case with the Care Coordinator at a minimum, once a month. This case review process helps to assure that the services are appropriate to address the youth's identified needs and that they meet "medical necessity" criteria.

b. Care Coordinator

The Care Coordinator (CC) is the case manager on the youth's FGC Team who promotes family and youth engagement in treatment, facilitates access to services and provides interagency collaboration and coordination to ensure timely, appropriate and integrated service delivery.

Upon enrollment, a youth's Care Coordinator serves as the main point of contact for family members and other stakeholders in a youth's life such as school officials, probation officers, and contracted service providers. Care Coordinators establish rapport with families via psychoeducation, system navigation assistance, as well as modeling and guidance to empower parents to advocate for their child's best interests in a variety of interagency settings. Care Coordinators work collaboratively with other child serving agencies to engage in a Coordinated Service Plan (CSP) that outlines all pertinent parties involved with the youth and family, each entity's goals, strategies and plans. The initial CSP, however, is developed in the welcome meeting with the Clinical Lead and family present with the purpose of determining treatment direction and the appropriate service for the family. The Care Coordinator is responsible for making the referral to the contracted provider agency in a timely manner to ensure service delivery within thirty (30) days of eligibility determination, or immediately, if the youth has immediate needs. Within thirty (30) days of the welcome meeting, the Care Coordinator is responsible for convening a full CSP meeting with all stakeholders at the table. Contracted providers are expected to participate in the CSP development and meetings when they are involved with the youth.

The Care Coordinator maintains contact with the family and providers monthly to facilitate the integration, coordination, and monitoring of behavioral health services. Quarterly CSP meetings are arranged by the Care Coordinator to ensure that all parties involved are working together congruently and in the best interest of the child. The Care Coordinator is responsible to bring CSP team updates and other pertinent information related to the youth and family to the attention of the Clinical Lead via the case review process so adjustments can be made as needed and medical necessity can be assessed.

c. Co-Management

CAMHD youth and their families receive most of their direct clinical services from contracted provider agencies, based on the performance standards included in this manual. The services provided should reflect the best clinical thinking of both the contracted service providers and the CAMHD-assigned FGC Team of the Clinical Lead and the Care Coordinator. The contracted service provider and CAMHD should work together to develop a clear formulation of the youth and family difficulties, and to pursue optimal outcomes.

Although the FGC Team maintains authority over decisions about authorizing treatment, including the type of care, number of hours, etc., the youth's treating therapist and his/her supervisor maintain authority over the clinical choices made in the work day to day with the youth and family. The FGC Team gathers ongoing information from the provider about the

youth's clinical presentation, strengths, problematic events, and response to treatment interventions to help inform decisions about treatment authorization. The Clinical Lead's consultation may help the team consider different treatment options and suggest ways to improve the ongoing therapeutic approach.

Contracted providers are responsible for coordination of services provided within their agency and for maintaining regular communication with the Clinical Lead and Care Coordinator. Coordination and communication are particularly important in settings where there are multiple staff providing services for a youth. Contracted providers 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. Threshold

The CAMHD analyzed its own local data to determine appropriate length of stay guidelines for each service in its array. By using local aggregate outcome data as entered by CAMHD and its contracted providers, CAMHD has determined the point in treatment at which youth, on average, stop showing significant improvements in their clinical progress. Information about these time frames for each type of care are 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 five years to determine the time frame in which the majority of youth showed maximum improvement based on these measures. This time frame is provided to guide service authorization decisions, based on available data, but are not meant to be an absolute end point in any treatment service. Treatment must have ongoing review by the Clinical Lead to ensure the youth will continue to benefit from further treatment. As CAMHD continues to use data to improve its practices and inform clinical decision making, the use of a secondary review may be necessary if supported by data and will be implemented to ensure effective and efficient service delivery.

B. ELIGIBILITY

CAMHD is committed to providing timely services, individualized planning and access to an array of services. CAMHD services, whether they are delivered by employees or contracted providers, 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.

1. Eligibility Criteria

CAMHD serves Hawai'i youth with "high need" for mental health treatment services, sometime referred to as youth who have Severe Emotional and Behavioral Disturbances (SEBD). To be eligible, youth must:

a. Meet criteria for a mental health diagnosis as determined by a Qualified Mental Health Professional (QMHP).
   i. The diagnosis must be listed in the Diagnostic and Statistical Manual of Mental Health Disorder, 5th Edition (DSM5)
      1. Substance Use Disorders on their own do not qualify youth for CAMHD services, but they can co-occur with a psychiatric disorder.

2. Youth who have moderate to severe Developmental Disabilities are not eligible for CAMHD services, but those with mild Developmental Disorders that co-occur with a psychiatric disorder may qualify.

b. Demonstrate significant functional impairment. This means the youth is showing significant difficulties functioning in several life domains.
   i. CAMHD uses the Child and Adolescent Functional Assessment Scale (CAFAS) to determine whether youth meet this criterion.

c. Be funded by one of the following:
   i. Their QUEST-Integration insurance;
   ii. Office of Youth Services (OYS) through a referral from the Director of OYS;
   iii. State General Funds accessed for youth who are referred by their Department of Education (DOE) Individual Educational Program (IEP) Team; or
   iv. By qualifying for a special CAMHD grant project. Current projects offering free services for qualified youth include:
      1. Kealahou Services is Oahu's program for girls who have experienced significant trauma; or
      2. OnTrack - Hawaii is Oahu's First Episode Psychosis (FEP) program for youth and young adults who have a psychotic disorder.

More information about these grants funded programs and their admission criteria can be obtained by calling the CAMHD Clinical Services Office (808-733-9856).

2. Eligibility and 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 co-occur with 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.

3. Application

Application forms for CAMHD Services are available on the CAMHD website http://health.hawaii.gov/camhd/family-guidance-center-forms/ and from every Family Guidance Center (FGC). There is a special version of the application form for use by the Department of Education (DOE) to refer Special Education students who may be eligible for CAMHD because of their IEP. All DOE referrals for non-QUEST youth must include an Emotional-Behavioral Assessment or other diagnostic evaluation.

A parent or legal guardian must sign a consent form agreeing to have their child evaluated to determine their eligibility for CAMHD services. The form is included as part of the application along with a form to allow inter-agency release of information if needed. Any family interested in applying for CAMHD services can get help completing the form through their local Family

Guidance Center. Applications should include an existing Mental Health Evaluation that is less than twelve (12) months old when one is available to help expedite the process.

4. Enrollment

The intake process for new applications are coordinated by the Mental Health Supervisor(s) (MHS1s) in the local Family Guidance Centers. The MHS1 will conduct a brief phone or in-person interview with the parent/guardian requesting services in order to gather basic information about the youth and the help being sought. When appropriate, the MHS1 will schedule a Mental Health Evaluation, with one of the FGC's Clinical Leads or with an outside provider to determine an initial working diagnosis and to assess functional impairment. Referrals from IEP Team must be accompanied by an evaluation with a mental health diagnosis within the past twelve (12) months. Once an adequate Mental Health Evaluation is available, the Clinical Lead uses the information to assess functional impairment of the youth to make an eligibility determination and completes the enrollment process. Those youth who are eligible are assigned to a Care Coordinator and a Clinical Lead, and parents/guardians are contacted to begin CAMHD services with a welcome meeting. For youth who are not found eligible, parents are contacted and informed of the decision. They are provided information both about the CAMHD appeals process and about ways to get alternative help for their child.

5. Welcome Meeting

A welcome meeting is an introductory meeting for the family to the FGC Team consisting of, at a minimum, the Clinical Lead and Care Coordinator. This meeting is the FGC Teams initial opportunity to engage the family in their treatment via psycho-education and rapport building. FGC Team members engage in shared decision making with families by explaining the clinical findings of their child's evaluation, presenting a range of medically necessary treatment options and providing guidance around which service would be the best fit for the family based on the family's stated goals as documented in the CMP and initial CSP.

6. Use of Telehealth to Improve Access

Telehealth technology may be used to help deliver needed services by MHPs or QMHPS to remote areas when travel distances and costs make in-person delivery impractical. All services provided by telehealth shall be consistent with Hawaii Revised Statute 226 (2016), CMS regulations, and MedQUEST guidelines. In general, telehealth services shall be used to serve families within an agency's contracted geographic area. When necessary and approved by the CAMHD Clinical Lead, coverage by the contracted agency's staff on another island may be provided via telehealth. The family/youth must agree to the use of telehealth services, and necessary equipment and telecommunications services must be available to them. If the family/youth do not agree to the use of telehealth, services must be provided in-person only.

Telehealth service delivery must be clinically appropriate as evidenced by the CAMHD Clinical Lead's approval thru incorporation of telehealth on the youth's Clinical Management Plan (CMP). The Clinical Lead may modify the plan for telehealth use based on service effectiveness or outcomes. Some aspects of the treatment plan may be better suited to the use of telehealth than others. For example, parenting skills work with a parent may work well, whereas play therapy with a young child probably will not.

In most cases, there should be an initial in-person meeting with the youth and family to plan future services and discuss use of telehealth. This may also be during the "pre-admission meeting" and include the Care Coordinator and/or the Clinical Lead. Following this, direct services may include use of the telehealth modality for the majority or even all

of the clinical contacts. However, the FGC Clinical Lead may set case-specific requirements for an increased proportion of onsite services to ensure good youth outcomes. The provider therapist must detail the plan for telehealth use on the MHTP and discuss it in treatment team meetings. The provider agency's supervising QMHP is expected to oversee some portion of direct telehealth services via "sitting in" virtually on a percentage of youth visits. The provider agency QMHP and MHP conducting telehealth services are required to have training in therapeutic service delivery via telehealth.

Telehealth facilities. Contracted agencies that wish to provide services via telehealth must meet a number of technical requirements. Each Agency is required to use one single technical platform for all telehealth services delivered by the agency (examples: Zoom, VSee, Microsoft Teams, etc.) The technical platform must allow full-screen bi-directional video and audio communication, sufficient for therapeutic use by CAMHD-credentialed contracted agency therapists. The agency must ensure youth-serving staff training and support in the equipment and platform used.

Billing for this service must include clinical notation of the services as via telehealth, and billing should include a telehealth modifier (e.g. -GT). Telehealth equipment must allow for audio and video transmission and receipt without noticeable issues of lagging audio/video. Provider agencies may choose to supply their technical equipment or communication services, to youth or families for telehealth service provision. The CAMHD Clinical Leads and/or the Clinical Services Office may require stricter terms for telehealth video size or video/audio quality and in- person provision, based on the particular needs of the youth.

A HIPAA-compliant secure platform is required (with minimum 128-bit encryption), under a signed Business Associate Agreement (BAA) with the telehealth service technical platform provider. Copies of this agreement and technical service details shall be supplied to CAMHD on request.

C. EVALUATIONS

Clinical Evaluations of youth are vital to the development and implementation of effective treatment plans for youth with complex needs. At the same time, overly lengthy or complex assessment procedures can interfere with the timely provision of services and undermine the treatment process. Within CAMHD's system, there has been an attempt to strike a balance between thoroughness and timeliness of mental health evaluations. Individualized decisions about the need for in-depth testing and data collection guides the process. 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 or program.

1. Initial Mental Health Evaluations

When families first apply for CAMHD services for a youth, they may be referred to a CAMHD Clinical Lead or contracted service provider for an Initial Mental Health Evaluation (IMHE) if no diagnostic evaluation is available from previous mental health providers. These evaluations are specifically designed to provide a picture of a youth's presenting symptoms, diagnosis, strengths, needs, and environment, so that decisions can be made regarding the most effective treatment interventions, including decisions about the youth's eligibility for CAMHD services.

Evaluations are part of the set of information that is used in planning strategies for treatment interventions and are necessary prior to initiation of any treatment. IMHE reports are completed using the IMHE template (See Appendix 4) and provide information about the youth's developmental course, family history, trauma history, school functioning, social roles, substance use, psychiatric and medical history, current diagnoses, and recommendations for treatment within the context of an integrated clinical formulation. The Child and Adolescent Functional Assessment Scale (CAFAS) or Preschool and Early Childhood Functional Assessment Scale (PECFAS), and the Youth and Parent report versions of the Ohio Scales are to be included in the evaluation to inform treatment recommendations. CAFAS ratings are integrated into the IMHE template.

The IMHE is designed to be completed in a relatively brief period of time, based on around two hours of interview time with the youth and caregiver(s). The IMHE template utilizes checkboxes and drop-down menus in lieu of paragraphs of complex text in order to expedite the production of the written report. Some youth who enter CAMHD based on this somewhat cursory evaluation will need additional mental health evaluations to guide treatment. In this case, the treatment team may refer for additional evaluations such as a General Mental Health Evaluation.

2. General Mental Health Evaluation

At any point in a youth's treatment when the Clinical Lead and/or the treatment team has additional questions about a youth's diagnosis, clinical formulation, treatment needs, etc., a General Mental Health Evaluation (GMHE) may be authorized and conducted. As part of the GMHE, 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 only performed as part of a GMHE and is described in the evaluation report. A separate authorization for psychological testing is required.

CAMHD may also conduct or contract for a GMHE 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

3. Summary Annual Evaluation

To remain eligible for CAMHD services, youth must have an annual evaluation to establish that they still have a qualifying diagnosis and to determine his/her ongoing need for intensive mental health services. All contracted service providers must perform a Summary Annual Evaluation (SAE) as part of their service delivery as specified in the specific level of care standard for CAMHD youth in their care at the time the annual evaluation is due. The contractor is obligated to perform this evaluation for CAMHD youth who have received at least three (3) months of services from the contractor. The SAE addresses significant changes, current status, confirms diagnosis and consequent recommendations. Contractors utilize the SAE template CAMHD has developed for this evaluation (See Appendix 5).

4. Psychosexual Assessment

CAMHD contracts with specialists in juvenile sexual offending to provide Psychosexual Assessments. These assessments shall be provided**,** as needed, for any registered CAMHD youth who is arrested, charged or adjudicated for a sexual offense. This assessment is a specialized evaluation that identifies 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.

D. SERVICE/TREATMENT PLANNING

Each youth's treatment will be directed by a set of inter-related plans 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 centered.

1. Clinical Management Plan (CMP)

The CMP provides an overview of CAMHD's planned clinical approach to a youth's care. It includes recommended focus areas for treatment and specifies appropriate treatment targets that are consistent with these focus areas and the youth's diagnostic picture. It provides recommendations about the level of care most suitable to address the youth's needs, the probable length of this care and alternative treatments that the family may consider. This plan also looks further into the future and provides recommendations about likely types of care to follow the current services (See Appendix 6 - CMP Template).

The Initial CMP is developed by the Clinical Lead assigned to the youth, based on the Initial Mental Health Evaluation and/or any past reports available when the youth enters CAMHD. A draft CMP is prepared for discussion with the youth and family during the welcome meeting and is revised based on the youth's and family's input. The CMP is included in the referral packet that is sent to prospective contracted service providers and serves as a description of what the Family Guidance Center is requesting from the contracted provider. As the youth progresses in treatment, the CMP is updated regularly to reflect changes in the team's understanding of the clinical situation and changes in the overall clinical management plan.

2. Coordinated Service Plan (CSP)

The CSP provides a summary of all the services being provided to a youth and family by the larger child-serving system, including services provided by Dept. of Education, Child Welfare, Family Court, Office of Youth Services, etc. It includes contact information for all the workers involved with the youth, and the plans developed by sister agencies are included as attachments to the CSP. The Coordinated Service Planning 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 notes resources available through the service system and shall include some naturally occurring resources in the youth's family and community. The purpose of the CSP process is to coordinate efforts across public agencies and other supports and services. The workers involved with the youth from all of these agencies are members of the CSP Team, along with the youth, his/her parent(s) or guardian(s), the treating therapist(s), and the Care Coordinator/Clinical Lead team assigned to the youth (See Appendix 7 - CSP template).

The initial CSP is developed by the Care Coordinator assigned to the youth. The Care Coordinator develops a draft CSP based on intake information to share with the youth and family in the welcome meeting and edits the plan based on their input. A CSP meeting with all the team members shall be convened within the first quarter of active CAMHD services. The Care Coordinator convenes monthly treatment team meetings that include, minimally, participation by the treating therapist(s), the parent/guardian and youth are always invited to participate with the Clinical Lead included as needed. CSP meetings that include the larger team shall be convened quarterly, and the CSP meeting may substitute for that month's treatment team meeting. Treatment team and CSP meetings may be held via telephone or video-conferencing when necessary.

The CSP includes safety/crisis prevention planning and transition planning (see Appendix 7- CSP template). Planning for a youth's transition to adulthood should begin early (ages 15-17) and shall be documented in the youth's CSP for all youth seventeen (17) years and older.

3. Pre-admission Meeting

A pre-admission meeting introduces the family to the contracted service provider who will be providing their treatment. Present at this meeting are, at a minimum, the legal guardian, provider and CC. The goal of this meeting is to engage the family in the treatment process from the point of entry into the service by establishing lines of communication and clarifying treatment expectations. This discussion includes outlining treatment targets, family participation in treatment, discharge criteria and safety/crisis planning which will be documented in the mental health treatment plan.

4. Mental Health Treatment Plan (MHTP)

The contractor provider is responsible for the development, implementation, review, revision and adjustments to the MHTP at least quarterly (See Appendix 8 – MHTP template). 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 service provider, family and the Care Coordinator. The major areas of focus for the treatment plan are derived from the CMP. Within these areas, the provider is expected to work with the family and youth to articulate measurable goals that are meaningful to them. 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 Care Coordinator 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 plan should be developed and submitted to the CC within ten (10) calendar days of intake (except where otherwise specified in the service specific standards).

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

a. Crisis Prevention and Intervention Planning

The crisis prevention and intervention plan document 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 prevention and intervention plan are an expected component of the MHTP that builds on available information about the youth through the youth's personal safety plan contained in the CSP (See Appendix 7- CSP template). The safety plan should be updated 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 component 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 shall 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. Contracted provider, Care Coordinator, 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 the behaviors or other symptoms that resulted in the admission, describe a projected timeline for meeting them, and identify any aftercare resources needed. As treatment progresses, 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 contracted provider must write a discharge summary and submit to the appropriate Center within ten (10) days of service termination. A preliminary discharge summary may be necessary in emergency situations if imminent services are needed. Informal discussions between discharging and admitting contracted providers about the youth's needs, successful strategies, etc. are also encouraged with proper consents. The discharge summary shall include at least the following components:

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.

E. REFERRAL PROCESS FOR CONTRACTED SERVICES

CAMHD provides an array of intensive mental health services through its Family Guidance Centers and contracted service providers. The Care Coordinator is a vital link in the referral process and makes referrals to contracted provider agencies. The referrals are made within three (3) business days after the determination of strengths and needs through the youth's CMP and CSP 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 services can be provided, except for Emergency Services that must be provided immediately. Without service authorization contracted providers cannot bill for services rendered. Service authorization represents an upper limit on the amount of service that may be billed. CAMHD relies on the clinical judgement of contracted provider therapists to determine whether or not to utilize all of the time authorized. Contracted provider therapists are expected to avoid providing more hours or days of treatment than is clinically appropriate to meet the youth's needs. In cases requiring crisis response that causes the provider to go over the allotted authorization, the provider must contact the Care

Coordinator or Clinical Lead within 30 days of the services rendered to request a retro-authorization. The Clinical Lead will write a clinical justification note to support the retro-authorization.

It is expected that all youth will have access to needed services. The role of the Care Coordinator is to make referrals to contracted 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 contracted provider on another island, CAMHD will pay for the travel costs for admission, discharge and for CAMHD approved therapeutic passes.

1. Referral Process

The contracted provider is expected to accept all appropriate service referrals in accordance with contractual requirements. All referrals will include recommended focus areas for treatment and appropriate treatment targets that are consistent with these focus areas and the youth's diagnostic picture and anticipated duration of treatment. Within three (3) working days of need identification, the Care Coordinator will submit a referral packets as follows.

a. Referrals packets for all services will include:
   i. CAMHD Referral Form & Referral Acceptance Form (See Appendix 10)
   ii. Current Coordinated Service Plan (CSP) with Clinical Management Plan (CMP)
   iii. Current CAFAS
   iv. IEP (as applicable)
   v. Current mental health/emotional behavioral assessment (within twelve (12) months)
   vi. Current FBA (if applicable)
   vii. Any recent admission/discharge summaries (if applicable)
   viii. Additional out-of-home requirements provided with referral or at intake:
      1. Tuberculosis (TB) test results within 12 months. A positive TB must be accompanied by written medical clearance from the treating physician indicating the youth is safe to participate in out-of-home treatment.
      2. Physical Examination within the last 12 months.
      3. Immunization Record (for youth under age 12).

2. Contracted Provider Referral Acceptance Protocol

The referral acceptance process is described in CAMHD Policy and Procedure 80.614 "Referral Acceptance Protocol" (See Appendix 9). The contracted provider is expected to follow the referral acceptance process outlined below:

a. Within two (2) working days of receipt of the referral packet from the Care Coordinator, the contracted provider shall complete and return to CAMHD the Referral Acceptance Form (See Appendix 10) found in the referral packet to confirm a date for initiation of services. If the requested service is available, the admission/start date shall be as soon as possible, but must be within fourteen (14) days of acceptance otherwise the youth must be placed on the agency's waitlist.

b. Waitlist Protocol
   i. The youth is placed on the provider waitlist according to the date of acceptance.
   ii. The CC is informed of the youth's position on the waitlist / waitlist number via the Referral Acceptance Form

1. If CAMHD determines that a youth needs to be prioritized for clinical or administrative reasons, the Clinical Services Office will contact the provider to prioritize the youth.
2. The provider will complete and submit to CAMHD the Weekly Census Report on Client Status and Waitlisted Youth Form (See Appendices 12? & 11?).

c. If, for any reason, a contracted provider's Clinical Director believes a youth is not appropriate for their level of care, the contracted provider's Clinical Director must contact the Family Guidance Center Clinical Lead, verbally and in writing (per the Referral Acceptance Form Appendix 10), to explain why they believe the youth is not appropriate for that level of care. Within three (3) days, the Family Guidance Center Clinical Lead will review and discuss the concerns with the contracted provider's Clinical Director in an attempt to resolve the issues. If the contracted provider's Clinical Director and Family Guidance Center Clinical Lead come to an agreement that the level of care is appropriate, the contracted provider will give the Care Coordinator an anticipated date for the initiation of services.

d. If the concerns cannot be resolved in this manner, the contracted provider or CAMHD has the option to request an independent evaluation. The evaluation needs to be completed within fourteen (14) days at the contracted provider'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 contracted provider 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 13) and submit it to the Clinical Services Office (CSO). The CSO will fax the Medical Director's approval or disapproval to the contracted provider within three business days of receipt of the form.

e. If the independent evaluation determines that the level of care is not appropriate, the Family Guidance Center and its Clinical Lead will accept and review the independent psychiatrist's recommendations. The CMP/CSP team will determine the appropriate level of care and send out referral packets to other appropriate contracted providers. CAMHD will reimburse the contracted provider 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.

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

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

F. COMMITMENT TO SERVE ALL YOUTH

Contracted providers will be expected to provide all youth accepted for 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 contracted provider 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 9). If a contracted provider seeks to terminate services for a youth already in out-of-home program:

1. The contracted provider is required to complete a full internal review that includes a review documented by the contracted provider's psychiatrist.

2. The contracted provider is required to report the results of this review to CAMHD and the CSP team prior to any further action being taken.
3. If a Family Guidance Center receives notification that a contracted provider wants to eject a youth, the Family Guidance Center Clinical Lead will contact the contracted provider's Clinical Director to review and discuss the issue. If the contracted provider's Clinical Director and the Family Guidance Center Clinical Lead come to an agreement that the level of care continues to be appropriate, the contracted provider is expected to maintain the youth in its program.
4. If the Family Guidance Center Clinical Lead and the contracted provider's Clinical Director are not in agreement, the contracted provider's Clinical Director has the option to request an independent assessment, at the contracted provider's cost, from a Hawai'i licensed, American Board of Medicine Specialties Board Certified Child and Adolescent Psychiatrist, who is independent of the contracted provider and CAMHD. The contracted provider must complete the "CAMHD Independent Psychiatric Consultation Form" (See Appendix 13) for the CAMHD Medical Director's approval of the independent consultant. The contracted provider 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 Family Guidance Center will accept the determination and initiate appropriate and timely transition services for the youth. The contracted provider will be requested to maintain the youth for at least ten (10) days to allow for transition preparation.
6. CAMHD will reimburse the contracted provider for 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 contracted provider is expected to maintain the youth in its program.

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

G. TRAINING

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 Contracted Providers

a. Contracted providers 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 contracted provider agency staff/contracted consultants with an emphasis on training for provider staff who can train others within their agencies.

c. Contracted providers must designate a staff person responsible for staff and/or sub-contracted provider training in all aspects of the delivery of services. The contracted provider'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 contracted providers 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 CAMHD Performance Standards;
xvii. Client's rights and responsibilities;
xviii. CAMHD sentinel events documentation and reporting requirements;
xix. Safety of clients and staff; and
xx. Overview of CAMHD Performance Monitoring.

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 count toward training hours. 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.

H. SUPERVISION

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

Contracted providers must have policies and procedures and the mechanism to ensure supervision of all clinical services and staff. The contracted provider is responsible for maintaining and tracking supervision records. Supervision shall include review of clinically relevant case details, present and planned treatment targets, interventions employed, assessment of youth progress, assessment of effectiveness of interventions, and follow-up on previous recommendations. Supervision documentation must include the supervisee's actions, supervisor's recommendations and follow-up between sessions.

Supervision shall also include professional development of appropriate boundaries, power differential and appropriate use of authority, as well as transference and countertransference issues. Supervision includes utilizing a combination of methods such as case reviews, direct observation, coaching, and role modeling/training to improve the skills and enhance job performance.

Contracted providers shall have a process for evaluating 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. Contracted providers shall monitor the staff evaluation process for its effectiveness in helping staff acquire the needed skills.

All contracted provider personnel (employees or subcontractors) must have an individualized supervision plan based on a needs assessment completed annually, at minimum unless stated otherwise, by their respective supervisor. Documentation of individual supervision session must include date, duration, name and credentials of supervisor, along with the goals, 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.

1. Qualified Mental Health Professional (QMHP) Requirements:

A QMHP shall participate in at least two (2) hours group supervision per month with other QMHPs or MHPs within the agency as evidenced by documentation in their supervision file. QMHPs working half-time or less may adjust the supervision requirements to one (1) group supervision per month. QMHP's may credit regular participation in CAMHD's Evidence-Based Services Committee (EBS), HBR Rounds or CBR/HBR Clinical Lead meetings towards the QMHP supervision requirements. Documentation of attendance shall be maintained by the QMHP and submitted to contractor for inclusion in the supervision file. A QMHP may supervise the equivalent of no more than ten (10) full-time MHP's or Paraprofessionals.

2. Mental Health Professional (MHP) Requirements:

A 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. MHPs working half-time or less may adjust the supervision schedule with one (1) hour individual and one (1) hour group. A MHP may supervise the equivalent of no more than ten (10) full-time Paraprofessionals. A Supervising MHP Exception Request may be granted to allow certain MHPs to supervise other MHPs and/or Paraprofessionals up to the ten (10) full-time equivalent limit if approved (See Appendix 14). Supervising MHPs must be supervised by a QMHP.

3. In-Home Paraprofessional (IH Para) Requirements:

In-Home Paraprofessional services can only be provided by those Paraprofessionals credentialed at level 2. The In-Home Paraprofessionals must receive at least four (4) hours of supervision a month from a QMHP or an MHP. At least one (1) hour must be individual, clinical, youth-specific supervision and three (3) hours may be group supervision that may be conducted in conjunction with MHPs. In-Home Paraprofessionals working fifteen (15) hours or less a week may adjust the supervision schedule to one (1) hour individual and one (1) hour group. An IH Para shall not supervise other paraprofessionals.

The contractor shall develop an individualized supervision plan based on a needs assessment of the In-Home Para skills. The skills and knowledge of In-Home Paras shall be assessed by a MHP or QMHP at the beginning of their employment and at least annually thereafter. Assessments shall focus on skills in effectively providing therapeutic behavior management techniques. Contractors are expected to develop an assessment instrument that meets the needs of their program. Competency Assessment for Paraprofessionals in Residential Programs (See Appendix 15) is an example which may be adapted as necessary, if desired.

4. Out-of-Home Paraprofessional (OOH Para) Requirements:

Paraprofessional workers in residential programs work on a team with colleagues, and seldom need to function completely independently. Problematic attitudes toward youth or faulty behavior management efforts are observed by others for the most part. As a result, the supervision needs of these workers are different from those of other paraprofessionals in the CAMHD system, such as those who work independently with families and youth in their homes or in the community. CAMHD has developed the following supervision standards specifically for paraprofessional workers in residential programs.

Out-of-Home Paraprofessional services may be provided by Paraprofessionals credentialed at Level 1 or 2. The Out-of-Home Paraprofessionals must receive at least once a week clinical group supervision focused on treatment goals and interventions including de-escalation

techniques for youth within the milieu by a MHP or QMHP and can be part of a shift-change meeting. At least a half hour once a month individual professional development supervision that is based on an assessment of the OOH Para skills and attitudes shall be conducted by a MHP, QMHP or Paraprofessional in the role of shift leader or charge nurse. Paraprofessionals working fifteen (15) hours a week or less may adjust the supervision schedule to a half hour individual and one (1) clinical group per month. OOH Paras shall not supervise other paraprofessionals unless the OOH Para is a shift leader or charge nurse.

The skills and knowledge of OOH Paras shall be assessed by a MHP or QMHP at the beginning of their employment and every six (6) months thereafter for their first two (2) years and continued annually thereafter. Assessments shall focus on skills in effectively providing therapeutic behavior management techniques. Contracted providers are expected to develop an assessment instrument that meets the needs of their program. Competency Assessment for Paraprofessionals in Residential Programs (See Appendix 15) is an example which may be adapted as necessary, if desired.

These assessments shall be based on direct observations from the paraprofessional's supervisor(s) working in the milieu, as well as an analysis of relevant program data such as youth grievances about staff and staff involvement in restraints and other sentinel events and incidents that may be decreased by effective behavior management techniques. Assessment results shall be used to develop a supervision plan for the OOH Para, which may include a higher frequency of supervision meetings or other specific training procedures when skills are found to be lacking as well as additional assessments of skills. These assessments shall be documented and kept with the supervisee's clinical supervision documentation.

5. Supervision Summary Table

Supervision Requirements Summary		
Credential Level	**Individual Supervision**	**Group Supervision**
QMHP		2 hours per month
QMHP < .5 FTE		1 hour per month
MHP	1 hour per month	2 hours per month
MHP < .5 FTE	1 hour per month	1 hour per month
IH Para 2	1 hour per month	3 hours per month
IH Para 2 <15 hrs. wk.	1 hour per month	1 hour per month
OOH Para 1 or 2	½ hour per month	4x a month
OOH Para 1 or 2 <15 hrs. wk.	½ hour per month	1x a month

I. CREDENTIALING

CAMHD is committed to ensuring that staff is competent and qualified to provide the intervention/services to youth as evidenced by meeting the following credentialing requirements. CAMHD requires all contracted providers to adhere to federal and state standards for healthcare services that include Medicaid, Hawaii revised statutes, and Prison Rape Elimination Act (PREA). Contractors are advised to provide their prospective employees/sub-contractors the CAMHD credentialing packet at time of application or hiring to ensure adequate time for processing of CAMHD credentialing. Employment will be contingent on meeting CAMHD credentialing requirements. No employee/sub-contractor shall have direct access to CAMHD youth until he/she has been credentialed.

1. Comprehensive Background Screening

A comprehensive background check is required for every individual that has direct contact with children and youth receiving contracted services:

a. State and federal criminal history check using the individual's current legal name and fingerprint
b. Child Abuse and Neglect screening
c. Adult protective services screening
d. National Sex Offender registry
e. List of Excluded Individuals/Entities (LEIE) database check
f. Additional required primary source verification required for any individual who holds or has held a vocational license nationally

CAMHD delegates the primary source verification as noted in P&P 80.308.3 Delegation of Credential Primary Source Verification (See Appendix 17). This is documented in the employee's personnel file. The Contracting agency is responsible for reviewing the documentation, taking actions as needed, and promptly notifying CAMHD of any changes that may affect the individual's credentialing status.

2. 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, trainees, volunteers, 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 (See Appendix 18 & 19).

a. All professionals contracted or employed by contractors to provide direct services to youth and families must be at least 18 years of age and 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.
b. 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.
c. Contractors shall ensure prompt and accurate reporting of current staff and contractors as well as terminations. Evidence of contractors' accountability is exhibited through CAMHD Credentialing Reporting. Contracted agencies' compliance with this requirement is used in the yearly delegation of credentialing agency oversight evaluation.
d. Individual credentialing files for each direct care and supervisory employee and subcontractors shall be established separately from general personnel files.
e. Licensed individuals shall meet continuing education requirements as outlined by the Hawaii State Professional and Vocational Licensing Division and will not be individually monitored by CAMHD. The renewal of the licensure by the respective licensure board shall constitute completion of all required continuing education requirements.

3. Individual Practitioner Credentialing Information

a. Qualified Mental Health Professional (QMHP):

i. 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

ii. A Clinical or Educational Psychologist with a current Hawai'i license in Psychology.

OR

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

OR

iv. A Hawai'i Licensed Clinical Social Worker (LCSW).

OR

v. A Hawai'i Licensed Marriage and Family Therapist (LMFT).

OR

vi. A Hawai'i Licensed Mental Health Counselor (LMHC).

b. Mental Health Professional (MHP):

i. 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

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

AND

Must have at least one (1) year of full-time, clinically supervised progressive work experience inclusive of residency, internship, or practicum in the treatment of youth in a mental health or behavioral health setting.

OR

ii. 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

iii. A Hawai'i Licensed Social Worker (LSW).

OR

iv. Personnel with a master's degree from a nationally accredited university that is eligible for Professional and Vocational Licensing (PVL) in Hawaii. Included are national board-certified behavioral analyst, marriage and family therapist, mental health counselor, psychologist, social worker, school psychologist, or psychiatric nurse.

And

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 behavioral health setting. Experience may be substituted for experience with certificates in a specialty such as Certified Substance Abuse Counselors (CSAC).

AND

v. All MHPs must be supervised by a QMHP or Supervising MHP.

c. Paraprofessional Level 2:

v. Personnel with a bachelor's degree from a nationally accredited university in Psychology, Social Work, Nursing, Mental Health or Behavioral Health Counseling.

OR

vi. Personnel with an associate degree or equivalent from a nationally accredited university in either Psychology, Social Work, Nursing, Counseling, with at least two (2) years of full-time, clinically supervised work experience in the treatment of children or adolescents in a mental health or behavioral health setting.

OR

vii. Personnel with a high school diploma must have at least four (4) years of full-time, clinically supervised work experience in the treatment of children and adolescents in a mental health or behavioral health setting.

AND

viii. Must be supervised by a QMHP, MHP or Supervising MHP

d. Paraprofessional Level 1:

i. Licensed in related service areas to include (but not limited to) Speech language Pathologist or Occupational Therapists.

OR

ii. Personnel with a college degree from an accredited university in a field of study other than Psychology, Social Work, Nursing, Mental Health or Behavioral Health Counseling.

AND

At least one (1) year experience providing direct care to children and adolescents.

OR

Completion of thirty (30) hours of orientation and documented shadowing of at least three shifts before being allowed to work independently. This training shall be completed within three (3) months from the initial credentialing date.

OR

iii. A High School diploma or equivalent.

AND

At least one (1) year experience providing direct care to children and adolescents.

OR

Completion of thirty (30) hours of orientation and documented shadowing of at least three shifts before being allowed to work independently. This training shall be completed within three (3) months from the initial credentialing date.

AND

iv. Must be supervised by a QMHP, MHP, or Supervising MHP or Paraprofessional.

J. BILLING

Contracted providers are anticipated to align documentation and billing practices with national best-practices, and federal standards for healthcare services. The authorization of any services or treatment is not a guarantee of payment. The contracted provider's staff or subcontractors providing care must meet all the CAMHD, Federal and State requirements to ensure documentation produced

substantiates services provided. Contracted providers are expected to engage in comprehensive internal compliance programs of internal clinical documentation review, feedback, and auditing. Contracted providers are equally expected to cooperate with ongoing CAMHD quality assurance, compliance, and audit programs. Contracted providers shall allow CAMHD, MedQUEST or their audit contractors to conduct unannounced on-site inspection of any and all provider locations. These are required to ensure appropriate reviews of documentation for compliance, and to foster cycles of continuing quality improvement.

Contracted provider agencies shall submit the required CAMHD documentation for billing, the Service Provider Monthly Treatment and Progress Summary (MTPS). Contracted providers will be responsible for the electronic submission of the MTPS into CAMHD's system a minimum of five (5) working days prior to submitting billing claims. Contracted provider must data enter the current MTPS before payment will be made for services. The current system access to submit this information is provided via secure logins distributed to specific contracted provider staff along with the URL for the website. As discussed, in the Core Components of the current CAMHD System section of this book, CAMHD has a Commitment to improving our information system performance, and contracted providers must anticipate that methods and schedule requirements for electronic submission of data such as the MTPS are expected to change over the next several years as our information system develops, in keeping with national standards. The system access and mechanisms for submitting this information are anticipated to change in future contract years, based on scheduled systems changes to be identified in future CAMHPS revisions.

All contracted providers are required to adhere to the CAMHD billing and reporting requirements. Contracted provider's submission must comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), CAMHD, applicable federal Medicaid, and Hawaii MedQUEST policies and procedures for healthcare services billing. Contracted providers are also responsible for planning, implementing, and maintaining their own information systems. Contracted providers must also provide to CAMHD a functional e-mail address that can receive documents as well as notices. CAMHD does not provide technical support for provider information systems or e-mail.

Contracted providers are required to have computer hardware that supports Internet connectivity, Internet services, email, and maintain compliance with standards for employees and contractors with access to Electronic Protected Health Information (ePHI). Contracted providers are responsible for maintaining all documentation and systems in compliance with the HIPAA and associated security standards. Please reference https://www.hhs.gov/hipaa/for-professionals/security/laws-regulations/index.html for further information. Contracted providers are required to maintain a current and updated Security Risk Assessment (SRA) for their information technology assets, and a System Security Plan (SSP) for their Electronic Health Record or Case Management System, in alignment with national best-practices for privacy and information risk mitigation. Please reference https://www.healthit.gov/providers-professionals/security-risk-assessment-tool for additional information. Further, under DOH policy, all contractors are required to provide appropriately redacted copies of their SRA to the State for evaluation and assurance.

CAMHD electronic billing systems and interfaces are anticipated to change over the course of the next few years, with the associated details posted and training provided in advance. Contractors shall utilize electronic billing as the standard mechanism, and paper billing requests may be granted on a limited case-by-case basis.

All contracted providers shall be required to provide detailed clinical and encounter-based case encounter documentation to the CAMHD on demand, per services timeline expectations, and for further billing or quality reviews. This is to substantiate the appropriate documentation for proof of

services, and to ensure quality of the care provided. Example documents may include, but are not limited to: Mental Health Treatment Plans, Monthly Treatment Progress Summaries, Therapy Progress Notes, Treatment Team Meeting Notes, Mental Health Assessments, Summary Annual Assessments, Residential Treatment Center Shift Notes, and Daily/Weekly Census Reports. Once CAMHD electronic systems are modernized and notice given, contracted providers shall be required to submit these documents electronically via either an electronic interface or secure file transfer (SFTP) from the contracted provider systems, and/or via a login to a State-offered Provider Portal into the CAMHD system. Once this capability is made available and training provided, contracted providers shall be expected to supply CAMHD with this full set of case-specific documents, to ensure State staff have the appropriate information to improve youth outcomes, case progress, and program compliance. Contracted providers are required to ensure all staff provisioned access to State systems requires compliance with and audit of the State-defined IT Acceptable Use Policies, set by the State Enterprise Technology Services Offices (ETS) and DOH. CAMHD technical staff may provide additional training on request, and contracted providers shall ensure their staff are available on a regular, no less than annual, schedule to ensure appropriate system and billing procedures are followed.

Original monthly claims must be submitted within thirty (30) calendar days after the last day of each calendar month. All submissions and corrections must be properly received by CAMHD (electronic system or limited paper billing under written exception terms) ninety (90) days after the last day of the billing month. No claims will be accepted by CAMHD standard after the 90-day billing period and contracted provider shall insure that no claim is from a provider who is on the List of Excluded Individual/Entities (LEIE) or the Excluded Parties List System (EPLS) from the Office of Inspector General (OIG).

Should a provider have an issue and require billing for services beyond the 90-day standard period, documented contact in the form of a written appeal for billing extension must be made to CAMHD (sent to Provider Relations for HSMO Billing Section approval) before the end of the 90-day period or no extension will be granted. The written billing extension appeals may be granted by CAMHD for an additional period up to 180 days after the services date. No claims for services shall be accepted and paid by CAMHD after 180 days, for any circumstances other than State errors.

K. 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 CAMHD youth registration number (CR#), 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 three (3) days of the service. 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. Youth name and CR#;
   ii. Complete date of service (including month, day and year);
   iii. Start and end time of service or start time and duration of service (for non-day rate services);
   iv. Place of service;
   v. Type of service (Individual Therapy, Family Therapy, Group Therapy);
   vi. CAMHD Does not pay for travel time. When meeting with a client in a different location than the one before, there must be at minimum, a fifteen (15) minute break between encounters. If the travel time takes more than fifteen (15) minutes, then the actual time must be accounted for;
   vii. DAP note (Data, Assessment, Plan format including:
      1. Plan of treatment to include 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.
   viii. Full name, title, signature and signature date of service provider; and
   ix. Full name, title, signature and signature date of supervisor (if applicable).
   x. Contracted provider shall audit home and community-based therapist and paraprofessional support notes to ensure compliance with CAMHD standards.

c. Electronic medical records are permitted, and must meet the following criteria:

   i. Electronic records must be backed-up in full, via offsite disaster recovery capacity as required under HIPAA, and it is NOT necessary to maintain a printed copy of the full record in a print file for each youth;
   ii. The electronic record must meet all Medicaid documentation standards;
   iii. Must contain two (2) youth identifiers including the CAMHD-assigned Medical Record Number;
   iv. Each note must include an electronic signature;
   v. Each note must have the date, time and duration of services;
   vi. Each note must have a clear description of the services provided;

vii. An exported or printed record must have agency and/or CAMHD Center letterhead or headings on each page; and

viii. The agency must maintain the systems in compliance with HIPAA, including regularly updated Security Risk Assessment (SRA) that is to be submitted to the CAMHD.

d. The focus in the content of notes shall clearly evidence the relationship of the intervention(s) to the youth's 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 (e.g. treatment-related telephone conversations, treatment team meetings, consultations with ancillary service providers).

2. Monthly Treatment and Progress Summary (MTPS)

Contracted service providers must electronically submit Monthly Treatment and Progress Summary (MTPS) reports to CAMHD by the 5th business day of each month describing the provided services 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 TPS 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 https://health.hawaii.gov/camhd/files/2017/11/MTPS-form.pdf) and the "Instructions and Codebook for Provider Monthly Treatment Summaries" (See website https://health.hawaii.gov/camhd/files/2017/11/MTPS-codebook.pdf). Contractors are responsible for ongoing training of their clinicians and supervisors in accurate completion of the MTPS.

As noted earlier, CAMHD is committed to improving our information system performance, this includes aligning our documentation and billing practices to national best-practice standards. One of the anticipated changes will be the incorporation of the MTPS elements into the progress notes. Scheduled changes will be announced in advance of the change.

L. SERVICE QUALITY

CAMHD is committed to ensuring appropriate and effective services for eligible youth and their families. Services are designed to, 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.

Contracted providers/employees shall participate with the integration of services across domains as needed. Contracted providers/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 encourages individuals with specific concerns regarding service quality to bring them to the attention of the contracted provider agency, Family Guidance Center, and/or CAMHD Central Administrative Office, as appropriate.

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

CAMHD personnel, including Care Coordinators, Clinical Leads, Facilities Certification Specialists, Grievance Specialists, Provider Relations Specialist and Program Monitoring Specialist 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 Family Guidance Center and contracted providers) for any youth that is receiving services, and conducts regular reviews of child status, treatment practices, and contractor's performance as part of its accountability and oversight functions.

M. PREFORMANCE MANAGEMENT

The CAMHD Performance Management Unit conducts continuous monitoring of performance data for all contracted provider agencies. Performance data in CAMHD are tracked and analyzed across all domains of service delivery and care. Services are monitored through tracking of trends, patterns, and quality of services. Contractors are expected to engage in ongoing quality assurance activities to improve their services and integration with the system. Site visits are an integral part of the program monitoring process; providers are expected to cooperate with CAMHD's monitoring efforts, including accommodating both scheduled and unannounced visits.

1. Program Monitoring

The Program Monitoring Section provides on-going oversight and technical support to contracted provider agencies. Program Monitors work closely with contracted providers to continually evaluate program performance, provide feedback and recommendations, monitor implementation of strategies for improvement and provide technical assistance or referrals for assistance. Standard monitoring activities include:

a. Administrative Reviews

Administrative Reviews are conducted to evaluate the adequacy of quality assurance and performance improvement processes within agencies, the quality of supervision and training practices, policies and procedures, the ability to implement necessary corrective actions, and the effectiveness of internal response to consumer concerns. Administrative Review results, reported in the Annual Program Review, will include program strengths, opportunities for improvement, and activities to sustain program success. Agencies with demonstrated patterns of administrative compliance will not be monitored as intensely or as frequently as agencies needing more intensive oversight.

b. Case-Based Reviews

Case-based Reviews provide an in-depth look into the status of youth served, and how well programs and local service systems are performing for them. Reviewers examine child

status and program performance for a chosen sample of youth through interviews with multiple respondents and review of case records. Determinations with the support of a structured protocol are made regarding how well youth are doing along dimensions of child well-being, and how well basic program functions (e.g. understanding of the youth's situation, treatment planning and implementation, producing effective results, etc.) are being carried out. Aggregate data is analyzed to glean patterns of performance across program functions, and to provide a context for the overall determination of performance for the agency.

c. Investigations

When necessary, investigations will be conducted in response to clinical and/or programmatic concerns as identified by sentinel event reports or complaints. CAMHD Program Monitoring staff may make unannounced visits to any/all Provider location for investigational purposes.

d. Quarterly Quality Assurance Reports

Contractors must submit Quarterly Quality Assurance 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 Program Monitoring Section every quarter, no later than forty-five (45) calendar days following the end of each quarter. The Quarterly Quality Assurance Report is to include the following information:

ix. Sentinel Events / Reportable Incidents
x. Clinical Supervision & Training Activities
xi. Clinical Documentation

2. Sentinel Event and Reportable Incident System

The CAMHD Sentinel Event and Reportable Incident reporting system is designed to track and document the occurrence of sentinel events and reportable incidents as reported by contracted provider agencies. All contractors must have internal policies and procedures regarding sentinel events and reportable incidents in accordance with CAMHD's Sentinel Events and Reportable Incidents Policy and Procedure 80.805 (See Appendix 20).

a. Sentinel Events

CAMHD contracted providers shall notify the youth's parent/legal guardian, CC and the Sentinel Events reporting line of all sentinel events, within twenty-four (24) hours of occurrence. CAMHD contracted providers must also submit a written hard copy report on the CAMHD Sentinel Event Report Form (See Appendix 21) to CAMHD Clinical Services Office and the CAMHD Family Guidance Center within three (3) business days of the event.

b. Reportable Incidents

CAMHD contracted providers must notify youth's parent/legal guardian and CC of Reportable Incidents within twenty-four (24) hours of occurrence. CAMHD contracted providers must also submit a written hard copy report on the CAMHD Reportable Incident form (See Appendix 22) to the CAMHD Clinical Services Office and the respective CAMHD Family Guidance Center within five (5) business days of the event.

3. Grievance and Complaints

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 among the Family Guidance Center, contracted provider (if applicable), and the family. If resolution is not possible in direct exchange, families and providers have additional recourse through the CAMHD Grievances and Complaints Process (See Appendix 23). Youth and/or families are informed of these processes upon registration at a Family Guidance Center.

N. RISK MANAGEMENT

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

1. Safety

CAMHD requires contracted providers 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.

Contracted providers shall manage, control, or alter potentially harmful conditions, situations, or operations including those which can lead 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.

2. 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 contracted providers 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:

a. 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;
b. Reviewing and updating restraint and seclusion policies and procedures regularly, based on clinical outcomes;

c. 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;
d. Adequate allocation of resources to prevent the frequent use of restraint or seclusion; and
e. 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 its Seclusion and Restraint Policy and Procedures 80.602 (See appendix 24). 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.

3. 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 contracted 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.

O. ADDITIONAL REPORTING REQUIREMENTS

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

1. Weekly Census Report on Client Status
All out-of-home levels of care including Transitional Family Homes, Therapeutic Respite Home, Community-Based Residential Programs, and Hospital-Based Residential treatment services are required to submit a Weekly Census Report on Client Status Form and Waitlisted Youth form (See Appendices 12 & 11) in standard format to CAMHD's Clinical Services Office, no later than Tuesday noon of each week either by fax or electronically.

2. 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.

3. Title IV-E Administrative Reports:
In accordance with CAMHD's efforts to maximize federal reimbursement, quarterly submission of Title IV-E Contracted Agency Quarterly Training Report (See Appendix 25) and Room and Board Report will be submitted by applicable contractors to the CAMHD Fiscal Section as required.

4. Accreditation:
All Providers are required to have at minimum at least one national accreditation such as 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.

5. Facilities Information Requirements:

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

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

6. 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).

7. 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.

P. 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 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, sexual orientation, gender identity, 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 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 manner.
- 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 contracted providers must adhere to these rights in the provision of behavioral health services to eligible youth. Each contracted provider 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 contracted provider 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 Care Coordinator is required to review the Service Principles and Consumer Rights & Responsibilities (See Appendix 26) with parents and youth (as appropriate) as well as the Notice of Privacy Practices.

Q. 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 when the billing day begins at 12:00 am. The bed holds may be authorized only when the contracted program is at their bed capacity. A maximum of three (3) bed holds may be authorized per episode of care, reimbursed at one hundred percent (100%) of the unit rate. Bed holds are utilized for youth who:

a. elope from a program or
b. require an acute admission, or
c. require short-term detainment in the Detention Home or Hawaii Youth Correctional Facility

The contracted provider must accept the youth back into the program at any time during the authorized bed hold period, unless it has been determined, at the cost of the contractor, through an evaluation by a CAMHD approved independent psychiatrist that an alternate service is necessary. Results of this evaluation must be provided to CAMHD in writing prior to any action being taken. If the youth returns after the 3-day bed hold has been utilized, the contractor is obligated to accept the return of the youth if there are vacant beds. The youth shall be given a priority and expedited readmission if the admission is being sought within a thirty (30) day period from discharge date. No new referral packet shall be required for this youth. If there is no vacant bed, the contractor is obligated to put the youth on the waitlisted youth list with an anticipated admission date. CAMHD reserves the right to execute contractual action if the contracted provider is unable or unwilling to meet the needs of the youth. The program prioritizes the "Waitlisted Youth" list by date of referral. If there is a clinical or administrative need, CSO will prioritize the youth with the program.

2. Therapeutic Passes

Therapeutic passes are used by CAMHD to hold a bed space for a youth in an out-of-home program who is temporarily out of the program to visit family/caregiver. Therapeutic passes will be authorized whenever a youth will not be present at the program when the billing day begin at 12:00 am. Therapeutic passes are reimbursed at one hundred percent (100%) of the unit rate for the number of days specified in the service-specific standard.

A therapeutic pass is defined as a pass 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 pass to the youth's home or post-treatment environment and requires prior authorization by the Clinical Lead. 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.

R. PROVIDER RELATIONS LIAISON

The CAMHD recognizes that our contracted provider agencies and their staff play an important and vital role in the provision of quality services to our consumers. This role calls for a strong partnership between CAMHD and it contracted network of providers.

The CAMHD Provider Relations Liaison serves as CAMHD's continuous communication linkage with the providers to promote positive relationships and satisfaction with the CAMHD staff, including its Centers. The broad goal of Provider Relations Liaison is to strengthen the relationship between CAMHD and its network of contracted providers.

If a provider agency or one of its staff has an issue or concern regarding their contracted provision of services, the agency or staff may submit the issues by phone 808-733-9857, U.S. Postal Service (to the Provider Relations Liaison at 3627 Kilauea Avenue, Honolulu, Hawaii 96816). The fax is: 808-733-9357.

Issues or concerns must contain at minimum:

- Providers Name
- Providers Contact Information
- Clear Explanation of the Issue/Concern
- Providers Position on Such Issue/Concern

The Provider Liaison will acknowledgment receipt of the issue/concern and will respond back to you, if the issue or concern has been referred to a specific department, specializing in your area of concern/need, the Provider Liaison will follow-up to insure the issue/concern has been resolved.

Below is a description of the activities and services of the Provider Relations Liaison:

- Resolve Provider Related Issues;
- Review issues considering patterns/trends for improvement opportunities and from the perspectives of both CAMHD and the providers and bring them to the attention of the various CAMHD Sections and Leadership;
- Assist and support providers to effectively and efficiently work through the labyrinth of CAMHD processes and systems;
- Respond to Provider inquiries and concerns regarding CAMHD policies and procedures. To communicate CAMHD activities that impact the providers through coordinating the annual Provider Satisfaction Survey and the twice-yearly Decision Support Collaborative (DSCO) Party, as well as, through routinely scheduled provider meetings.

S. ACCOUNTABILITY/SERVICE STANDARDS

All contracted providers 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.

SECTION II:

SERVICE SPECIFIC PERFORMANCE STANDARDS

SECTION II – PART A:

EMERGENCY MENTAL HEALTH PERFORMANCE STANDARDS

A. CRISIS MOBILE OUTREACH (CMO)

Definition	This service provides telephone stabilization and 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.
Goals	1. Prompt assessment and evaluation in the community. 2. Stabilization in the least restrictive environment. 3. Crisis resolution. 4. Linkage to appropriate services. 5. Reduction of inpatient and law enforcement interventions.
Services Offered	1. Initial screening & triage over the phone to determine the nature of the crisis, completed within fifteen (15) minutes of notification from the Crisis Line of Hawaii. 2. Support, consultation and referral services are provided based on the initial assessment. 3. If the situation cannot be resolved to the caller's satisfaction over the phone, immediate response is required, with a maximum arrival time within forty-five (45) minuets of notification. 4. Provide crisis intervention and counseling. 5. Arrangement of and assist with transportation to a Therapeutic Crisis Home if needed. 6. Crisis Case Management, including obtaining information regarding any providers/agencies involved with youth and notifying the involved parties about the crisis the next business day. 7. Crisis Case Management 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. All request for Crisis Mobile Outreach Services must originate from the Crisis Line of Hawaii; 2. 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; 3. The youth may be displaying acute psychotic symptoms such as delusions, hallucinations, and thought disorganization that are unmanageable; or 4. The youth evidences lack of judgment, impulse control, or cognitive/perceptual abilities.

<table>
<tr><td rowspan="5">Authorizations</td><td colspan="4">Prior authorization is not required for this level of care.</td></tr>
<tr><td colspan="4">CAMHD LOC code: 4102</td></tr>
<tr><td rowspan="4">Unit = fifteen minutes</td><td>Credential</td><td>HCPCS code</td><td>Modifier</td></tr>
<tr><td>QMHP</td><td>H2011</td><td></td></tr>
<tr><td>MHP</td><td>H2011</td><td></td></tr>
<tr><td>Para 2</td><td>H2011</td><td></td></tr>
<tr><td>Discharge Criteria</td><td colspan="4"><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.</td></tr>
<tr><td>Service Exclusions</td><td colspan="4">Not to be utilized by Hospital-Based Residential and/or Community-Based Residential programs.</td></tr>
</table>

Staffing Requirements

In addition to the staffing requirement listed in the general standards, these staff requirements must also 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. The program must have a licensed psychiatrist on staff or contracted consultant. The psychiatrist must be available twenty-four (24) hours/seven (7) days a week for psychiatric consultation.
3. At a minimum, crisis mobile outreach staff must be:
   a. An MHP with one (1) year supervised clinical experience in providing direct crisis response for youth.

      OR

   b. A Paraprofessional level 2 with a bachelor's degree either in Social Work, Psychology, Counseling, Nursing, or another related area of study, with two (2) years specialized crisis response experience.
      i. A CAMHD-approved Training Plan may substitute for experience.
4. All staff must be CAMHD credentialed.
5. The program must have the capacity to adjust staffing whenever necessary to ensure an adequate number of CMO staff are available to simultaneously manage multiple calls / service requests within required response times.
6. 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 also 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 responding 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 Family Guidance Center, the crisis worker contacts the Care Coordinator (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 contracted provider has policies and 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 agency's psychiatrist will direct the staff regarding additional actions or preparations to take.
9. Staff are expected to remain with the youth at any emergency unit until the youth is transported to a Therapeutic Crisis Home (TCH), released to his/her home or the decision is made to admit the youth to acute.
10. If the crisis worker believes Therapeutic Crisis Home is needed, then the worker will contact the program's on-call psychiatrist for consultation.
11. The Crisis Mobile Outreach contracted provider and the Therapeutic Crisis Homes contracted provider will have a memorandum of understanding which allows for the efficient admission of youth determined to be in need of crisis placement.
12. The contracted provider will have policies and procedures that delineate the admission process into Therapeutic Crisis Homes.
13. The contracted provider will work closely with local Emergency Departments and Police Departments to provide services for youth experiencing a behavioral health crisis but do not meet criteria for acute psychiatric admission.
14. 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.
15. 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.

16. 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.
17. Please see Section I General Standards for additional clinical operation requirements:
    - A. Core Components of Current CAMHD System
        - Commitment to Clinical Excellence & Co-management of Care
    - F. Commitment to Serve All Youth;
    - G. Training;
    - H. Supervision;
    - I. Credentialing;
    - L. Service Quality;
    - N. Risk Management:
    - O. Additional Reporting Requirements
    - P. Youth Rights and Confidentiality

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. 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 Family Guidance Center by closure of the next business day if the youth is registered with CAMHD.
5. A copy of the note documenting the results of the agency follow-up call to the family is sent to the Family Guidance Center by the closure of the next business day after the follow-up call, if the youth is registered with CAMHD.
6. Please see Section I General Standards for additional documentation requirements:
    - N. Maintenance of Service Records:
        - Progress Notes;

B. THERAPEUTIC CRISIS HOME (TCH)

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 CSP team as applicable.
Admission Criteria	At least **one** (1) of the following criteria is met: 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 may be provided with no prior authorization required. Youth may be admitted via Mobile Crisis Outreach or via Center Clinical Lead with parental consent.

Reauthorization	Unit = one (1) day	HCPCS code	H0037
	Clinical Lead may reauthorization up to four (4) units. This is a crisis stabilization service and is not expected to have stays of longer than seven (7) days.		
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 also 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. This professional is responsible for the Therapeutic Crisis Home 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 contracted providers QMHP or a QMHP supervised MHP. One (1) hour of the required supervision may be multi-family or group supervision.
4. The contracted provider 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 also 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 contracted provider and the Crisis Mobile Outreach contracted provider will have a memorandum of understanding which allows for the efficient admission of youth determined to be needing crisis placement.
3. The contract provider 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 Therapeutic Crisis Home.
5. In addition to all requirements for licensure of transitional families, contract provider 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; 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.
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 contract provider.
7. The transitional family home will have no more than two (2) minor youth in the home plus 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 Therapeutic Crisis Home agency, the CSP team, and the family, through the Care Coordinator (CC) if the youth is registered with CAMHD, to keep everyone apprised of the youth's status and progress.
14. Contact with the CC should occur at the time of admission to the Therapeutic Crisis Home and daily contact with the CC is maintained, if the youth is registered with CAMHD.
15. For youth who are not registered with CAMHD, the program assists families with referral for eligibility determination including referrals of non-IDEA youth for DOE identification.
16. Follow-up services for youth who do not qualify for CAMHD are arranged through the families' medical insurance or community resources.
17. Upon contract execution, all contract providers of Therapeutic Crisis Home services shall submit a list of families with all of the following information required on the TFH Profile Form (See Appendix 27). The contract provider 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 contract provider 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 contract provider 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.
20. Please see Section I General Standards for additional clinical operation requirements:
    - A. Core Components of Current CAMHD System
        - Commitment to Clinical Excellence & Co-management of Care
    - F. Commitment to Serve All Youth;
    - G. Training;
    - H. Supervision;
    - I. Credentialing;
    - L. Service Quality;
    - N. Risk Management:
    - O. Additional Reporting Requirements
    - P. Youth Rights and Confidentiality

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. If a crisis plan does not exist, the Therapeutic Crisis 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 CAMHD when needed including how to refer to DOE for a comprehensive evaluation to determine IDEA eligibility.
8. 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 seventy-two (72) hours of service.
9. 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.
10. Please see Section I General Standards for additional documentation requirements:
    - D. Service/Treatment Planning:
        - Mental Health Treatment Plan including crisis and discharge components;
        - Discharge Summary;
    - J. Billing
    - N. Maintenance of Service Records:
        - Progress Notes;

SECTION II – PART B:

INTENSIVE MENTAL HEALTH SERVICES PERFORMANCE STANDARDS

A. ANCILLARY SERVICES

<table>
<tr><td>Definition</td><td>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.</td></tr>
<tr><td>Services Offered</td><td>Supportive services that facilitate mental health treatment delivery as outlined in the CMP/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.</td></tr>
<tr><td>Admission Criteria</td><td><u>All</u> <u>the following criteria must be met</u>:
1. The clinically appropriate requested services/items are required to allow the youth to meet the goals identified in the CMP/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 after all other resources are exhausted.</td></tr>
<tr><td>Authorizations</td><td>The need for clinically appropriate services/items is identified in the CMP/CSP, approved by the Clinical Lead.
<table>
<tr><th>Description</th><th>Unit</th><th>Credential</th><th>HCPCS Code</th><th>Modifier</th></tr>
<tr><td>1:1 Support</td><td>60 minutes</td><td>Para 1 or 2</td><td>T1019</td><td></td></tr>
<tr><td>Interpreter</td><td>15 minutes</td><td></td><td>T1013</td><td>HA</td></tr>
<tr><td>Mainland Tx</td><td>Day</td><td></td><td>H0019</td><td></td></tr>
<tr><td>Travel</td><td>Dollar</td><td></td><td>A0140</td><td></td></tr>
<tr><td>Medical/ Dental/Vision</td><td>Dollar</td><td></td><td></td><td></td></tr>
</table></td></tr>
<tr><td>Re-Authorization</td><td>The approval of the amounts greater than 5000 units requires the Division Administrator approval.
Unit = One (1) Dollar</td></tr>
<tr><td>Continuing Stay Cri17teria</td><td><u>All</u> <u>the following criteria are met as determined by clinical review at least quarterly</u>:
1. Services/items are being provided as indicated in the CMP/CSP and documented in progress notes and in plan reviews;
2. There are regular and timely assessments and documentation of youth/family response(s) to services. Timely and appropriate modifications are made to plans as needed;
3. Goals, objectives, and discharge planning as related to ancillary funded services/items are reviewed at least quarterly;
4. The youth/family continues to be actively involved in treatment interventions and treatment planning; and
5. The youth/family continues to be in need of ancillary funded services/items.</td></tr>
</table>

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	1. No educational or basic health services are to be provided through ancillary services. 2. 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 to youth and families, then only a practitioner credentialed by CAMHD shall be allowed to perform this service.
2. Individual Practitioner Credentialing Information

a. Qualified Mental Health Professional (QMHP):

i. 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

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

OR

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

OR

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

OR

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

OR

vi. A Hawai'i licensed Mental Health Counselor (LMHC).

Clinical Operations

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

Documentation

1. The PHAO must submit a Manual Service Authorization Form to the CAMHD fiscal office.
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:
    - D. Service/Treatment Planning:
        - Mental Health Treatment Plan including crisis and discharge components. If any major changes occur in the course of treatment, the all components of the MHTP should be updated;
        - Discharge Summary;
    - J. Billing
    - N. Maintenance of Service Records:
        - Progress Notes;
        - Monthly Treatment and Progress Summary

Ancillary Services Sub-level of Care: One-to-One (1:1) Paraprofessional Support

Purpose – The purpose of 1:1 paraprofessional support is to assist youth in Out-of-Home Treatment with additional support while transitioning into treatment, to assist with stabilization of youth in treatment, to avert hospitalization or prevent treatment failure. *This is a short-term, time-limited service that must be clinically justified.*

Process – The clinical team (the contracted program therapist and/or clinical director and FGC Clinical Lead) meet (by phone or in person) to discuss the clinical issues warranting this service. Upon agreement that 1:1 support is justified, the program therapist or clinical director submits a clinical justification to the Care Coordinator.

The Clinical Justification must include the following:

1. Reason for the request (describe the behaviors and issues that support the request for ancillary services)
2. Paraprofessional support function – describe what the 1:1 support staff will do to address the crisis, transition, or stabilization issue(s).
3. Requested number of hours per week and length of time. The requested start date must be no earlier than two working days from the submission of the request.
4. Provide the contact name and fax number of the individual the Memorandum of Agreement (MOA) is to be addressed.
5. Requested start date. Retro-authorizations are not permitted.
6. The One-to-One (1:1) Paraprofessional Support must be credentialed as a CAMHD Paraprofessional level 1 or 2 prior to initiating services.

Upon receipt of the Clinical Justification the Care Coordinator forwards the request to CAMHD's Clinical Services Office. Direct requests to Resource Manager at Telephone 733-9347 FAX 733-9875.

Ancillary Services of Paraprofessional Support may be authorized for *up to* eight hours per day, seven days per week for a period of 45 days. Upon review (consisting of a clinical assessment of the initial 6-week authorization and submission of a separate request) a Continued Authorization ***may be authorized for up to another six-week period of time.

All requests require CAMHD Medical Director or Chief Psychologist approval.

*****Manual Billing is required: The PHAO must submit a Manual Service Authorization Form to the CAMHD Fiscal Office. An MOA is generated by the Clinical Services Office and a copy is provided to the program and the Center PHAO and CC. The provider must submit a copy of the MOA with their manual bill to the CAMHD fiscal office.

B. PARENT SUPPORT SERVICE (PSS)

Definition	Face-to-face supportive interactions with the caregiver for a CAMHD youth, focused on helping the family participate fully in and benefit from mental health treatment. This service is provided by individuals: 1) who have lived experience as a caregiver within the mental health system of care for youth and 2) who have been certified to provide peer support by the National Federation of Families or another certifying body. The service is provided under the supervision of a Mental Health Professional (MHP) in order to meet Medicaid requirements, and it is documented in the youth's record. The need for Parent Support Services shall be documented in the CMP/CSP as part of a comprehensive, individualized plan of care for the youth.
Service Offered	Parent Support Services include all the following components: 1. Accepting referrals from Family Guidance Center (FGC) Care Coordinators to work with parents, including contacting families and setting up an initial pre-admission meeting. When possible, Parent Support providers will be introduced to the family by the Care Coordinator (CC) as part of the intake process, and the CC will obtain the caregiver's written consent to share information with the Parent Support Provider. 2. Meeting with the caregiver face-to-face to identify the family's needs and goals, and to provide encouragement and emotional support. 3. Attending treatment planning, CSP development, or other multi-agency meetings with the parent to support them in communicating their needs/goals to the treatment team, and to help professionals understand the family perspective. 4. Helping the caregiver find ways of meeting their needs and navigating the complicated system of care. This may include helping parents to identify and connect with community resources, qualify for government benefits, and seek out adult mental health/substance abuse treatment resources. 5. Facilitating group support opportunities for parents (parent groups must have a ratio no greater than 8 participants per facilitator). 6. Providing education, training and mentoring to caregivers including: orienting them to the FGC, educating them about mental health issues and the system of care, providing training in areas such as advocacy skills, parenting skills, and leadership skills. 7. Mentoring emerging parent leaders in new roles such as serving on the board of a local agency or on a statewide committee related to Children's services.
Admission Criteria	Parent support services may be provided to the caregiver (parent, grandparent, formal or informal foster parent, stepparent, etc.) of any youth who meets eligibility criteria for CAMHD or who is in the process of eligibility determination.

<table>
<tr><td rowspan="4">Authorizations</td><td colspan="4">CAMHD LOC code:</td></tr>
<tr><td>Unit</td><td>Credential</td><td>CPT code</td><td>Modifier</td></tr>
<tr><td>fifteen (15) minutes</td><td>Para 1 or 2</td><td>H0038</td><td></td></tr>
<tr><td colspan="4">Clinical Lead may authorize up twelve (12) units [three (3) hours] for a pre-admission meeting for introductory and planning between the Parent Partner and the caregiver.</td></tr>
<tr><td>Reauthorization</td><td colspan="4">Clinical Lead may reauthorize up to thirty-two (32) units [eight (8) hours] per thirty (30) days up to ninety (90) days based on a Family Support Plan submitted by the Parent Partner.</td></tr>
<tr><td>Continuing Stay Criteria</td><td colspan="4"><u>All</u> the following criteria must be met as determined by clinical review:
1. The family service plan includes clear goals to be addressed through peer/family support services;
2. The caregiver wants continued peer support;
3. There is evidence that the family is benefitting from peer support services; and
4. The youth and family continue to be engaged in treatment through CAMHD.</td></tr>
<tr><td>Discharge Criteria</td><td colspan="4">The youth/caregiver are no longer in need of or eligible for the service due to one (1) of the following:
1. The youth is no longer eligible for CAMHD services;
2. The goals on the Family Support Plan are completed; or
3. The youth and caregiver no longer desire the service.</td></tr>
<tr><td>Service Exclusions</td><td colspan="4">None</td></tr>
<tr><td>Clinical Exclusions</td><td colspan="4">None</td></tr>
</table>

Staffing Requirements:

In addition to the staffing requirement listed in the general standards, these staff requirements must also 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 Mental Health Professional (MHP) on staff who has oversight and supervision responsibilities for all staff decisions made regarding services to families.
2. Parent Support services shall be provided by personnel that meet all the following requirements:
   a. Has had lived experience as the primary caregiver for a youth with serious mental health challenges;
   b. Has been certified as a Parent Support Provider (PSP) by the National Federation of Families in Children's Mental Health or the equivalent or is in the process of achieving within one (1) year of start date;
   c. Is Credentialed by CAMHD as a Paraprofessional (Para) level 1 or 2; **AND**
   d. Is working under the supervision of an MHP. The supervisor is expected to review all the supervisees work in detail.

Clinical Operations:

In addition to the clinical operation 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 clinical operation requirements will supersede the general standards.

1. Parent Support Service providers shall coordinate with the CC and with other system of care agencies such as education, juvenile justice system, and/or child welfare as needed to provide services.
2. The Parent Support Organization 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.
3. The Parent Support Organization shall establish written policies which govern the provision of services in natural settings and which document that the organization respects youths' and/or families' right to privacy and confidentiality when services are provided in these settings.
4. The Parent Support Organization shall establish written procedures/protocols for handling emergency and crisis situations that describe: methods for assuring the safety of staff and family members, guidelines for when to consult with the program MHP and what to document in the youth's chart.
5. The Parent Support Organization shall establish written policies and procedures governing the provision of outreach services, including methods for protecting the safety of staff who engage in outreach activities.
6. The Parent Support Organization shall establish written policies and procedures around the use of personal vehicles for outreach services and for transporting clients when necessary.
7. Please see Section I General Standards for additional clinical operation requirements:
    - A. Core Components of Current CAMHD System
        - Commitment to Clinical Excellence & Co-management of Care
    - E. Referral Process for Contracted Services:
    - F. Commitment to Serve All Youth;
    - G. Training;
    - H. Supervision;
    - I. Credentialing;
    - L. Service Quality;
    - N. Risk Management:
    - O. Additional Reporting Requirements
    - P. Youth Rights and Confidentiality

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. The Parent Support Provider (PSP) develops a written Family Support Plan with the caregiver, identifying the kinds of support the caregiver would like to receive from the PSP. In addition, the PSP works with the CC to assure that Parent Support is included as a service on the youth's CMP/CSP. The written Family Support Plan shall be submitted to the CAMHD FGC within ten (10) calendar days of the PSP's first meeting with the family.
2. PSPs shall provide a written service note for each face-to-face contact with a caregiver, and for indirect service activities (e.g. team meeting attendance, phone calls with team members) that are billed. Service notes shall document the types of support provided, who was present in the meeting, the goals addressed, and the start time and end time of each encounter.

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

C. INITIAL MENTAL HEALTH EVALUATION (IMHE)

Definition	An Initial Mental Health Evaluation (IMHE) provides information concerning a youth's functional impairment, mental health diagnoses and current mental health needs. The IMHE utilizes a digital template (download at http://health.hawaii.gov/camhd/ click on Provide Relations Forms link) which assures collection of the information required to make a determination regarding eligibility for CAMHD services (See Appendix 4 for sample form). This strengths-based evaluation process produces a document that is based on the CAMHD IMHE template. The template includes drop-downs and check boxes to make it easier for evaluators to complete it efficiently in order to expedite entry into CAMHD services. This service includes review of available records, interviews with the youth and caregiver(s), administration of the CAMHD version of the youth and parent Ohio Scales (Appendix 28 & 29), and production of a written report using the CAMHD IMHE template. Feedback about the results of the report may be provided to the youth and caregiver(s) during a meeting with the evaluator or in a CAMHD welcome meeting with the family and Care Coordinator.
Services Components	Collect data needed to complete the IMHE template within twenty-one (21 days) of the referral and authorization: 1. Review any available records about the youth and incorporate their findings. 2. Interview the caregiver(s) about their presenting concerns, their family situation, youth's history, and youth's current functioning in the domains specified by the Child and Adolescent Functional Assessment Scale (CAFAS). 3. Interview the youth individually and perform a mental status exam, documenting findings in the IMHE template (See Appendix 4). 4. Be attentive to information that may suggest an imminent risk of some kind (e.g. suicidal thoughts, self-harming behavior) and intervene as clinically appropriate. Develop a safety plan (See Appendix 3) with the youth and family if indicated. 5. Administer the CAMHD version of the Youth and Parent Ohio Scales questionnaire (Appendix 28 & 29) to the youth and caregiver(s). 6. Summarize and synthesize the available information in a clinical formulation and provide current DSM5/ICD10 diagnoses; 7. Offer treatment recommendations, including suggestions regarding the need for additional assessment, treatment modality, priority problems to be targeted, ways to utilize strengths, etc. 8. Recommendations should describe the youth's needs to be addressed, 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 is at high risk of elopement, needs 24/7 line of sight

<table>
<tr><td></td><td>supervision in a self-contained highly structured setting, etc., but do not specify “a locked residential program” or “the Benchmark program”).
9. Recommendations shall include treatment interventions that are provided in the least restrictive manner that will address the needs of the youth and family.
10. Submit the signed typed IMHE template report to the FGC within twenty-one (21) days from the date of referral. If more time is needed, the evaluator shall contact the Intake Coordinator with his/her reasons for the time extension requested.
11. When the IMHE is completed by a contracted provider:
a. The QMHP who writes or supervises the evaluation retains full responsibility for the content, decisions about diagnoses, etc.
b. The report must comply with CAMHD standards as determined by Clinical Lead before results or recommendations are shared with the youth/caregivers or other team members. If there are concerns about adherence to the standards, the report will be returned to the evaluator for amendment. The Clinical Lead will review the report within one (1) week of submittal.
c. Upon CL’s acceptance 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 permissible.</td></tr>
<tr><td>Admission Criteria</td><td>The youth is enrolled with a CAMHD Center and is in the process of eligibility determination for CAMHD services;</td></tr>
<tr><td>Authorizations</td><td>CAMHD LOC code: 5101
<table>
<tr><th>Unit</th><th>Credential</th><th>CPT code</th><th>Modifier</th></tr>
<tr><td rowspan="2">fifteen (15) minutes</td><td>QMHP</td><td>90791</td><td></td></tr>
<tr><td>MHP</td><td>90791</td><td></td></tr>
</table>
Clinical Lead may authorize may be up to twelve (12) units [three (3) hours] for evaluation activities.

<u>Billing limits:</u>

Procurement units reflect the time required for completing the review of data and the evaluation interviews. 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.</td></tr>
<tr><td>Reauthorizations</td><td>If the evaluator requests additional units with a clear justification for why this is needed, the Clinical Lead may determine that the more comprehensive General Mental Health Evaluation (GMHE see Standard p. II-25) is needed and changes the initial authorization to reflect this more intensified need for the GMHE.</td></tr>
</table>

	Feedback session: Once the Clinical Lead confirms that the IMHE report adheres to these standards, an additional four (4) units [one (1) hour] may be authorized for a feedback session with the youth/family.
Discharge Criteria	**One** (1) of the following criteria is met: 1. The evaluation sessions are completed, the typed report, using the IMHE template, has been submitted to the intake coordinator, the report has been accepted by the Clinical Lead, and the feedback session has been held; or 2. The youth/family no longer wants to participate in this service and stops attending assessment meetings or revokes consent in writing prior to the completion of the report[1].
Service Exclusions	The IMHE generally should NOT be conducted on youth who have already been found eligible for CAMHD services. When more assessment information is needed regarding CAMHD youth, a General Mental Health Evaluation should be conducted. The Annual Summary Evaluation should be conducted to update the IMHE. An Initial 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 evaluation will be performed on youth whose results may be invalid due to the active influence of a substance, substance abuse withdrawal, or similar cause; or 3. No evaluation that is primarily for legal purposes unrelated to the youth's mental health treatment including custody evaluations, parenting evaluations, or other court ordered testing.
Clinical Exclusions	Youth in need of immediate crisis stabilization because of active suicidal, homicidal, or psychotic behavior are excluded. Once stable, a youth who otherwise meets the eligibility criteria may be referred into this service;

Staffing Requirements

1. The provider of a 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

[1] The youth/family may revoke consent to be evaluated any time 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.

development of the diagnoses and recommendations. The supervisor is to co-sign the report acknowledging supervisory responsibility for the evaluation.

2. Evaluators 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 system 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 any time during the evaluation process, but once the report is completed 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 it further. However, this may impact service delivery.

Documentation

1. Progress notes document all evaluation activities.
2. The complete IMHE template is submitted to the Intake Coordinator within twenty (21) days from date of referral and authorization. Requests for an extension of this timeline should be directed to the Clinical Lead and should include an explanation for why the extension is needed.
3. The completed IMHE template is typed and includes:
   a. Identifying information: youth name, date of birth (DOB), legal guardian, home school, grade level, IDEA status;
   b. Reason for referral, including any specific referral question(s);
   c. Diagnostic impression and justification for the diagnosis (DSM5/ICD10)
   d. Recommendations that speak to the youth's treatment needs and do not specify particular types of care or treatment programs.
   e. The report is signed by the evaluator (and his/her supervisor when applicable) acknowledging responsibility for the evaluation);
4. Professionally recognized standards of ethical practices are followed in all evaluations.

D. GENERAL MENTAL HEALTH EVALUATION (GMHE)

Definition	This service standard provides guidelines for the General Mental Health Evaluations that can be performed for a range of purposes. The GMHE provides needed information concerning a youth's psychosocial functioning, mental health diagnoses and current mental health needs. This general-purpose evaluation may be performed: • When an in-depth evaluation is needed to establish the correct diagnosis and determine treatment needs for a youth newly referred for CAMHD services. • When comprehensive clinical and historical information about a CAMHD youth is needed to assist with coordination of services and treatment planning at a later point in the treatment process; and/or • When focused clinical information is needed to address specific issues being considered by the youth's treatment team. This may include diagnostic questions, questions about personality functioning, or concerns about risk management. This strengths-based evaluation 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 standardized assessment instruments, a written report, 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 General Mental Health Evaluation report shall incorporate any psychological testing data collected.
Services Components	1. Complete the collection of data and write the evaluation report within thirty (30) days of the referral and authorization. 2. Document the reason for referral, referral source, and presenting concerns based on information provided by the person who initiated the referral and/or the guardian. 3. Review past mental health records, educational records and evaluations and synthesize the findings. 4. Interview the youth and perform a mental status exam. If desired, the Youth Mental Status Checklist (Appendix 30) may be included in the report. 5. Interview the parent(s), guardian, or other caregiver. 6. Be attentive to information that may suggest an imminent risk of some kind (e.g. suicidal thoughts, self-harming behavior) and intervene as clinically appropriate. Develop a safety plan (Appendix 3) with the youth and family if indicated. 7. Administer questionnaires to the youth and caregiver(s), utilizing instruments appropriate to the referral questions; initial evaluations should utilize the CAMHD version of the Youth and Parent Ohio Scales questionnaire (Appendix 28 & 29). 8. Incorporate the results of any Psychological Testing if

	completed as part of this evaluation (see Psychological Testing standard, p. II-38). 9. Summarize and synthesize the available information in a clinical formulation and provide current DSM5/ICD10 diagnoses. 10. Offer treatment recommendations, including suggestions regarding treatment modality, priority problems to be targeted, ways to utilize strengths, etc. 11. Recommendations should describe the youth's needs to be addressed, the intensity of the interventions and restrictiveness of the treatment setting, but MAY NOT name specific types of care, programs, or organizations (e.g. you may specify that a youth is at high risk of elopement, needs 24/7 line of sight supervision in a self-contained highly structured setting, etc., but do not specify "a locked residential program" or "the Benchmark program"). 12. Recommendations should 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 reasons for the time extension requested. 14. The QMHP who writes or supervises the evaluation retains full responsibility for the content, decisions about diagnoses, etc. a. The report must comply with CAMHD standards as determined by Clinical Lead before results or recommendations are shared with the youth/caregivers or other team members. If there are concerns about adherence to the standards, the report will be returned to the evaluator for amendment. The Clinical Lead will review the report within one (1) week of submittal. b. Upon CL's acceptance 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 permissible. 15. When performing the evaluation, ensure that the following information is included in the report: a. Information regarding psychosocial history, trauma and adverse events, 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. Ratings on the Child and Adolescent Functional

<table>
<tr><td></td><td>Assessment Scale (CAFAS) must be completed, based on the data collected. The CAFAS is integrated into the CAMHD Initial Mental Health Evaluation Template (See Appendix 4).</td></tr>
<tr><td>Admission Criteria</td><td><u>One</u> <u>of the following criteria must be met:</u>
1. The youth is enrolled with a CAMHD Center and is in the process of eligibility determination for CAMHD services; or
2. The youth is registered with a CAMHD Center and the Clinical Lead, in consultation with the treatment team determines there is a need for additional clinical information on the youth to inform treatment planning, and/or to address specific clinical questions.</td></tr>
<tr><td>Authorizations</td><td>CAMHD LOC code: 5102<table><tr><th>Unit</th><th>Credential</th><th>CPT Code</th><th>Modifier</th></tr><tr><td rowspan="2">fifteen (15) minutes</td><td>QMHP</td><td>90791</td><td>HA</td></tr><tr><td>MHP</td><td>90791</td><td></td></tr></table>Clinical Lead may authorize may be up to twenty-four (24) units [six (6) hours] for evaluation activities.

<u>Concurrent authorization:</u>
GMHE may be authorized at the same time as Psychological Testing (see p. II-38) when a comprehensive evaluation is needed.

<u>Billing limits:</u>
Procurement units reflect the time required for completing the review of data and the evaluation 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.</td></tr>
<tr><td>Reauthorizations</td><td>Evaluator may request additional units with a clear justification for why this is needed. The Clinical Lead may authorize up to sixteen (16) units [four (4) hours] if the need for additional hours are justified.

<u>Feedback session:</u>
Once the Clinical Lead confirms that the evaluation report adheres to these standards, an additional four (4) units [one hour] may be authorized for a feedback session with the youth/family.</td></tr>
<tr><td>Discharge Criteria</td><td><u>One</u> <u>(1) of the following criteria is met</u>:
1. The evaluation sessions are completed, the typed report has been submitted to the CC, the report has been accepted by the</td></tr>
</table>

	Clinical Lead, and the feedback session has been held; or 2. The youth/family no longer wants to participate in this service and stops attending assessment meetings or revokes consent in writing prior to the completion of the report[2].
Service Exclusions	General 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 evaluation will be performed 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 unrelated to the youth's mental health treatment including custody evaluations, parenting evaluations, 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.
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 General 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 evaluation.
2. Evaluators 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 any time during the evaluation process, but once the report is complete they can only revoke the consent to further

[2] The youth/family may revoke consent to be evaluated any time 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.

release beyond CAMHD. CAMHD as owner of the report will still maintain a copy in the file but will not release it further. However, this may impact service delivery.

Documentation

1. Progress notes document all evaluation activities.
2. The complete written report is submitted to the CC within thirty (30) days from date of referral and authorization. Requests for an extension of this timeline should be directed to the Clinical Lead and should include an explanation for why the extension is needed.
3. The typed written report includes:
   a. Date(s) of evaluation sessions 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 any specific referral question(s);
   d. Sources of information: including review of records, interviews, and assessment tools.
   e. Results of psychological testing if a separate authorization for testing has been issued.
   f. Diagnostic impression and justification for the diagnosis (DSM5/ICD10)
   g. Recommendations that speak to the youth's treatment needs and do not specify particular types of care or treatment programs.
   h. The report is signed by the evaluator (and his/her supervisor when applicable) acknowledging responsibility for the evaluation; and
   i. 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 evaluations.

E. SUMMARY ANNUAL EVALUATION (SAE)

Definition	This evaluation is performed in order to describe the current status of the youth and his or her circumstances. It is performed yearly, when the 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 evaluation and report, with feedback to the youth and his/her parent(s) or guardian(s). Contracted providers that are currently providing services and that have known the youth for at least three (3) months shall provide the SAE when it is due or as defined in the specific service standard.
Services Components	1. Obtain written informed consent before conducting evaluation. 2. Evaluation 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 SAE utilizes a digital template (download at http://health.hawaii.gov/camhd/ click on Provide Relations Forms link) which assures the collection of the information CAMHD requires (See Appendix 5 for sample form). 4. The CAFAS/PECFAS[3] information from the CC shall be included in the report. 5. The Ohio Scales (See Appendix 28 & 29), ASEBA checklist or other global measure of psychiatric symptoms (e.g. the BASC, Strengths and Difficulties Questionnaire) including Parent and youth self-report versions[4] obtained from CC shall be included in report. 6. Summarize and synthesize the available information in a clinical formulation and provide current diagnostic impression following the evaluation template. 7. Offer treatment recommendations, including suggestions regarding treatment modality, priority problems to be targeted, ways to utilize strengths, etc. 8. 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 is incorporated into the report template). 9. 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

[3] The PECFAS is the appropriate instrument for children under the age of 6 years.
[4] There are times when the youth will refuse to complete the symptom checklist, or the parent 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.

<table>
<tr><td></td><td>following:
a. Describe and address the chief complaint 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 youth’s particular needs, e.g. “the 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.
10. Complete the collection of data using the Summary Annual Evaluation template. Submit the signed report to the CC for review by the Clinical Lead within thirty (30) days of authorization or verbal request if request is being made to a service already being provided and required to conduct SAE as part of service delivery.
11. The report must comply with CAMHD standards as determined by Clinical Lead before results or recommendations are shared with the youth/caregivers or other team members. If there are concerns about adherence to the standards, the report will be returned to the evaluator for amendment. The Clinical Lead will review the report within one (1) week of submittal.
12. Upon approval of the report, a treatment team meeting will be scheduled with the youth and family/guardian within two (2) weeks to present evaluation results and just MHTP if needed. If, after extensive efforts are made (i.e. three attempts), the provider is not able to attend a treatment team meeting, a phone meeting is the alternative. Inability to contact the family within the specified time must be documented in the progress notes.</td></tr>
<tr><td>Admission Criteria</td><td><u>All the following criteria are met</u>:
1. Youth needs a SAE as part of the comprehensive delivery of services.</td></tr>
<tr><td>Authorizations</td><td>CAMHD LOC code: 5103
<table>
<tr><th>Unit</th><th>Credential</th><th>CPT code</th><th>Modifier</th></tr>
<tr><td rowspan="2">fifteen (15) minutes</td><td>QMHP</td><td>90791</td><td>52</td></tr>
<tr><td>MHP</td><td>90791</td><td>52</td></tr>
</table>
Clinical Lead may authorize up to eight (8) units [two (2) hours] for evaluation activities, only if the evaluation is NOT required as part of the services already being provided. If the evaluation is required as part of the scope of service already being procured, then the evaluation is billed under the existing service authorization.

<u>Billing limits:</u>
Procurement units reflect the time required for completing the</td></tr>
</table>

	review of data and evaluation 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 Clinical Lead confirms that the SAE adheres to these standards, an additional four (4) units [one (1) hour] may be authorized for a presentation of findings at a treatment team, **only if the evaluation is NOT required as part of the services already being provided.**
Discharge Criteria	**One** (1) of the following criteria is met: 1. The evaluation sessions are complete, the typed report has been submitted to the CC, the report has been approved by the Clinical Lead and discussed in a treatment team meeting. 2. The youth/family no longer wants to participate in this service and revokes consent in writing prior to the completion of the report[5].
Service Exclusions	SAE will not be considered medically necessary and will not be authorized under the following conditions: 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 a Mental Health Evaluation current within one (1) year or those being referred for a more in-depth Mental Health Evaluation. 5. The service currently being provided is required to conduct the evaluation 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:

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

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

OR

[5] The youth/family may revoke consent to be evaluated anytime during the evaluation process, but once the assessment is completed 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.

b. Credentialed by CAMHD as a Mental Health Professional (MHP)[6];

AND

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 evaluation.

2. Evaluators 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 also be followed. If the standards referenced here differ from those in the general standards, these clinical operations requirements will supersede the general standards.

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 conduct the evaluation 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 completed 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

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. Progress notes document all assessment activities.
2. The complete SAE template is submitted to the CC within thirty (30) days from date of authorization or verbal request if request is being made to a service already being provided and required to conduct SAE as part of service delivery.
3. The completed SAE template is type written and includes:
   a. Date(s) of evaluation 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 evaluation tools;
   e. The report is signed by the evaluator (and his/her supervisor when applicable) acknowledging responsibility for the evaluation); and
   f. The type written report includes all of the clinical information outlined in the standard, above.
4. Professionally recognized standards of ethical practices are followed in all evaluations.

[6] MST therapists who are credentialed as paraprofessionals may complete summary annual evaluations under supervision of their MST supervisor.

F. PSYCHOSEXUAL ASSESSMENT

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 General 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 DSM5/ICD-10 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.

<table>
<tr><td></td><td>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 comply with CAMHD standards as determined by Clinical Lead before results or recommendations are shared with the youth/caregivers or other team members. If there are concerns about adherence to the standards, the report will be returned to the evaluator for amendment. The Clinical Lead will review the report within one (1) week of submittal.
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.</td></tr>
<tr><td>Admission Criteria</td><td><u>All</u> <u>the following criteria must be met:</u>

1. The youth has been arrested, charged, or adjudicated for a sexual offense[7]; and
2. The CMP/CSP 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.</td></tr>
<tr><td>Authorizations</td><td>CAMHD LOC code: 5201
<table>
<tr><td>Unit</td><td>Credential</td><td>CPT Code</td><td>Modifier</td></tr>
<tr><td>fifteen (15) minutes</td><td>QMHP</td><td>96101</td><td>HK</td></tr>
</table>
Clinical Lead may authorize up to twenty-four (24) units [six (6) hours] for evaluation activities.

<u>Concurrent authorization:</u>

If there is no Mental Health Assessment current within one year, the Clinical Lead may also authorize the provider to complete a General Mental Health Evaluation along with the Psychosexual Assessment.

<u>Billing limits:</u></td></tr>
</table>

[7] When there are treatment-related concerns about the sexual behavior or attitudes of a youth, 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 Clinical Lead confirms that the evaluation report adheres to these standards, an additional four (4) units [one hour] may be authorized for a feedback session with the youth/family.
Discharge Criteria	At least **one** (1) of the following criteria are met: 1. The assessment sessions are completed, the written report has been approved by the 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[8].
Clinical Exclusions	Psychosexual Assessment will not be authorized under the following conditions: 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, youth may be referred for a General Mental Health Evaluation and Psychological Testing 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 any MHP may perform Psychosexual Assessments only 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.

Clinical Operations

[8] 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.

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); and
   i. The report is typed and includes all of the clinical information outlined in the aforementioned standard.
3. Professionally recognized standards of ethical practices are followed in all assessments.

G. PSYCHOLOGICAL TESTING

<table>
<tr><td>Definition</td><td>Psychological testing is performed as one component of a General Mental Health Evaluation, and it is not authorized as a stand-alone service. Psychological testing results must be integrated into the written General Mental Health Evaluation report and must be utilized to answer the referral question(s).

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.</td></tr>
<tr><td>Services Components</td><td>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 General Mental Health Evaluation report.</td></tr>
<tr><td>Admission Criteria</td><td><u>One</u> <u>of the following criteria are met:</u>
1. The Clinical Lead has determined that a mental health evaluation is needed to answer specific clinical questions or guide treatment planning; or
2. A mental health professional has determined that psychological testing is needed to supplement interview information in order to address the referral question(s).</td></tr>
<tr><td>Authorizations</td><td>CAMHD LOC code: 8101
<table><tr><th>Unit</th><th>Credential</th><th>CPT code</th><th>Modifier</th></tr><tr><td rowspan="2">fifteen (15) minutes</td><td>QMHP</td><td>96101</td><td></td></tr><tr><td>MHP</td><td>96101</td><td></td></tr></table>Clinical Lead may authorize up to sixteen (16) units [four (4) hours] for testing.

<u>Concurrent authorization</u>:

General Mental health evaluation must be authorized along with psychological testing.

<u>Billing limits:</u>

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</td></tr>
</table>

	payment for travel time, wait time, no shows, or cancellations.
Reauthorization	If under exceptional circumstances additional units are needed for testing activities, the provider must submit justification to the Clinical Lead. The 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. The Clinical Lead may authorize up to eight (8) units [two (2) hours]. No more than twenty-four (24) units of psychological testing may be authorized per twelve (12) month period.
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 General 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[9].
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 General 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 CAMHD credentialed as one (1) of the following:
   a. Credentialed as a Qualified Mental Health Professional (QMHP);

[9] 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.

OR

b. Credentialed 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 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 General Mental Health Evaluation including the incorporation of testing information is submitted to the CC within thirty (30) days from date of referral and authorization.

H. 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, DSM5/ICD-10 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. For adolescents this would include time spent interviewing guardians and youth separately; b. Description and history of presenting problems including psychiatric review of systems, past medical history, past psychiatric history, social history, history of development, educational achievement, involvement with juvenile justices, out of home placements or DHS involvement, and family history; c. Description of youth and family's strengths and resources; d. Description of current medical issues; e. Any ongoing substance use; f. Current medications;

<table>
<tr><td></td><td>
g. Complete mental status examination;
h. Safety evaluation for suicide, self-harm, aggression, homicidal thoughts, and for evidence of ongoing or past trauma;
i. Biopsychosocial 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) and expected prognosis;
j. DSM5/ICD-10 diagnostic impression;
k. Discussion of findings and recommendations with youth and family including fully explaining the benefits, risks, and alternatives; and
l. 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 comply with CAMHD standards as determined by Clinical Lead before results or recommendations are shared with the youth/caregivers or other team members. If there are concerns about adherence to the standards, the report will be returned to the evaluator for amendment. The Clinical Lead will review the report within one (1) week of submittal.
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.
</td></tr>
<tr><td>Admission Criteria</td><td>
<u>All</u> <u>the following criteria are met</u>:
1. The youth presents as medically complex or diagnostically complex and needing an initial or follow-up evaluation; and
2. Clinical case review with the Clinical Lead results in the determination that Psychiatric Diagnostic Evaluation may be beneficial to the client.
</td></tr>
<tr><td>Authorizations</td><td>
<table>
<tr><td colspan="4">CAMHD LOC code: 9101</td></tr>
<tr><td>Unit</td><td>Credential</td><td>CPT code</td><td>Modifier</td></tr>
<tr><td>fifteen (15) minutes</td><td>QMHP</td><td>90792</td><td></td></tr>
</table>
Clinical Lead may authorization up to eight (8) units [two (2) hours] for evaluation activity.

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
</td></tr>
</table>

	payment for travel time, wait time, no shows, or cancellations.
Reauthorization	The Clinical Lead may reauthorization four (4) units [one (1) hour] if the evaluating psychiatrist request additional units for one of the following conditions: 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.
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[10].
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.

[10] 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 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.

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. Developmental history;
      iv. Family history;
      v. History of out-of-home placements;
      vi. History of juvenile justice involvement;
      vii. History of educational achievement;
      viii. Description of individual and family strengths and resources;
      ix. Social history;
      x. Psychiatric review of systems;
      xi. Complete review of safety including suicidal thoughts and behaviors, self-harm, aggression, homicidal thoughts or behaviors, historical or current trauma experiences;
      xii. Description of current medical issues;
      xiii. Any ongoing substance use;
      xiv. Current medications;
      xv. Complete mental status examination;

xvi. 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) and prognosis expected;
xvii. Diagnostic impression: DSM5/ICD-10;
xviii. Discussion of findings and recommendations with young youth and family including fully explaining the benefits, risks, and alternatives;
xix. Reference of adherence to evidenced-based psychopharmacological practice;
xx. 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
xxi. Report is signed by the assessor acknowledging responsibility for the assessment.

I. 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. Assessing for General Medical Conditions that could account for, or impact, symptoms and making appropriate referrals to medical specialists when needed. 3. Making an appropriate plan with the youth and family that outlines the initiation, maintenance and discontinuation phases of pharmacotherapy. 4. Monitoring for drug-drug interactions and adjusting medications as necessary. This includes utilizing the smallest number of medications as well as the smallest dosages necessary to achieve optional results. 5. Reference and adherence to evidence-based psychopharmacological practices. 6. Determining overt physiological effects related to the medications used in the treatment of the youth's psychiatric condition, including side effects. 7. Determining psychological effects of medications used in the treatment of the youth's psychiatric condition using appropriate Rating Scales. 8. Monitoring compliance to prescription medication. 9. Determining impact of medication use on other components of the client's treatment. 10. Renewing prescription(s). 11. Appropriate monitoring of height, weight, vital signs, laboratory tests, and neurological findings in a standardized format such as the AIMS when appropriate. 12. Direct observation and assessment as described above are necessary components of medication monitoring and can be achieved through telehealth. 13. Full documentation of Informed Consent, including a signed description of potential benefits and risks as well as possible side effects of the prescribed medication that must be placed in the clinical record prior to initiation of medication. This will also include a discussion of reasonable alternatives to the medication being recommended. The Consent must be signed and dated by the youth's parent(s) or legal guardian.
Admission Criteria	**All** the following criteria are met: 1. The youth has been evaluated by a psychiatrist, and is deemed in need of medication to treat a behavioral, or other psychiatric

<table>
<tr><td></td><td>disorder to prevent admission to a more restrictive or intensive service level;
2. 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
3. The CMP/CSP includes this service as part of a larger treatment plan and not as a standalone service.</td></tr>
<tr><td>Authorizations</td><td>CAMHD LOC code: 10101
<table>
<tr><th>Unit</th><th>Credential</th><th>CPT code</th><th>Modifier</th></tr>
<tr><td>thirty (30) minutes</td><td>QMHP</td><td>90833</td><td></td></tr>
<tr><td>forty-five (45) minutes</td><td>QMHP</td><td>90836</td><td></td></tr>
<tr><td>sixty (60) minutes</td><td>QMHP</td><td>90838</td><td></td></tr>
</table>
Clinical Lead may authorization up to twenty-four (24) units [six (6) hours] for the first ninety (90) days.

<u>Billing limits</u>:

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.</td></tr>
<tr><td>Re-Authorization</td><td>Clinical Lead may reauthorization up to 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 Clinical Lead and the contract provider regarding the patient's adjustment.</td></tr>
<tr><td>Continuing Stay Criteria</td><td><u>All</u> <u>the following are met as determined by clinical review</u>:
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 the goal of treatment has 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 are active efforts being made and documented to involve them.</td></tr>
</table>

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 CAMHD. 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 culminate 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 within ten (10) days of assessment. 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/Treatment Planning:
     - Mental Health Treatment Plan including crisis and discharge components. 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
     - Monthly Treatment and Progress Summary

J. 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 attachment focused play-based interventions, 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> 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, review confidentiality and consent[11] 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 positive engagement, 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

[11] *Review specific issues regarding confidentiality and consent for services for adolescents.*

<table>
<tr><td></td><td>may include participation in transitional therapy sessions if the youth is transferred to a new level of care or new provider(s).</td></tr>
<tr><td>Admission Criteria</td><td><u>All</u> <u>the following criteria are met:</u>
1 The CMP/CSP includes this service and with identified treatment targets and objectives for this service prior to admission;
2 The youth must be identified as needing extra support to increase developmentally appropriate peer and adult interactions, coping skills and/or manage psychiatric illness;
3 There is reasonable expectation that the youth will benefit from this service, i.e., that therapy will remediate symptoms and/or improve functioning;
4 The youth is willing to participate in the service and the parent or guardian provides consent; and
5 If the youth is diagnosed with a disruptive behavior disorder and is age 12 or older, the use of one of the evidenced-based treatments (MST or FFT) 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.</td></tr>
<tr><td>Authorizations</td><td>CAMHD LOC code: 7101
<table>
<tr><th>Unit</th><th>Credential</th><th>CPT code</th><th>Modifier</th></tr>
<tr><td>thirty (30) minutes</td><td>QMHP</td><td>90832</td><td></td></tr>
<tr><td>Forty-five (45) minutes</td><td>QMHP</td><td>90834</td><td></td></tr>
<tr><td rowspan="2">sixty (60) minutes</td><td>QMHP</td><td>90837</td><td></td></tr>
<tr><td>MHP</td><td>90837</td><td>HK</td></tr>
</table>
Clinical Lead may authorize up to sixteen (16) units [four (4) hours] per thirty (30) days for up to ninety (90) days.

<u>Service limits:</u>

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 Clinical Lead will review and approve the request for additional units.

<u>Billing limits</u>:

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.</td></tr>
<tr><td>Reauthorization</td><td>The Clinical Lead may reauthorize up to sixteen (16) units [four (4) hours] per thirty (30) days for up to ninety (90) days.</td></tr>
<tr><td>Continuing Stay Criteria</td><td><u>All</u> <u>the following criteria must be met as determined by clinical review</u>:</td></tr>
</table>

	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-based approach is being utilized and it is being provided with adequate fidelity to the model; 4 At least <u>one</u> (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	<u>Youth is no longer in need of or eligible for this service due to **one** (1) of the following</u>: 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; or 5 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.
Service Exclusions	Not offered at the same time as any Out-of-Home service, IIH, IILS, ABI, Multisystemic Therapy, or 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 also 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 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 also 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:
   - A. Core Components of Current CAMHD System
     - Commitment to Clinical Excellence & Co-management of Care
   - E. Referral Process for Contracted Services:
   - F. Commitment to Serve All Youth;
   - G. Training;
   - H. Supervision;
   - I. Credentialing;
   - L. Service Quality;
   - N. Risk Management:
   - O. Additional Reporting Requirements
   - P. Youth Rights and Confidentiality

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 MHTP 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 Center within ten (10) calendar days of admission. This documentation is required for any reauthorization of Individual Therapy.

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 seventy-two (72) hours of service.
3. Please see Section I General Standards for additional documentation requirements:
    - D. Service/Treatment Planning:
        - Mental Health Treatment Plan including crisis and discharge components. If any major changes occur in the course of treatment, the all components of the MHTP should be updated;
        - Discharge Summary;
    - J. Billing
    - N. Maintenance of Service Records:
        - Progress Notes;
        - Monthly Treatment and Progress Summary

K. 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 and behavioral challenges. The family therapist helps the youth and family improve the quality of their connection by increasing the use of effective coping strategies, healthy communication, constructive problem-solving skills, and positive engagement. 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 positive engagement, 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 CMP/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

<table>
<tr><td></td><td>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.</td></tr>
<tr><td>Admission Criteria</td><td><u>All</u> <u>the following criteria are met</u>:
1. The CMP/CSP includes this service and with identified treatment targets and objectives for this service prior to admission;
2. 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;
3. Youth and family agree to active participation in treatment; and
4. If the youth is diagnosed with a disruptive behavior disorder and is age 12 or older, the use of one of the evidenced-based treatments (MST or FFT) 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.</td></tr>
<tr><td>Authorizations</td><td>CAMHD LOC code: 7103
<table>
<tr><th>Unit</th><th>Credential</th><th>CPT code</th><th>Modifier</th></tr>
<tr><td rowspan="2">fifteen (15) minutes</td><td>QMHP</td><td>90847</td><td></td></tr>
<tr><td>MHP</td><td>90847</td><td>HK</td></tr>
</table>
Clinical Lead may authorize up to sixteen (16) units [four (4) hours] per thirty (30) days for up to ninety (90) days.

<u>Service limits:</u>
The total time in Family 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 Clinical Lead will review and approve the request for additional units.

<u>Billing limits</u>:
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.</td></tr>
<tr><td>Reauthorization</td><td>The Clinical Lead may reauthorize up to sixteen (16) units [four (4)</td></tr>
</table>

	hours] per thirty (30) days for up to ninety (90) days.
Continuing Stay Criteria	**All** 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 CAMHD 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, IIH,

	IILS, ABI, Multisystemic Therapy, or FFT 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 also 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. 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 also 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:
   - A. Core Components of Current CAMHD System
     - Commitment to Clinical Excellence & Co-management of Care
   - E. Referral Process for Contracted Services:
   - F. Commitment to Serve All Youth;
   - G. Training;
   - H. Supervision;
   - I. Credentialing;
   - L. Service Quality;
   - N. Risk Management:
   - O. Additional Reporting Requirements
     - Weekly Census Report of Client Status
   - P. Youth Rights and Confidentiality

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 MHTP 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 Center with ten (10) calendar days of admission. This documentation is required for any reauthorization of Family Therapy.
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 seventy-two (72) hours of service.
3. Please see Section I General Standards for additional documentation requirements:
    - D. Service/Treatment Planning:
        - Mental Health Treatment Plan including crisis and discharge components. If any major changes occur in the course of treatment, the all components of the MHTP should be updated;
        - Discharge Summary;
    - J. Billing
    - N. Maintenance of Service Records:
        - Progress Notes;
        - Monthly Treatment and Progress Summary

L. 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> 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/CL to promote the integration of services across domains (home,

<table>
<tr><td></td><td>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.</td></tr>
<tr><td>Admission Criteria</td><td><u>All</u> <u>the following criteria are met</u>:
1. The youth must be age seven (7) through twenty (20) years;
2. The CMP/CSP include this service and identifies targets and objectives for this service prior to admission;
3. 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
4. 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.</td></tr>
<tr><td>Authorizations</td><td>CAMHD LOC code: 7102
<table><tr><th>Unit</th><th>Credential</th><th>CPT code</th><th>Modifier</th></tr><tr><td rowspan="2">fifteen (15) minutes</td><td>QMHP</td><td>90853</td><td></td></tr><tr><td>MHP</td><td>90853</td><td></td></tr></table>Clinical Lead may authorize four (4) group sessions per thirty (30) may be authorized for up to ninety (90) days.

If sessions are one (1) hour, sixteen (16) units [four (4) hours] per thirty (30) days can be authorized. If sessions are two (2) hours, thirty-two (32) units [eight (8) hours] per thirty can be authorized.

<u>Billing limits:</u>

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.</td></tr>
<tr><td>Reauthorization</td><td>Clinical Lead may reauthorize up to a ninety (90) days. The units authorized will depend on the planned length of each group session.</td></tr>
<tr><td>Continuing Stay Criteria</td><td><u>All</u> <u>the following criteria must be met</u>:
1. The evidence-based group therapy program has not been completed;</td></tr>
</table>

	2. Youth actively involved in treatment; 3. There are regular and timely assessments and documentation of the youth's response to the treatment; and 4. At least <u>one</u> (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	<u>Youth is no longer in need of or eligible for this level of service due to **one** (1) of the following</u>: 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 CAMHD. 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, IIH, IILS, ABI, Multisystemic Therapy, or FFT unless the Group 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	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 also be followed. If the standards referenced here differ from those in the general standards, these staffing requirements will supersede the general standards.

1. Group 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. 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 also 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:

- A. Core Components of Current CAMHD System
  - Commitment to Clinical Excellence & Co-management of Care
- E. Referral Process for Contracted Services:
- F. Commitment to Serve All Youth;
- G. Training;
- H. Supervision;
- I. Credentialing;
- L. Service Quality;
- N. Risk Management:
- O. Additional Reporting Requirements
  - Weekly Census Report of Client Status
- P. Youth Rights and Confidentiality

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 MHTP 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 Center with ten (10) calendar days of admission. This documentation is required for any reauthorization of Group Therapy.
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 seventy-two (72) hours of service.
3. Please see Section I General Standards for additional documentation requirements:
   - D. Service/Treatment Planning:
     - Mental Health Treatment Plan including crisis and discharge components. If any major changes occur in the course of treatment, the all components of the MHTP should be updated;
     - Discharge Summary;
   - J. Billing
   - N. Maintenance of Service Records:
     - Progress Notes;
     - Monthly Treatment and Progress Summary

M. 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 twelve to fourteen (12 to 14) 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 MHTP 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 CMP/ CSP and MHTP.
Admission Criteria	**All** the following criteria are met: 1. Youth is age eleven (11) to through seventeen (17). 2. There must be a reasonable expectation that the youth and family can benefit from FFT services within three to six (3 to 6) months; 3. 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 4. The CMP/CSP include this service and identifies targets and

<table>
<tr><td></td><td colspan="4">objectives for this service prior to admission.</td></tr>
<tr><td rowspan="5">Authorizations</td><td colspan="4">CAMHD LOC code: 7104</td></tr>
<tr><td>Unit</td><td>Credential</td><td>HCPCS code</td><td>Modifier</td></tr>
<tr><td rowspan="3">fifteen (15) minutes</td><td>QMHP</td><td>H2010</td><td></td></tr>
<tr><td>MHP</td><td>H2010</td><td>HK</td></tr>
<tr><td>PARA</td><td>H2010</td><td>HA</td></tr>
<tr><td colspan="4">Clinical Lead may authorize up to two hundred forty (240) units [sixty (60) hours] per thirty (30) days up to ninety (90) days.

<u>Billing limits</u>:

No billing for no shows, cancellation or travel time.</td></tr>
<tr><td>Reauthorization</td><td colspan="4">Clinical Lead may reauthorize up to two hundred forty (240) units [sixty (60) hours] per thirty (30) days up to ninety (90) days.

<u>Threshold</u>:

Average length of FFT treatment is three (3) months with most youth reaching a point of diminishing progress by the fourth (4) month.</td></tr>
<tr><td>Continuing Stay Criteria</td><td colspan="4"><u>All</u> <u>the following criteria are met as determined by clinical review:</u>

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 goals 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;
4. There is documented evidence of active family involvement in treatment as required by the treatment plan or there are 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.</td></tr>
<tr><td>Discharge Criteria</td><td colspan="4"><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</td></tr>
</table>

	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, ABI). 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 also 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 an FFT team supervisor. Supervisors must have training and experience in providing FFT.
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 also 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. All services must be provided with the youth and/or their caregiver's involvement. Any contact where the youth or family is not present—is NOT billable. The only exception is regularly scheduled treatment team meetings where the youth and caregiver are included members. These meetings may still happen and are billable even if the youth and family don't attend.
11. The majority of the service (80% or more) is provided face-to-face with the youth and their family. The use of Telehealth technology to deliver treatment when appropriate is considered face-to-face.
12. 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.

13. The Contractor must perform a Summary Annual Evaluation (SAE) for 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.
14. Please see Section I General Standards for additional clinical operation requirements:
    - A. Core Components of Current CAMHD System
        - Commitment to Clinical Excellence & Co-management of Care
    - E. Referral Process for Contracted Services:
    - F. Commitment to Serve All Youth;
    - G. Training;
    - H. Supervision;
    - I. Credentialing;
    - L. Service Quality;
    - N. Risk Management:
    - O. Additional Reporting Requirements
        - Weekly Census Report of Client Status
    - P. Youth Rights and Confidentiality

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. 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 seventy-two (72) 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:
    - D. Service/Treatment Planning:
        - Mental Health Treatment Plan including crisis and discharge components. If any major changes occur in the course of treatment, the all components of the MHTP should be updated;
        - Discharge Summary;
    - J. Billing
    - N. Maintenance of Service Records:
        - Progress Notes;
        - Monthly Treatment and Progress Summary

N. 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, and 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

<table>
<tr><td></td><td>and feedback to ensure model-fidelity.
13. Ongoing treatment planning, based on measurable behavioral goals, reflected in youth CMP/CSP and MHTP.</td></tr>
<tr><td>Admission Criteria</td><td><u>All</u> <u>the following criteria must be met</u>:

1. Youth is age twelve (12) through seventeen (17);
2. 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);
3. 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;
4. MST services are required to allow the youth to meet the goals identified in the CMP/CSP and improve his/her functioning in the home/community preventing movement to a higher level of care; and
5. 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).</td></tr>
<tr><td>Authorizations</td><td>CAMHD LOC code: 13201
<table><tr><td>Unit</td><td>Credential</td><td>HCPCS code</td><td>Modifier</td></tr><tr><td rowspan="3">fifteen (15) minutes</td><td>QMHP</td><td>H2033</td><td></td></tr><tr><td>MHP</td><td>H2033</td><td>HK</td></tr><tr><td>Para</td><td>H2033</td><td>HA</td></tr></table>Clinical Lead may authorization up to four hundred eighty (480) units [one hundred twenty (120) hours] per thirty (30) days for up to ninety (90) days.</td></tr>
<tr><td>Re-Authorization</td><td>Clinical Lead may reauthorization to four hundred eighty (480) units [one hundred twenty (120) hours] per thirty (30) days for up to sixty (60) days.

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.</td></tr>
<tr><td>Continuing Stay Criteria</td><td><u>All</u> <u>the following criteria are met as determined by clinical review:</u>

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 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</td></tr>
</table>

	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, ABI, 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 2 as specified in CAMHD credentialing requirements with the exception that paraprofessionals 2 must have a minimum of five (5) years of appropriate supervised experience as determined by the MST Service.
2. MST Clinical Supervisors must meet CAMHD requirements for QMHP. Licensed Ph.D. is preferred for the Clinical Supervisor positions.
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 the service eighty percent (80%) or more, is provided face-to-face with the youth and family. The use of Telehealth technology to deliver treatment when appropriate is considered face-to-face.
6. All services must be provided with the youth and/or their caregiver's involvement. Any contact where the youth or family is not present—is NOT billable. The only exception is regularly scheduled treatment team meetings where the youth and caregiver are included members. These meetings may still happen and are billable even if the youth and family don't attend.
7. 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.

8. 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.
9. 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.
10. The Contractor has established policies and procedures for handling emergency and crisis situations that describe methods for triaging youth who require psychiatric hospitalization.
11. 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.
12. The Contractor must perform a Summary Annual Evaluation for 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.
13. The Contractor must have an 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.
14. Please see Section I General Standards for additional clinical operation requirements:
    - A. Core Components of Current CAMHD System
        - Commitment to Clinical Excellence & Co-management of Care
    - E. Referral Process for Contracted Services
    - F. Commitment to Serve All Youth
    - G. Training
    - H. Supervision
    - I. Credentialing
    - L. Service Quality
    - N. Risk Management

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 seventy-two (72) hours of service.
5. Please see Section I General Standards for additional documentation requirements:
    - D. Service/Treatment 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;
    - J. Billing
    - N. Maintenance of Service Records:
        - Progress Notes
        - Monthly Treatment and Progress Summary

O. 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 Worker (PSW) service should be authorized to augment this level of care.
Services Offered	1. **Therapy services include family-and-youth-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. Intensive Family Therapy interventions. b. Psycho-education with family member and the youth to help them understand the youth's particular difficulties. c. 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. Caregiver Skills Menu can help parents identify skills they to develop or strengthen (See Appendix 33). d. Individual work with youth who have internalizing problems (depression, anxiety, post-traumatic stress disorder) utilizing evidence-based therapy approaches. e. Work with youth to support the building of positive coping skills. The Life Skills Menu (See Appendix 31) can be helpful in guiding youth to identify the areas where they need support or are motivated to acquire enhanced skills. f. Crisis management interventions. g. Support the youth and parents in to link up with other needed formal and informal supports in the community and school. h. 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 Mental Health Treatment Plan (MHTP) that identifies targets of treatment connected to realistic goals will be developed as part of the initial assessment**

	process and includes information from the pre-admission meeting (See Appendix 8)**.** The MHTP 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 component of the MHTP identifies the youth's problematic behaviors, setting events, triggers and preferred means of calming or regaining control along with the steps the caregivers will take in the event the behavior escalates out of control. The crisis plan builds on available information from the youth's personal safety plan in the CSP. The crisis plan must focus on early intervention for any problematic behavior to reduce the need to take reactive steps. b. The discharge component of the MHTP specifies discharge criteria directly linked to behaviors/symptoms that resulted in the admission, time frame for discharge and any aftercare resources needed to support the youth in the home and community. Planning begins at the pre-admission meeting and is revised throughout treatment to ensure that any potential obstacles to discharge are recognized and addressed before anticipated discharge date. c. If the services of a PSW for skills training is needed, the therapist will develop a clear plan for the PSW's service 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. d. Regularly schedule treatment team meetings to review progress, barriers, and ensure coordination across all team members is important to keeping treatment on track. 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 MHTP 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**: a. The PSW works conjointly with the 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 may not be more than two (2) hours a month. b. Works with the 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. c. Models behavior management skills and parenting approaches with parents during daily routines in the home. d. Implements crisis and safety plan, providing de-escalation interventions as outline in the plan. e. Collects 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. f. Provides "line of sight" supervision and works with the youth to support emotional regulation and acceptable behavior during community-based activities or household routines. g. Accompanies 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** the following criteria must be met: 1. The youth must be age three (3) through twenty (20) years; 2. 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; 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 MHTP and crisis plan with realistic discharge criteria along with expectations of family/guardian involvement in the treatment process. 4. 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; 5. 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

<table>
<tr><td></td><td>or there are specific non-disruptive symptoms that are identified for treatment by this service; and
6. The family/guardian(s) agree to active involvement in treatment and planning meetings, and the youth is willing to participate.</td></tr>
<tr><td>Authorizations</td><td>
<table>
<tr><td colspan="4">CAMHD LOC code: 13101</td></tr>
<tr><td>Unit</td><td>Credential</td><td>HCPCS code</td><td>Modifier</td></tr>
<tr><td rowspan="3">fifteen (15) minutes</td><td>QMHP</td><td>H0036</td><td></td></tr>
<tr><td>MHP</td><td>H0036</td><td>HK</td></tr>
<tr><td>PARA2</td><td>H0036</td><td>HA</td></tr>
</table>
<u>Pre-admission meeting authorization</u>:

Clinical Lead may authorize up to eight (8) units [two (2) hours] for an IIH therapist to attend a pre-admission meeting with the youth/family present for initial planning and match.

<u>Authorization for Therapist</u>:

Clinical Lead may authorize up to ninety-six (96) units [twenty-four (24) hours] per thirty (30) days for up to ninety (90) days.

<u>Authorization for PSW</u>:

The Clinical Lead may authorize additional units up to two hundred twenty-four (224) [fifty-six (56) hours]. The combined total for both the Therapist and the PSW must not exceed three hundred twenty (320) units [eighty (80) hours] per thirty (30) days for up to ninety (90) days.

<u>Conjoint work limit:</u>

Conjoint work is limited to eight (8) units [two (2) hours] per month. When the Therapist and the PSW work conjointly with the youth and/or family, only the therapist's time will be counted toward the daily and monthly maximums and will bill as usual. The PSW time will be billed as follows for conjoint time only:
<table>
<tr><td colspan="4">CAMHD LOC code: 13121</td></tr>
<tr><td>Unit</td><td>Credential</td><td>HCPCS code</td><td>Modifier</td></tr>
<tr><td>fifteen (15) minutes</td><td>PARA2</td><td>90887</td><td>HA</td></tr>
</table>
<u>Overlapping with Out-of-home treatment:</u>

Clinical Lead may authorize up to ninety-six (96) units [twenty-four (24) hours] for up to thirty (30) days for a therapist to begin engaging with a youth and his/her out-of-home treatment team. IIH services provided while overlapping with any out-of-home treatment will be billed as follows for overlapping time only:
<table>
<tr><td colspan="4">CAMHD LOC code: 13121</td></tr>
<tr><td>Unit</td><td>Credential</td><td>HCPCS code</td><td>Modifier</td></tr>
<tr><td rowspan="2">fifteen (15) minutes</td><td>QMHP</td><td>90887</td><td></td></tr>
<tr><td>MHP</td><td>90887</td><td>HK</td></tr>
</table>
<u>Billing limits:</u>

Daily billing must not exceed sixteen (16) units [four (4) hours] per</td></tr>
</table>

	day, including combined billing for the Therapist and PSW. No billing for no shows, cancellation or travel time. No billing for collateral contacts unless youth or caregiver is present during contact.
Reauthorization	Clinical Lead may reauthorize the Therapist for up to ninety-six (96) units [twenty-four (24) hours] per thirty (30) days for up to ninety (90) days. 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. <u>Threshold</u>: Average length of IIH treatment is eight (8) months with most youth reaching a point of diminishing progress by the sixth (6) month.
Continuing Stay Criteria	**<u>All</u>** <u>the following criteria are met as determined by clinical review:</u> 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 MHTP and safety plan are individualized and appropriate to the individual's changing condition with realistic, measurable and achievable goals, objectives and discharge criteria directed towards maintenance with family and community supports. 4. The MHTP 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 MHTP or there are active documented efforts being made to involve them unless it is documented as contraindicated; and 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.
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 MHTP; 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. 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; or 6. The youth/family no longer wants to participate in this service and revokes consent.
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, Functional Family Therapy or Adaptive Behavioral Intervention. 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 also 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. The Contractor is required to have a QMHP who provides twenty-four (24) hour on-call coverage seven (7) days a week.
3. Therapists must minimally be credentialed as an MHP with experience working with youth who have serious behavioral or emotional challenges.
4. PSWs must be credentialed as a paraprofessional level 2.
5. In many instances, the IIH Therapist will be sufficient to deliver the appropriate services, however; 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 Center Clinical Lead.
6. The PSW will work under the direct guidance of the IIH Therapist to meet the specific identified needs.
7. The ratio shall not exceed twelve (12) families per primary IIH therapist 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 also 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, CL 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 developed in the CSP identifies effective youth self-calming strategies that shall 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. The MHTP documents targets of treatment that are reflective of the youth's admission behaviors/symptom along with realistic goals and discharge criteria within ten (10) days of admission as part of the initial assessment process and preadmission meeting. The MHTP and crisis 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. The discharge plan component of the MHTP will document realistic discharge criteria directly linked to behaviors/symptoms that resulted in the admission, time frame for discharge and any aftercare resources needed to maintain the youth with the family in the community.
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. All services must be provided with the youth and/or their caregiver's involvement. Any contact where the youth or family is not present—is NOT billable. The only exception is regularly scheduled treatment team meetings where the youth and caregiver are included members. These meetings may still happen and are billable even if the youth and family don't attend.
10. The majority of the service (80% or more) is provided face-to-face with the youth and family. The use of Telehealth technology to deliver treatment when appropriate is considered face-to-face.
11. 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.
12. The Contractor has policies, which govern the provision of services in natural settings and which documents that it respects youths' and/or families' right to privacy and confidentiality when services are provided in these settings.
13. 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 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 efforts in the youth's chart.
14. 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.
15. The Contractor has policies and procedures around the use of personal vehicles for outreach services and for transporting clients when necessary.
16. 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.
17. The Contractor must perform a Summary Annual Evaluation for 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.
8. Please see Section I General Standards for additional clinical operation requirements:
    - A. Core Components of Current CAMHD System
        - Commitment to Clinical Excellence & Co-management of Care
    - E. Referral Process for Contracted Services:
    - F. Commitment to Serve All Youth;
    - G. Training;
    - H. Supervision;
    - I. Credentialing;
    - L. Service Quality;
    - N. Risk Management:
    - O. Additional Reporting Requirements
        - Weekly Census Report of Client Status

- P. Youth Rights and Confidentiality

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 MHTP 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 Center 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, conference calls with youth/caregiver and 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 seventy-two (72) 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.
4. PSWs must provide a written progress note for each face-to-face contact with the youth and/or family. The 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 IIH therapist. The original note must be maintained in the agency's master youth file within 72 hours of service.
5. Please see Section I General Standards for additional documentation requirements:
    - D. Service/Treatment Planning:
        - Mental Health Treatment Plan including crisis and discharge components. If any major changes occur in the course of treatment, the all components of the MHTP should be updated;
        - Discharge Summary;
    - J. Billing
    - N. Maintenance of Service Records:
        - Progress Notes;
        - Monthly Treatment and Progress Summary

P. 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).
Services Offered	1. **Therapy aimed at helping the youth/young adult with emotional and behavioral challenges while developing independent living skills include the following:** a. Each youth/young adult will be give assistance in accessing community resources such as: i. Assistance is provided with accessing needed financial assistance and benefits (e.g. applying for Social Security Disability benefits, obtaining housing subsidies, etc.); ii. Assistance is provided with obtaining appropriate services (e.g. vocational rehabilitation services; adult mental health services); and iii. Assistance is provided with obtaining support with any legal concerns (e.g. guardianship issues, birth certificate etc.). b. 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 (See Appendix 32 for Transition Shopping List): i. Social skills, including communication and problem-solving in personal relationships; ii. Emotion regulation skills, including anger control and conflict management; iii. Self-care skills (i.e. cooking, laundry, house-cleaning, personal hygiene); iv. Basic personal finances (i.e. developing a budget, balancing a checkbook; utilizing credit); v. Developing life goals and planning for the future, including career planning; vi. Understanding and taking charge of your own mental health treatment; vii. Taking charge of your own physical health including nutrition, healthy lifestyles, smoking cessation, and sexual and reproductive health;

viii. Chemical dependency education; and
ix. Parenting skills training.

c. Assistance developing vocational skills is provided in a practical, hands-on way:
   i. Investigating fields and jobs that might be of interest;
   ii. Doing volunteer work in areas consistent with career goals;
   iii. Assessing one's own job-relevant skills and writing a resume;
   iv. Obtaining job applications and interviewing for jobs;
   v. Finding sources of needed job training, including assistance working with DOE programs, vocation rehab programs, community college programs, GED programs, etc.; and
   vi. Coaching and support to help the young adult/youth stick with challenging training and job experiences.
d. 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:
   i. Psychoeducation for parents addressing concerns such as benefits, changes in confidentiality requirements, guardianship options etc.; and
   ii. Family therapy interventions (biological and/or foster).
e. Individual Therapy focused on mental health challenges utilizing evidenced-based approaches.

2. **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 MHTP 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 (See Appendix 8). The MHTP 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 component of the MHTP identifies the youth's problematic behaviors, setting events, triggers and preferred means of calming or regaining control. The crisis plan builds on available information from the youth's personal safety plan in the CSP. The crisis plan must focus on early intervention for any problematic behavior to reduce the need to take reactive steps.
   c. The discharge component of the MHTP 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. Planning begins at the pre-admission meeting and is revised throughout treatment to ensure that any potential obstacles to discharge are recognized and addressed before anticipated discharge date.

d. If the services of a PSW for skills training is needed, the therapist will develop a clear plan for the PSW's service in collaboration with the youth/young adult. 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.
e. Regularly schedule treatment team meetings to review progress, barriers, and ensure coordination across all team members is important to keeping treatment on track.

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 MHTP 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 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:**
   a. The PSW works conjointly with the therapist to plan interventions and to develop agreements with the youth/young adult 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, demonstrating skills for them to practice, etc. Concurrent work may not be more than two (2) hours a month.
   b. Implementing crisis and safety plans and providing crisis intervention and de-escalation.
   c. Working with the identified youth/young adult to support skill-building interventions being offered by the therapist which may include any of the following:
      i. Self-care skills (i.e. cooking, laundry, house-cleaning, personal hygiene);
      ii. Social skills, including communication and problem-solving in personal relationships;

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iii. Basic personal finances (i.e. developing a budget, balancing a checkbook; utilizing credit); and
iv. Emotion regulation skills, including anger control and conflict management.
d. Providing support to address vocational and other transition-related issues which may include any of the following:
i. Investigating fields and jobs that might be of interest;
ii. Doing volunteer work in areas consistent with career goals;
iii. Assessing one's own job-relevant skills and writing a resume;
iv. Obtaining job applications and interviewing for jobs;
v. Finding sources of needed job training, including assistance working with DOE programs, vocation rehab programs, community college programs, GED programs, etc.; and
vi. Coaching and support to help the young adult/youth stick with challenging training and job experiences.
e. Collecting detailed information about problematic behavior to help the therapist design effective interventions.
</td></tr>
<tr><td>Admission Criteria</td><td>
<u>All</u> <u>the following criteria are met:</u>

1. The youth must be sixteen (16) through twenty (20) years;
2. Youth/Young adult must be identified as needing intensive outpatient services focused on promoting growth toward independent living with in the CSP/CMP;
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; and
4. The youth adult/youth and/or family are amenable to actively working with program staff for the duration of the expected program period.
</td></tr>
<tr><td>Authorizations</td><td>
<table>
<tr><td colspan="4">CAMHD LOC code: 6112</td></tr>
<tr><td>Unit</td><td>Credential</td><td>HCPCS code</td><td>Modifier</td></tr>
<tr><td rowspan="3">fifteen (15) minutes</td><td>QMHP</td><td>H0036</td><td>HE</td></tr>
<tr><td>MHP</td><td>H0036</td><td>U1</td></tr>
<tr><td>PARA2</td><td>H0036</td><td>U2</td></tr>
</table>
<u>Pre-admission meeting authorization:</u>

Clinical Lead may authorize up to eight (8) units [two (2) hours] Therapist to attend a pre-admission meeting with the youth/young adult present for initial planning and match.

<u>Authorization for Therapist:</u>

Clinical Lead may authorize up to ninety-six (96) units [twenty-four (24) hours] per thirty (30) days for up to ninety (90) days.
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<tr><td></td><td>
PSW authorization:

The Clinical Lead may authorize additional units up to two hundred twenty-four (224) [fifty-six (56) hours]. The combined total for both the Therapist and the PSW must not exceed three hundred twenty (320) units [eighty (80) hours] per thirty (30) days for up to ninety (90) days.

Limited Conjoint work:

Conjoint work is limited to eight (8) units [two (2) hours] per month. When the Therapist and the PSW work conjointly with the youth/young adult and/or family, only the therapist's time will be counted toward the daily and monthly maximums and will bill as usual. The PSW time will be billed as follows for conjoint time only:
<table>
<tr><td colspan="4">CAMHD LOC code: 6122</td></tr>
<tr><td>Unit =</td><td>Credential</td><td>HCPCS code</td><td>Modifier</td></tr>
<tr><td>fifteen (15) minutes</td><td>PARA2</td><td>90887</td><td>U2</td></tr>
</table>
Overlapping with Out-of-home treatment:

Clinical Lead may authorize up to ninety-six (96) units [twenty-four (24) hours] for up to thirty (30) days for a therapist to begin engaging with a youth and his/her out-of-home treatment team. IIH services provided while overlapping with any out-of-home treatment will be billed as follows for overlapping time only:
<table>
<tr><td colspan="4">CAMHD LOC code: 6122</td></tr>
<tr><td>Unit</td><td>Credential</td><td>HCPCS code</td><td>Modifier</td></tr>
<tr><td>fifteen (15) minutes</td><td>QMHP</td><td>90887</td><td>HE</td></tr>
<tr><td></td><td>MHP</td><td>90887</td><td>U1</td></tr>
</table>
Billing limits:

Daily billing must not exceed sixteen (16) units [four (4) hours] per day, including combined billing for the Therapist and PSW.

No billing for no shows, cancellation or travel time. No billing for collateral contacts unless youth/young adult or caregiver is present during contact.
</td></tr>
<tr><td>Reauthorization</td><td>
Clinical Lead may reauthorize the Therapist for up to ninety-six (96) units [twenty-four (24) hours] per thirty (30) days for up to ninety (90) days.

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.

Threshold:

Average length of IILS treatment sixth (6) months.
</td></tr>
<tr><td>Continuing Stay Criteria</td><td>
All 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
</td></tr>
</table>

	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 MHTP 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; 4. The MHTP 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 are active documented efforts being made to involve them unless it is documented as contraindicated; 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 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 youth/young adult or parent/guardian is not participating in treatment or in following program rules. 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; 4. 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 5. 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.
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, Functional Family Therapy, or Adaptive Behavioral Intervention 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/young adult is in need of immediate crisis stabilization because of active suicidal, homicidal, or psychotic behavior. Once stable, youth/young adult 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 also 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. The program is required to have a QMHP who provides twenty-four (24) hours on-call coverage, seven (7) days a week.
3. IILS Therapists must, at minimum, be an MHP with experience providing transition to independent living services to youth/young adults with serious emotional and behavioral challenges.
4. PSWs must be credentialed as a paraprofessional level 2.
5. 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 Clinical Lead.
6. The PSW will work under the direct guidance of the IILS Therapist to meet the specific identified needs.
7. 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. The MHTP documents targets of treatment that are reflective of the youth's admission behaviors/symptom along with realistic goals and discharge criteria within ten (10) days of admission as part of the initial assessment process and preadmission meeting. The MHTP and crisis 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. The discharge plan component of the MHTP will document realistic discharge criteria directly linked to behaviors/symptoms that resulted in the admission, time frame for discharge and any aftercare resources needed to support 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. All services must be provided with the youth/young adult involvement. Any contact where the youth/young adult s not present—is NOT billable. The only exception is regularly scheduled treatment team meetings where the youth and caregiver are included members. These meetings may still happen and are billable even if the youth and family don't attend.
9. The majority of services [eighty percent (80%) are provided face-to-face with youth/young adult and their family. The use of Telehealth technology to deliver treatment when appropriate is considered face-to-face.
10. 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 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 efforts in the youth's chart.
11. 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.

12. 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.
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 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.
16. The Contractor must perform a Summary Annual Evaluation for 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.
17. Please see Section I General Standards for additional clinical operation requirements:
    - A. Core Components of Current CAMHD System
        - Commitment to Clinical Excellence & Co-management of Care
    - E. Referral Process for Contracted Services:
    - F. Commitment to Serve All Youth;
    - G. Training;
    - H. Supervision;
    - I. Credentialing;
    - L. Service Quality;
    - N. Risk Management:
    - O. Additional Reporting Requirements
        - Weekly Census Report of Client Status
    - P. Youth Rights and Confidentiality

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 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, conference calls with youth/caregiver and 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 seventy-two (72) 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. PSWs must provide a written progress note for each face-to-face contact with the youth/young adult and/or family. The 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 IIH therapist. The original note must be maintained in the agency's master youth file within 72 hours of service.
5. Please see Section I General Standards for additional documentation requirements:
    - D. Service/Treatment Planning:
        - Mental Health Treatment Plan including crisis and discharge components. If any major changes occur in the course of treatment, the all components of the MHTP should be updated;
        - Discharge Summary;
    - J. Billing
    - N. Maintenance of Service Records:
        - Progress Notes;
        - Monthly Treatment and Progress Summary

Q. ADAPTIVE BEHAVIORAL INTERVENTION

Definition	This specialized intensive outpatient service is used to provide treatment and support to youth who have co-occurring mental health needs and developmental disabilities (MH-DD) and their families. It is designed to enhance the family's capacity to sustain the youth in their current living environment and to prevent the need for placement outside the home due to behavioral challenges. Adaptive Behavioral Intervention (ABI) also may be used to help re-unify the family after the youth has been placed outside the home or to support the transition to a new resource family for foster youth with both developmental disabilities and behavioral difficulties. This service is family-and youth-centered; it utilizes evidence-based or evidence-informed interventions and adheres to CASSP principles. This service may be delivered in the family's home or community. Youth with MH-DD frequently require support from several child-serving agencies, and this level of care incorporates some indirect case coordination activities along with standard behavioral and therapeutic interventions to help families manage their child's complex needs. This service assists families in incorporating their own strengths and their informal support systems to help improve and maintain the youth's functioning. ABI generally will be provided by a team that includes a therapist (MHP or QMHP) and at least one Paraprofessional Support Worker (PSW).
Services Offered	1. **Therapy services including family- and youth-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 may include: a. Gathering information to develop a behavioral Assessment of the youth's problematic behavior in the home or community setting. b. Developing behavioral support plans with families, based on the assessment, to target challenging behavior and develop positive coping skills. c. Working with families to implement home-based behavioral support plans. (This may include modeling/coaching and paraprofessional support). d. Individual work with youth who have internalizing problems (depression, anxiety, post-traumatic stress disorder) utilizing evidence-based therapy approaches that are adjusted as needed to accommodate the youth's developmental level. e. Family Therapy interventions to improve family communication, decrease conflict, improve relationships, etc. f. Crisis management interventions. g. Psycho-education with family members and the youth to help them understand the youth's particular difficulties and limitations. h. 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. 2. **Paraprofessional Support services to reinforce and extend the work of the therapist.** Paraprofessional interventions may include: a. Collecting detailed information about problematic behavior to help the therapist complete an assessment and design effective interventions. For example, recording incidents of non-compliance during the morning routine. b. Working with the identified youth and/or care-giver 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. c. Providing support to transition-age youth to implement plans developed to address vocational and other transition-related issues. For example, the Paraprofessional could support the youth with obtaining job applications, preparing for a job interview, learning to use public transportation, etc. d. Providing "line of sight" supervision and working with the identified youth to support emotional regulation and acceptable behavior during community-based activities or house-hold routines. e. Modeling behavior management skills and parenting approaches for parents during daily routines in the home. f. Implementing crisis and safety plans and providing crisis intervention and de-escalation. g. Accompanying the client or caregiver in order to support their participation in important meetings/appointments or activities. 3. **Active coordination of community-based services being provided for the youth.** This can be done by either the therapist or the paraprofessional working with the family. Because of the complex, specialized needs of youth with MH-DD, this service includes indirect case coordination activities including: a. Taking the lead role in coordinating the work of paraprofessionals, volunteers, family members and other support people to help the family assure that the youth is making progress, that learning is occurring between settings (e.g. school staff are teaching and learning from-based staff) and that the youth is adequately supervised. b. Scheduling team meetings with all the involved agencies, and keeping various stakeholders informed about the youth.

	c. Investigating additional services, benefit programs, youth activities, educational resources, etc. that might be needed by the youth and assisting the family to access them. d. Attending school meetings and working with school-based providers to assure continuity with the school program. e. Arranging training for various support people around how best to work with the youth. f. Coordinating with medical providers, especially psychiatrists to assure good communication and adherence to medical regimens. 4. A MHTP that identifies targets of treatment connected to realistic goals, objectives, and discharge criteria will be developed as part of the initial assessment process and will include information from the pre-admission meeting (See Appendix 8). The treatment plan shall target challenging behavior related to a mental health need and shall not be focused primarily on the acquisition of basic adaptive skills. The 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. A clear plan for use of the Paraprofessional Support Worker's services is incorporated into the treatment plan. 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 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 specifies discharge criteria directly linked to behaviors/symptoms that resulted in the admission, the time frame for discharge and any aftercare resources needed to transition the youth and family to a lower level of care or out of CAMHD services. 5. 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 MHTP 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

<table>
<tr><td></td><td>measures that are meaningful to the youth's presenting concerns (e.g. giving the Child Behavior Checklist to monitor symptoms)</td></tr>
<tr><td>Admission Criteria</td><td><u>All</u> <u>the following criteria are met</u>:

1. The youth must be age three (3) through twenty (20) years;
2. The youth has documented borderline, mild or moderate deficits in intellectual functioning (e.g. tested IQ less than 85; assessment from a QMHP that estimates the youth is functioning in the mild range of intellectual disability, etc.);
3. The youth is displaying behavioral and and/or emotional difficulties in the home or community (not only in school) and there is a reasonable likelihood that ABI services will lead to specific, observable improvements in the youth and family's functioning;
4. Pre-admission meeting is held with the youth/young adult, family/guardian, CC and other relevant treatment team members to identify: 1) targets to be addressed in the treatment and safety plan, 2) realistic discharge criteria and 3) 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 becomes the primary target for the first month of this service; and
5. The family/guardian(s) agree to active involvement in treatment and planning meetings, and the youth is willing to participate.</td></tr>
<tr><td>Authorizations</td><td>CAMHD LOC code: 13103
<table>
<tr><th>Unit</th><th>Credential</th><th>HCPCS code</th><th>Modifier</th></tr>
<tr><td rowspan="3">fifteen (15) minutes</td><td>QMHP</td><td>H0036</td><td>HI</td></tr>
<tr><td>MHP</td><td>H0036</td><td>U3</td></tr>
<tr><td>PARA2</td><td>H0036</td><td>U4</td></tr>
</table>
<u>Pre-admission meeting authorizations:</u>

Clinical Lead may authorize up eight (8) units [two (2) hours] for an ABI therapist to attend a pre-admission meeting with the youth/family present for initial planning and match

<u>Authorization for Therapist:</u>

Clinical Lead may authorize up to ninety-six (96) units [twenty-four (24) hours] per thirty (30) days for up to ninety (90) days.

<u>Authorization for PSW:</u>

The Clinical Lead may authorize additional units up to two hundred twenty-four (224) [fifty-six (56) hours]. The combined total for both the Therapist and the PSW must not exceed three hundred twenty</td></tr>
</table>

(320) units [eighty (80) hours] per thirty (30) days for up to ninety (90) days.

Conjoint work limit:

Conjoint work is limited to eight (8) units [two (2) hours] per month. When the Therapist and the PSW work conjointly with the youth and/or family, only the therapist's time will be counted toward the daily and monthly maximums and will bill as usual. The PSW time will be billed as follows for conjoint time only:

CAMHD LOC code: 13123			
Unit	Credential	HCPCS code	Modifier
fifteen (15) minutes	PARA2	90887	U4

Overlapping with Out-of-home treatment:

Clinical Lead may authorize up to ninety-six (96) units [twenty-four (24) hours] for up to thirty (30) days for a therapist to begin engaging with a youth and his/her out-of-home treatment team. IIH services provided while overlapping with any out-of-home treatment will be billed as follows for overlapping time only:

CAMHD LOC code: 13123			
Unit	Credential	HCPCS code	Modifier
fifteen (15) minutes	QMHP	90887	HI
	MHP	90887	U3

Billing limits:

Daily billing must not exceed sixteen (16) units [four (4) hours] per day, including combined billing for the Therapist and PSW.

No billing for no shows, cancellation or travel time. No billing for collateral contacts unless youth or caregiver is present during contact.

Reauthorization

Authorization for Therapist:

Clinical Lead may reauthorize the Therapist for up to ninety-six (96) units [twenty-four (24) hours] per thirty (30) days for up to ninety (90) days.

Authorization for PSW:

The Clinical Lead may authorize additional units up to two hundred twenty-four (224) [fifty-six (56) hours]. The combined total for both the Therapist and the PSW must not exceed three hundred twenty (320) units [eighty (80) hours] per thirty (30) days for up to ninety (90) days.

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. The maximum allowed hours shall not be authorized after the first three months of services except in unusual circumstances when very intensive intervention continues to be medically necessary.

	Threshold: Average length of ABI treatment is 4 months.
Continuing Stay Criteria	**All** the following criteria are met as determined by clinical review: 1. All admission criteria continue to be met; 2. The measurable treatment goals have not been met and there are regular and timely assessments and documentation of youth/family response to services. Data on progress have been presented in a visual or tabular format showing changes over time and reviewed with the family and treatment team. Timely and appropriate modifications have been made to services and plans as needed; 3. The documented MHTP and safety plan is individualized and appropriate to the individual's changing condition with realistic, measurable and achievable goals, objectives and discharge criteria. The treatment plan has been shared with relevant team members. 4. The MHTP 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 are active documented efforts being made to involve them unless it is documented as contraindicated. 6. There is reasonable expectation that continued treatment will improve behaviors or there is reasonable evidence that the youth will decompensate or experience relapse if services are discontinued. 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	Youth is no longer in need of or eligible for services 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. Targeted symptoms and/or maladaptive behaviors have lessened to a level of severity which no longer requires this level of care as documented by attainment of goals in the MHTP; 3. The parent/guardian or youth is unable to participate in treatment. 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; 4. 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. 5. Youth/family has demonstrated no progress toward treatment goals and/or deterioration in functioning for at least a three (3) month period, and clinical review has determined that the youth is not benefiting from this service; or 6. The youth/family no longer wants to participate in this service and revokes consent.
Service Exclusions	ABI 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 except in cases where the youth has a planned discharge from out-of-home care within thirty (30) days. ABI 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 any other intensive outpatient services (e.g. MST, FFT, Intensive In-Home, Intensive Independent Living Skills). 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, as an alternative to incarceration within juvenile justice, as an alternative to specialized schooling, or 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. ABI 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 requirement listed in the general standards, these staff requirements must also 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 has oversight and supervision responsibilities for all staff decisions made regarding youth/family treatment.
2. ABI Therapists must minimally be credentialed as an MHP with experience working with youth who have serious behavioral or emotional challenges.
3. Paraprofessional Support Worker (PSW) must be credentialed as a paraprofessional level 2.
4. The program provides a therapist with experience working with youth who have serious behavioral or emotional challenges and/or with youth who have developmental disabilities. As discussed in a

later section, the program will provide additional training to assure that all therapists develop expertise in working with youth who have co-occurring MH-DD.
5. ABI 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 Clinical Lead.
6. The PSW will work under the direct guidance of the Therapist to meet the specific identified needs of the youth and family.
7. The ratio shall not exceed ten (10), families per primary ABI therapist (team leader). 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 also 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 interventions.
2. A preadmission meeting is required to obtain youth, family, CC, CL 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 developed in the CSP identifies effective youth self-calming strategies that shall 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. Program has an intake process that includes integration of information available regarding the youth and family into the treatment planning process to ensure appropriate and effective treatment. Program also has an established protocol for orienting the youth and family to the program.
4. ABI services are individually designed for each family, 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.
5. ABI 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.
6. All services must be provided with the youth and/or their caregiver's involvement. Any contact where the youth or family is not present—is NOT billable. The only exception is regularly scheduled treatment team meetings where the youth and caregiver are included members. These meetings may still happen and are billable even if the youth and family don't attend.
7. The majority of the service (80% or more) is provided face-to-face with the youth and family. The use of Telehealth technology to deliver treatment when appropriate is considered face-to-face.
8. Service delivery is preceded by a thorough assessment of the youth and their family so that an appropriate and effective treatment plan can be developed.
9. The Contractor has 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.
10. The Contractor has developed a training program, in collaboration with CAMHD, that assures professional and paraprofessional staff understand the particular needs and vulnerabilities of youth with co-occurring MH-DD.

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 procedures/protocols 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 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 efforts in the youth's chart.
13. 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.
14. Each 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 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 treatment plan.
    e. Description of how the developmental needs of youth with intellectual disabilities are accommodated in the program model and in-service planning.
16. The Contractor shall conduct a Summary Annual Evaluation for youth in their care at the time the annual assessment is due for youth who have received at least three (3) months of services from the Contractor. See Summary Annual Evaluation performance standard.
17. Please see Section I General Standards for additional clinical operation requirements:
    - A. Core Components of Current CAMHD System
        - Commitment to Clinical Excellence & Co-management of Care
    - E. Referral Process for Contracted Services:
    - F. Commitment to Serve All Youth;
    - G. Training;
    - H. Supervision;
    - I. Credentialing;
    - L. Service Quality;
    - N. Risk Management:
    - O. Additional Reporting Requirements
    - P. Youth Rights and Confidentiality

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 within ten (10) calendar days of admission. This documentation is required for any re-authorization of Adaptive Behavioral Intervention services.

2. ABI 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, conference calls with youth/caregiver and 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 seventy-two (72) hours of service.
3. When a PSW is involved with a youth/family, their progress notes shall be co-signed by the ABI therapist; the Monthly Treatment and Progress Summary (MTPS) shall be completed by the ABI therapist and shall include descriptions of the work done by the PSW when applicable.
4. PSWs must provide a written progress note for each face-to-face contact with the youth and/or family. The 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 IIH therapist. The original note must be maintained in the agency's master youth file within 72 hours of service.
5. Please see Section I General Standards for additional documentation requirements:
    - D. Service/Treatment Planning:
        - Mental Health Treatment Plan including crisis and discharge components. If any major changes occur in the course of treatment, the all components of the MHTP should be updated;
        - Discharge Summary;
    - J. Billing
    - N. Maintenance of Service Records:
        - Progress Notes;
        - Monthly Treatment and Progress Summary

R. INTENSIVE OUTPATIENT HOSPITALIZATION

Definition	Intensive Outpatient Hospitalization (IOH) 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 service 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. IOH 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 IOH 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) time 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: a. Weekly individual and family therapy; b. At least twice a month group therapy; c. Daily educational programming; and d. Other planned activities appropriate to youth's needs and as indicated in the MHTP. 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 or another educational plan, as applicable. 6. Integrated individualized substance abuse assessment, counseling and education, as indicated in the youth's plan. 7. A documented MHTP that identifies targets of treatment connected to realistic goals, and measurable discharge criteria will be developed as part of the initial assessment process and

	includes information from the pre-admission meeting (See Appendix 8). A safety plan and larger crisis plan components of the MHTP will also be developed to identify interventions that are helpful in addressing target behavior. The MHTP and all component parts will be evaluated and revised as necessary as treatment proceeds and the youth, family/guardian and other relevant treatment team members will be included in this process. a. The crisis component of the MHTP identifies the youth's problematic behaviors, setting events, triggers and preferred means of calming or regaining control along with the steps the caregivers will take in the event the behavior escalates out of control. The crisis plan builds on available information from the youth's personal safety plan in the CSP. The crisis plan must focus on early intervention for any problematic behavior to reduce the need to take reactive steps. b. The discharge component of the MHTP 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 relevant 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 IOH provider will notify the other behavioral health provider(s) of the youth's current status to ensure care is coordinated.
Admission Criteria	**All** the following criteria must be met: 1. 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. 2. One of the following risk to self, others 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 the above behaviors are not 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; 3. 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; 4. 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; 5. The CMP and 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 evidence-based treatments (MST, FFT) before seeking IOH admission, unless there is clear and compelling documented clinical evidence that the youth is inappropriate for an evidence-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.
Authorizations	CAMHD LOC code: 27101 Unit = one (1) day | HCPCS code H0035 Clinical Lead may authorization may be up to fifteen (15) units at a time.
Reauthorization	Clinical Lead may reauthorization up to fifteen (15) units at a time. <u>Threshold:</u> Average length of IOH treatment is 40 days
Continuing Stay Criteria	**All** <u>the following criteria must be met as determined by clinical review</u>: 1. Youth actively involved in treatment process and at least <u>one</u> 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 evident and is 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; 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	IOH 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, ABI) except when documented in IOH's treatment/discharge plan and within two (2) weeks of discharge from the IOH 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 also 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);
   e. A DOE teaching staff; and
   f. Activities therapist/ Recreation therapist/Occupational therapist based on the needs of the population.
5. Staff must be CAMHD credentialed as defined in the general standards.
6. CAMHD will delegate to the HBR programs the credentialing of Qualified Mental Health Professionals only. The Contractor shall follow all CAMHD Credentialing Policies and Procedures related to the credentialing of MHPs and Paraprofessionals level s 1 or 2.
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.
8. 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.

9. 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.

Clinical Operations

In addition to the clinical operation 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 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 reflected in the goals in the MHTP. Discussion of the youth's self-calming strategies will be identified for the safety plan that will be incorporated into the youth's crisis plan in the MHTP. The preadmission meeting also facilitates the discussion 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-5 assessments, 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. The MHTP documents targets of treatment that are reflective of the youth's admission behaviors/symptom along with realistic goals and discharge criteria within ten (10) days of admission as part of the initial assessment process and preadmission meeting. The MHTP and crisis 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. The discharge plan component of the MHTP will document 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 ten (10) calendar days of discharge and sent to the referring Center.
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 Center where the youth is registered to seek approval from the CAMHD Medical Director or designee for such staffing to help stabilize the youth (See Ancillary performance standard for one-on-one Paraprofessional Support).
18. Please see Section I General Standards for additional clinical operation requirements:
    - A. Core Components of Current CAMHD System:
        - Commitment to Clinical Excellence & Co-management of Care;
    - E. Referral Process for Contracted Services;
    - F. Commitment to Serve All Youth;
    - G. Training;
    - H. Supervision;
    - I. Credentialing;
    - L. Service Quality;
    - N. Risk Management:
    - O. Additional Reporting Requirements:
        - Weekly Census Report of Client Status;
    - P. Youth Rights and Confidentiality.

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. 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.
2. A written MHTP 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.

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. 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 seventy-two (72) 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 weekly 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 notes for each youth in the program.
5. To ensure continuity of care, providers are required to provide discharge summaries as described in the general standards within ten (10) 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 at discharge, statement of status at discharge and any recommended follow-up treatment including medications and follow-up appointments which is given to the parent/guardian at discharge and sent to the referring CAMHD Center.
6. Please see Section I General Standards for documentation requirements including the following:
   - D. Service/Treatment Planning:
     - Mental Health Treatment Plan including crisis and discharge components. If any major changes occur in the course of treatment, the all components of the MHTP should be updated;
     - Discharge Summary;
   - J. Billing;
   - N. Maintenance of Service Records:
     - Progress Notes;
     - Monthly Treatment and Progress Summary;
   - O. Additional Reporting Requirements:
     - Attendance and Encounter Records.

S. 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. A documented MHTP will be developed with the team to help inform the therapeutic goals and strategies utilized within TRH. Additionally, the crisis plan component shall be revised for use within the TRH.
Admission Criteria	**All** the following criteria are met: 1. Youth resides in the family home or in a DHS resource family Home; 2. Youth receives an intensive in-home service through CAMHD; 3. The CMP identifies Therapeutic Respite Home as necessary to preserve the youth's living situation and specifies how and when the service will be utilized; and 4. The youth is between the ages of three (3) and seventeen (17).
Authorizations	CAMHD LOC code: 28940 Unit = one (1) day | HCPCS code H0045 Clinical lead may authorize up to two (2) units per every thirty (30) days for up to ninety (90) days. Billing limits: A maximum of two (2) units [two (2) days] may be used in any single episode.
Reauthorization	Clinical Lead may reauthorize up to two (2) units per every thirty (30) days for up to ninety (90) days.
Continuing Stay Criteria	**All** admission criteria continue to be met.
Discharge Criteria	**One** (1) of the following criteria is 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/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; or 6. Youth requires a higher level of care.
Service Exclusions	<u>TRH is not considered medically necessary and will not be authorized under any of the following circumstances:</u> 1. Not offered at the same any out-of-home service; or 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 also 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 with experience in providing service to youth/families and who is knowledgeable of evidenced-based treatments and best practice treatments. This professional is responsible for the Therapeutic Respite Home program and for those in care.
4. The program has QMHP or MHP providing on-call coverage twenty-four (24) hours per day/seven (7) days a week.
5. 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.
6. Youth who are unable to attend regularly scheduled day activities (e.g. school, work) must be provided supervision and therapeutic structure by program staff.
7. All transitional family 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 also 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 plus 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, Contractors of Transitional Family Homes Services shall submit a list of families with the following information required on the TFH Profile Form (See Appendix 27). 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 or on-call 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:
    - A. Core Components of Current CAMHD System
        - Commitment to Clinical Excellence & Co-management of Care
    - E. Referral Process for Contracted Services
    - F. Commitment to Serve All Youth
    - G. Training
    - H. Supervision

- I. Credentialing
- L. Service Quality
- N. Risk Management
- O. Additional Reporting Requirements
- P. Youth Rights and Confidentiality

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:
    - D. Service/Treatment Planning
    - J. Billing
    - N. Maintenance of Service Records:
        - Progress Notes
        - Monthly Treatment and Progress Summary

T. 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. Transitional Family Homes (TFH) 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. The youth are generally capable of attending their home school or an alternative community educational or vocational program. TFHs 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 TFH 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 care giver 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. 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. 4. Culturally relevant recreational and social group activities that that support the development of interpersonal relating and life skills. 5. Coordination with school personnel to implement and provide academic support in the TFH setting. 6. Treatment team participates in regular meetings (no less than once a month) with transitional home parents in order to

*See performance standard for service referenced.

	monitor the youth's progress and discuss treatment strategies and services. 7. A documented MHTP that identifies targets of treatment connected to realistic goals will be developed as part of the initial assessment process and includes information from the pre-admission meeting and CMP. The MHTP will be evaluated and revised as necessary, at least monthly as treatment proceeds and will include the youth, family/guardian and other relevant treatment team members. a. The crisis component of the MHTP identifies the youth's problematic behaviors, setting events, triggers and preferred means of calming or regaining control along with the steps the caregivers will take in the event the behavior escalates out of control. The crisis plan builds on available information from the youth's personal safety plan in the CSP. The crisis plan must focus on early intervention for any problematic behavior to reduce the need to take reactive steps. b. The discharge component of the MHTP 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. Planning begins at the pre-admission meeting and is revised throughout treatment to ensure that any potential obstacles to discharge are recognized and addressed before anticipated discharge date. 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 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** the following criteria are met: 1. The youth must be between the ages of three (3) and seventeen (17); 2. 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; 3. If the youth's primary problem is a disruptive behavioral disorder there must be documentation of the use of one of the

<table>
<tr><td></td><td>available evidenced-based treatments for disruptive behavior disorders (MST, FFT) unless there is documentation of clear and compelling clinical evidence that the youth is inappropriate for one of these approaches at this time;
4. Youth's documented needs can appropriately be met in a structured and consistent family-like environment;
5. Family/guardian agree to active involvement in treatment and planning meetings;
6. Youth agrees to active involvement in treatment;
7. The CMP identifies problem areas and treatment strategies to be addressed within this treatment setting; and
8. 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 crisis plan and reflected in the realistic discharge criteria along with expectations of family/guardian involvement in the treatment process.</td></tr>
<tr><td rowspan="3">Authorization</td><td colspan="2">CAMHD LOC code: 28401</td></tr>
<tr><td>Unit = One (1) day</td><td>HCPCS code H0018</td></tr>
<tr><td colspan="2">Clinical Lead may authorize up to thirty (30) units per every thirty (30) days for up to ninety (90) days.</td></tr>
<tr><td>Reauthorization</td><td colspan="2">Clinical Lead may reauthorize up to thirty (30) units per every thirty (30) days for up to ninety (90) days.

<u>Threshold</u>:

Average length of TFH treatment is eight (8) months, with most youth reaching a point of diminishing progress by the sixth (6) month.</td></tr>
<tr><td rowspan="6">Additional HCPCS Codes</td><td colspan="2"><u>Therapeutic passes</u>:

Clinical Lead may authorize up to eight (8) therapeutic passes. A maximum of three (3) units [three (3) days] at a time may be utilized.</td></tr>
<tr><td colspan="2">CAMHD LOC code: 28774</td></tr>
<tr><td>Unit = One (1) day</td><td>HCPCS code H0018 HE</td></tr>
<tr><td colspan="2"><u>Bed holds</u>: Clinical Lead may authorize up to three (3) bed holds per episode of care.</td></tr>
<tr><td colspan="2">CAMHD LOC code: 28712</td></tr>
<tr><td>Unit = One (1) day</td><td>HCPCS code H0018 HA</td></tr>
<tr><td>Continuing Stay Criteria</td><td colspan="2"><u>All</u> <u>the following are met as determined by clinical review</u>:

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 goals of treatment have not yet been achieved. If progress is not being made, there has been a MHTP adjustment in consultation with the Center Clinical Lead;
3. The documented MHTP is individualized and appropriate to the</td></tr>
</table>

	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; 4. The MHTP 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	Discharges from the program are conducted in a thoughtful, planned manner through co-management and regular communication among the provider, center, family, and other treatment team members. Discharges from the program which are not conducted in conjunction with a previously agreed upon plan devised by the team (including the Center and family) will be considered ejections. 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 MHTP 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 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; 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	TFH is not considered medically necessary and will not be authorized under any of the following circumstances: 1. Not offered at the same time as any other out-of-home service; 2. Not offered at the same time as any Intensive In-Home Therapy, Multisystemic Therapy, Functional Family Therapy, Intensive Independent Living Skills, or Adaptive Behavioral Intervention 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; or 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 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 also 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 with experience in providing service to youth/families and who is knowledgeable of evidenced-based treatments and best practice treatments. This professional is responsible for the Therapeutic Respite Home program and those care.
4. The program has a QMHP or MHP to providing 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 also be followed. If the standards referenced here differ from those in the general standards, these clinical operation requirements will supersede the general standards.

8. Services are available twenty-four (24) hours a day, seven (7) days a week.
9. Contractor is to follow all applicable professional practice standards and ethical guidelines.
10. The program provides transitional family parents with a written plan for providing emergency and psychiatric care prior to youth being treated in the family home.
11. 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.

12. 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.
13. 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 developed in the CSP identifies effective youth self-calming strategies that shall 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.
14. 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 crisis plan within their milieu.
15. 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.
16. The contractor and/or family shall establish reasonable curfews taking into consideration the age and circumstances of the individual youth.
17. The transitional family home will have no more than two (2) minor youth in the home plus 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.
18. A QMHP or 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 the program is without a QMHP/MHP to provide therapy services, the Contractor shall ensure that there is coverage of duties via sub-contract so that the weekly services are continued.
19. 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 27). 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.
20. 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; recordation, 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.
21. 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.

22. 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.
23. 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.
24. When the Contractor has documented the clinical need for Ancillary Service one-on-one staffing, the Contractor will request the assistance of the CAMHD Center where the youth is registered to seek approval from the CAMHD Medical Director or designee for such staffing to help stabilize the youth (See Ancillary performance standard for one-on-one Paraprofessional Support).
25. The Contractor must perform a Summary Annual Evaluation for 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.
26. Up to 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.
27. Authorization of therapeutic passes beyond the threshold of eight (8) passes must undergo a Center 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.
28. Up to three (3) 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, adjudicated to the Hawaii Youth Correctional Facility or on elopement status per episode of care.
29. Youth who are discharged from the program due to acute admission, detainment, adjudication or elopement status, will be given priority and expedited readmission if admission is sought within a thirty (30) day period from discharge. This means they shall have priority for any open bed, and a new referral packet shall not be required.
30. Please see Section I General Standards for additional clinical operation requirements:
    - A. Core Components of Current CAMHD System
        - Commitment to Clinical Excellence & Co-management of Care
    - E. Referral Process for Contracted Services:
    - F. Commitment to Serve All Youth;
    - G. Training;
    - H. Supervision;
    - I. Credentialing;
    - L. Service Quality;
    - N. Risk Management:
    - O. Additional Reporting Requirements
        - Weekly Census Report of Client Status
    - P. Youth Rights and Confidentiality
    - Q. Bed Holds and Therapeutic Passes:

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.

4. 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 Center within ten (10) days of admission. This documentation is required for any re-authorization of Transitional Family Home services
5. 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 seventy-two (72) hours of service.
6. 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.
7. To ensure continuity of care, the provider is required to provide discharge summaries as described in the general standards within ten (10) calendar days of discharge.
8. Please see Section I General Standards for additional documentation requirements:
    - D. Service/Treatment Planning:
        - Mental Health Treatment Plan including crisis and discharge components. If any major changes occur in the course of treatment, the all components of the MHTP should be updated
        - Discharge Summary
    - J. Billing
    - N. Maintenance of Service Records:
        - Progress Notes;
        - Monthly Treatment and Progress Summary
    - O. Additional Reporting Requirements:
        - Attendance and Encounter Records

U. COMMUNITY-BASED RESIDENTIAL 3 (CBR 3)

Definition	Community-Based Residential 3 (CBR3) programs provide twenty-four (24) hour, seven (7) days a week treatment and supervision in a safe and therapeutic environment. A trauma-informed, non-coercive approach is utilized in the milieu. This service provides youth with integrated treatment 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 setting that includes onsite education, diagnostic, and treatment services that cannot be provided in the community. The treatment primarily provides social, psychosocial, educational, and rehabilitative training and focuses on reintegration back into the family. Active 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 issues. CBR3 programs are required to provide transitional supports to the youth and family in order to facilitate discharge to a "stepped-down," less intensive service. This can include home-based follow-up services for up to sixty (60) days post-discharge (See Transitional Support Service standard).
Services Offered	1. Evidence-based treatment interventions, milieu-based programming, and activities designed to improve the functioning of the youth served. 2. An orderly schedule and normalized routine of therapeutic activities consistent with a trauma-informed approach are 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. Group therapy at a minimum five (5) times a week. 5. The treatment is family-centered and includes regular, intensive individual and family therapy (at least three (3) therapy sessions a week). At minimum one (1) of these therapy sessions shall be a modality-driven family therapy session in support of safely transitioning the youth to his/her home/community. In cases where there is no family/guardian to participate in family therapy, discussions with social worker or care coordinator to support transitioning the youth to his/her home/community is acceptable. 6. Comprehensive psychiatric services to include medical evaluation, medication review, adjustment, and monitoring at least once (1) a month or as indicated by treatment plan. Psychiatrist is available for consultation with program staff

	as needed to guide treatment. 7. On-site DOE educational program that addresses the youth's educational needs including the educational goals and objectives identified in the youth's IEP (if applicable). 8. Structured pre-vocational and vocational training activities as applicable. 9. Integrated individualized substance abuse counseling and education as indicated in youth's plan. 10. A documented MHTP that identifies targets of treatment connected to realistic goals will be developed as part of the initial assessment process and includes information from the pre-admission meeting and CMP. The MHTP will be evaluated and revised as necessary, at least monthly as treatment proceeds and will include the youth, family/guardian and other relevant treatment team members. a. The crisis component of the MHTP identifies the youth's problematic behaviors, setting events, triggers and preferred means of calming or regaining control along with the steps the caregivers will take in the event the behavior escalates out of control. The crisis plan builds on available information from the youth's personal safety plan in the CSP. The crisis plan must focus on early intervention for any problematic behavior to reduce the need to take reactive steps. b. The discharge component of the MHTP 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. Planning begins at the pre-admission meeting and is revised throughout treatment to ensure that any potential obstacles to discharge are recognized and addressed before anticipated discharge date. 10. Treatment is designed to include all members of the family/caregivers, 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. 12. The CBR3 program will provide, when clinically indicated, direct transitional support services to facilitate a successful discharge from the program and engagement in the step-down services. This service includes home-based intervention to conclude the family therapy work started while in the residential treatment program. When a youth steps-down to another island, telehealth technology shall be used to deliver these interventions (See Transitional Support Service

	performance standard).
Admission Criteria	**All** the following criteria must be met: 1. The youth shall be between the ages of twelve (12) through seventeen (17) years of age; 2. There is clinical evidence that the youth would be a risk to self or others if not in a residential treatment program and is medically necessary as evidenced by **one** of the following: a. Severe functional impairment in at least three (3) domains of the youth's life (i.e. home, school, emotions); 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; 3. Documentation of an adequate trial of active treatment in a less restrictive level of care that has been unsuccessful or there is clear and compelling documented clinical evidence that the youth is inappropriate for a trial of less restrictive treatment; 4. The CMP identifies problem areas and treatment strategies to be addressed within this treatment setting.; 5. Family/guardian agree to active involvement in treatment and planning meetings; 6. Youth agrees to active involvement in treatment; and 7. 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 crisis plan and reflected in the realistic discharge criteria along with expectations of family/guardian involvement in the treatment process.
Authorizations	CAMHD LOC code: 30201 Unit = one (1) day | HCPCS code H0019 U3 Clinical Lead may authorize up to thirty (30) units per thirty (30) days for up to ninety (90) days.
Reauthorization	Clinical Lead may reauthorize up to thirty (30) units per thirty (30) days for up to ninety (90) days. Threshold: Average length of CBR3 treatment is five (5) months with most youth reaching a point of diminishing progress by the seventh (7) month.
Additional HCPCS Codes	Therapeutic passes: Clinical Lead may authorize up to five (5) therapeutic passes. A maximum of three (3) units [three (3) days] at a time may be utilized.

<table>
<tr><td></td><td colspan="2">CAMHD LOC code: 30772</td></tr>
<tr><td></td><td>Unit = one (1) day</td><td>HCPCS code H0019 HK</td></tr>
<tr><td></td><td colspan="2"><u>Bed holds:</u>

Clinical Lead may authorize up to three (3) bed holds per episode of care.</td></tr>
<tr><td></td><td colspan="2">CAMHD LOC code: 30706</td></tr>
<tr><td></td><td>Unit = one (1) day</td><td>HCPCS code H0019 U6</td></tr>
<tr><td>Continuing Stay Criteria</td><td colspan="2"><u>All</u> <u>the following are met as determined by clinical review</u>:
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. If progress is not being made, there has been a MHTP adjustment in consultation with the Center Clinical Lead;
3. The documented MHTP 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 MHTP has been shared with the relevant team members;
4. The MHTP includes a formulated discharge plan that is directly linked to the behaviors and/or symptoms that resulted in admission, and begins to identify post CBR3 resources;
5. There is documented evidence of active family involvement in treatment as required by the MHTP at least weekly or there are active documented efforts being made to involve them unless it is documented as contraindicated; and
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.</td></tr>
<tr><td>Discharge Criteria</td><td colspan="2">Discharges from the program are conducted in a thoughtful, planned manner through co-management and regular communication among the provider, center, family, and other treatment team members. Discharges from the program which are not conducted in conjunction with a previously agreed upon plan devised by the team (including the Center and family) will be considered ejections.

<u>Youth may be discharged due one (1) of the following criteria:</u>

1. The youth's documented MHTP 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</td></tr>
</table>

	of the discharge process the CC will 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; 5. The youth or parent/guardian is not participating in treatment or 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 and to improve family participation; 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 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 and the Center has been consulted regularly for assistance; or 7. Youth exhibits new symptoms and/or maladaptive behaviors which cannot be safely and effectively addressed through this service.
Service Exclusions	CBR3 is not considered medically necessary and will not be authorized under any of the following conditions: 1. Not offered at the same time as any other out-of-home services; 2. Not offered at the same time as Intensive In-Home, Multisystemic Therapy, Functional Family Therapy, Intensive Independent Living Skills or Adaptive Behavioral Intervention services except when the youth will be discharged from CBR3 within thirty (30) days of the 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; or 4. No admissions that are being used solely for the convenience of child protective services housing, as an alternative to incarceration within juvenile justice, as an alternative to specialized schooling or 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 also be followed. If the standards referenced here differ from those in the general standards, these staffing requirements shall supersede the general standards.

1. The program has an assigned QMHP who is knowledgeable of evidenced-based treatment. The QMHP is responsible for the treatment program and for those in care. The program must have a QMHP for 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/clinical supervisor;
   c. QMHP or MHP therapist(s);
   d. Licensed registered nurse;
   e. CSAC or an individual with equivalent specialized substance abuse training and experience on staff or contracted consultant;
   f. Paraprofessional Residential Counselor level 1 or 2; and
   g. Depending on the needs of the youth, the services of qualified professionals and specialists in medicine, psychology, behavioral analysis, 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 at least 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 routine 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. Program shall have weekly case reviews with all levels of staffing to ensure everyone is knowledgeable about youths' treatment target and interventions to support their progress.
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 DOE 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).
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 either through the agency psychiatrist or private practitioner if the youth is under the care of a private provider. The psychiatrist shall also provide regular consultation to staff around medications, diagnostics and other clinical issues.
12. 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. If the youth requires hospitalization, the psychiatrist shall be available to assist and 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 is 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 also 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 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 developed in the CSP identifies effective youth self-calming strategies that shall 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 MHTP and crisis plan within their milieu.
7. The MHTP documents targets of treatment that are reflective of the youth's admission behaviors/symptom along with realistic goals and discharge criteria within ten (10) days of admission as part of the initial assessment process and preadmission meeting. The MHTP and crisis 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. The discharge plan component of the MHTP will document 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 is appropriate when transitioning a youth back to the community but require careful consideration of the risk assessment and treatment gains is to be completed before engaging in any step-down process. The use of community resources such as attending public school shall 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 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 youth's IEP as applicable. The program works with the DOE to ensure adherence to the youth's IEP, so credits eared while in treatment will be accepted by the home school. The program also works with the

DOE to ensure 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 shall have written policies and procedures and train staff on securing and storing medications, labeling and administering medications as ordered, recording medication administration, documenting youth request for adjustment or change and any side effects as well as notifying physician or advanced practice registered nurse immediately of possible side effects and proper disposal 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 intervention is needed and deploys the psychiatrist as needed. The QMHP or Psychiatrist shall 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 Service one-on-one staffing, the Contractor will request the assistance of the CAMHD Center where the youth is registered to seek approval from the CAMHD Medical Director or designee for such staffing to help stabilize the youth (See Ancillary performance standard for one-on-one Paraprofessional Support).
18. The Contractor shall perform a Summary Annual Evaluation for 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).
19. Up to 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. Up to three (3) bed hold days may be used to reserve the bed for a youth who is absent from the program for acute admission, detainment in the Detention Home, adjudicated to the Hawaii Youth Correctional Facility or on elopement status per episode of care.
21. Youth who are discharged from the program due to acute admission, detainment, adjudication or elopement status, will be given a priority and expedited readmission if admission is sought within a thirty (30) day period from discharge date. This means they shall have priority for any open bed, and a new referral packet shall not be required.
22. Please see Section I General Standards for additional clinical operation requirements:
    - A. Core Components of Current CAMHD System
        - Commitment to Clinical Excellence & Co-management of Care
    - E. Referral Process for Contracted Services
    - G. CAMHD Continuity of Care
    - I. Training
    - H. Supervision
    - I. Credentialing
    - L. Service Quality
    - N. Risk Management
    - O. Additional Reporting Requirements
        - Weekly Census Report of Client Status

- P. Youth Rights and Confidentiality
- Q. Bed Holds and Therapeutic Passes:

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 shall supersede the general standards.

1. A written MHTP identifying targets of treatment with realistic goals and discharge criteria linked to the admission behavior/symptoms will be submitted to the CAMHD Center within ten (10) days of admission. This documentation is required for any reauthorization of CBR3 service.
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 MHTP goals, 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. Original progress notes shall be maintained in the agency's master youth file within seventy-two (72) hours of service.
    a. Weekly Individual/family/group therapy progress notes are placed in the chart.
    b. The psychiatrist 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 note by the responsible educational/recreational/occupational/behavioral specialist are placed in the chart.
3. To ensure continuity of care, the provider is required to provide discharge summaries as described in the general standards within ten (10) calendar days of discharge.
4. Please see Section I General Standards for additional documentation requirements:
    - D. Service/Treatment Planning:
        - Mental Health Treatment Plan including crisis and discharge components. If any major changes occur in the course of treatment, the all components of the MHTP should be updated;
        - Discharge Summary;
    - J. Billing
    - N. Maintenance of Service Records:
        - Progress Notes;
        - Monthly Treatment and Progress Summary
    - O. Additional Reporting Requirements:
        - Attendance and Encounter Records

V. COMMUNITY-BASED RESIDENTIAL 2 (CBR 2)

Definition	Community-Based Residential 2 (CBR2) 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. CBR2 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. CBR2 programs are required to provide transitional supports to the youth and family in order to facilitate discharge to a "stepped-down," less intensive service. This can include home-based follow-up services for up to 60 days post-discharge (See Transitional Support Service performance standard).
Services Offered	1. Evidence-based treatment interventions and a supportive milieu to implement the services described above. 2. A normalized routine, an orderly schedule and therapeutic activities designed to improve behavior and functioning and support the development of appropriate daily 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. Group therapy at a minimum five (5) times a week to address the target population defined above. 5. The treatment is family-centered and includes regular, intensive individual and family therapy (at least three (3) therapy sessions a week). At minimum one (1) of these therapy sessions shall be a modality-driven family therapy session in support of safely transitioning the youth to his/her home/community. In cases where there is no family/guardian to participate in family therapy, discussions with probation officer or care coordinator to support transitioning the youth to his/her home/community is acceptable.

	6. Comprehensive psychiatric services to include medical evaluation, medication review, adjustment, and monitoring at least once (1) a month or as indicated by treatment plan. Psychiatrist is available for consultation with program staff on treatment as needed. 7. On-site DOE educational program that addresses the youth's educational needs including the educational goals and objectives identified in the youth's IEP (if applicable). 8. Structured pre-vocational and vocational training activities as applicable. 9. Integrated individualized substance abuse counseling and education as indicated in the youth's plan. 10. Structured pre-vocational and vocational training activities as applicable. 11. A documented MHTP that identifies targets of treatment connected to realistic goals will be developed as part of the initial assessment process and includes information from the pre-admission meeting and CMP. The MHTP will be evaluated and revised as necessary, at least monthly as treatment proceeds and will include the youth, family/guardian and other relevant treatment team members. a. The crisis component of the MHTP identifies the youth's problematic behaviors, setting events, triggers and preferred means of calming or regaining control along with the steps the caregivers will take in the event the behavior escalates out of control. The crisis plan builds on available information from the youth's personal safety plan in the CSP. The crisis plan must focus on early intervention for any problematic behavior to reduce the need to take reactive steps. b. The discharge component of the MHTP 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. Planning begins at the pre-admission meeting and is revised throughout treatment to ensure that any potential obstacles to discharge are recognized and addressed before anticipated discharge date. 12. Treatment is designed to include all members of the family, not just the specific youth through regular family therapy and therapeutic home passes. 13. 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. 14. The CBR2 program will provide, when clinically indicated, direct transitional support services to facilitate a successful discharge from the program and engagement in the step-down services. This service includes home-based intervention to

<table>
<tr><td></td><td>conclude the family therapy work started while in the residential treatment program. When a youth steps-down to another island, telehealth technology shall be used to deliver these interventions (See Transitional Support Service performance standard).</td></tr>
<tr><td>Admission Criteria</td><td><u>All</u> <u>the following criteria are met</u>:
1. Males only, between the ages of twelve (12) and seventeen (17) years old who meets all the following criteria:
a. The youth has a severe emotional and/or behavioral disorder(s);
b. The youth is known to have sexual behavior problems and has engaged in sexually deviant or aggressive behaviors with or without adjudication;
c. Identified as needing specialized treatment and poses a moderate risk to others based on specialized assessment; 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;
2. 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;
3. The CMP identifies problem areas and treatment strategies to be addressed within this treatment setting;
4. Family/guardian agree to active involvement in treatment and planning meeting;
5. Youth agrees to active involvement in treatment; and
6. 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 crisis plan and reflected in the realistic discharge criteria along with expectations of family/guardian involvement in the treatment process.</td></tr>
<tr><td rowspan="3">Authorizations</td><td colspan="2">CAMHD LOC code: 30303</td></tr>
<tr><td>Unit = one (1) day</td><td>HCPCS Code H0019 U2</td></tr>
<tr><td colspan="2">Clinical Lead may authorize up to thirty (30) units per every thirty (30) days for up to ninety (90) days.</td></tr>
<tr><td>Reauthorization</td><td>Clinical Lead may reauthorize up to thirty (30) units per every thirty (30) days for up to ninety (90) days.
<u>Threshold:</u>
Average length of CBR2 is ten (10) months with most youth reaching a point of diminishing progress by the sixth (6) month.</td></tr>
<tr><td>Additional HCPCS Codes</td><td><u>Therapeutic passes:</u>
Clinical Lead may authorize up to five (5) therapeutic passes. A maximum of three (3) units [three (3) days] at a time may be</td></tr>
</table>

<table>
<tr><td></td><td>utilized.
CAMHD LOC code: 30773
Unit = one (1) day | HCPCS code H0019 HE
<u>Bed holds:</u>
Clinical Lead may authorize up to three (3) bed holds per episode of care.
CAMHD LOC code: 30709
Unit = one (1) day | HCPCS code H0019 U5</td></tr>
<tr><td>Continuing Stay Criteria</td><td><u>All</u> <u>the following criteria are met as determined by clinical review</u>:
1. Youth is actively involved in treatment process and continues to meet admission criteria;
2. Progress in relations to mastery of the specific treatment targets enumerated in the definition of this service is evident and can be described in objective terms, but goals of treatment have not yet been achieved;
3. The documented MHTP 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 MHTP 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 CBR2 resources;
5. There is documented evidence of active family involvement in treatment as required by the MHTP 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.</td></tr>
<tr><td>Discharge Criteria</td><td><u>Youth is no longer in need of or eligible for this service due to</u> <u>one</u> <u>(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</td></tr>
</table>

	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	<u>CBR2 is not considered medically necessary and will not be authorized under the following conditions:</u> 1. Not offered at the same time as any other out-of-home services; 2. Not offered at the same time as Intensive In-Home Therapy, Multisystemic Therapy, Functional Family Therapy, Intensive Independent Living Skills, or Adaptive Behavioral Intervention services *except* in cases where the youth has a planned discharge from CBR2 within thirty (30) days of referral; 3. No admission and/or continued stays which are solely for parent/guardian convenience and not related to the care and treatment of a youth; or 4. No admission that is being used solely for the convenience of child protective services housing, as an alternative to incarceration within juvenile justice, as an alternative to specialized schooling or 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 also 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 are 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 for sexualized behavior. The QMHP is responsible for the treatment program and for those in care. The program must have a QMHP for on-call coverage twenty-four (24) hours per day/seven (7) days a week
3. Staff providing therapy must be a QMHP or 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/clinical supervisor;
   d. QMHP or MHP therapist;
   e. Licensed Registered Nurse;
   f. CSAC on staff or contracted consultant;
   g. Paraprofessional residential counselor levels 1 or 2; and
   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. The overnight shift will maintain a staff to youth ratio of 1:6. Two (2) staff must be on duty per living unit with at least one (1) staff awake during overnight shift.
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. Program shall have weekly case reviews with all levels of staffing to ensure everyone is knowledgeable about youths' treatment target and interventions to support their progress.
10. Youth that are ill or otherwise unable to attend school must be supervised by an available staff wherever the youth is located.
11. The DOE 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).
12. The CSAC will provider 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 assessments as needed.
13. The psychiatrist (staff or consultant) provides psychiatric services at intervals of at least one (1) face-to-face visit a month with each youth served. The Contractor must assure that each youth receives the needed psychiatric services either through the agency psychiatrist or private practitioner if the youth is under the care of a private provider. The psychiatrist shall also provide regular consultation to staff around medication, diagnosis and other clinical issues.
14. 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. If the youth requires hospitalization, the psychiatrist shall be available to assist and 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 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 also 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) male 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 assess and manage identified risks.
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 developed in the CSP identifies effective youth self-calming strategies that shall 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.
9. 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 MHTP and crisis plan within their milieu.
10. The MHTP documents targets of treatment that are reflective of the youth's admission behaviors/symptom along with realistic goals and discharge criteria within ten (10) days of admission as part of the initial assessment process and preadmission meeting. The MHTP and crisis 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.
11. The discharge plan component of the MHTP will document 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.
12. Planned use of community resources is 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.
13. The Program shall conduct a risk assessment using normed or evidenced-based tools 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.
14. 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.

15. 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.
16. 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.
17. 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.
18. 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 adherence to the youth's IEP, so credits eared while in treatment will be accepted by the home school. The program also works with the DOE to ensure a smooth transition back to the home school or alternative transition plans for those who are not returning to their home schools.
19. The Contractor shall 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.
20. The Contractor shall have 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.
21. 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 Center where the youth is registered to seek approval from the CAMHD Medical Director or designee for such staffing to help stabilize the youth (See Ancillary performance standard for one-on-one Paraprofessional Support).
22. The Contractor must perform a Summary Annual Evaluation for 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.
23. Up to five (5) therapeutic passes are allowed per episode of care for each youth in the program to assist him 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.
24. Up to three (3) 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, adjudicated to the Hawaii Youth Correctional Facility or on elopement status per episode of care.
25. Youth who are discharged from the program due to acute admission, detainment, adjudication or elopement status, will be given priority and expedited readmission if admission is sought within a thirty (30) day period from discharge. This means they shall have priority for any open bed, and a new referral packet shall not be required.

26. Please see Section I General Standards for additional clinical operation requirements:
    - A. Core Components of Current CAMHD System
        - Commitment to Clinical Excellence & Co-management of Care
    - E. Referral Process for Contracted Services:
    - F. Commitment to Serve All Youth;
    - G. Training;
    - H. Supervision;
    - I. Credentialing;
    - L. Service Quality;
    - N. Risk Management:
    - O. Additional Reporting Requirements
        - Weekly Census Report of Client Status
    - P. Youth Rights and Confidentiality
    - Q. Bed Holds and Therapeutic Passes

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 MHTP identifying targets of treatment with realistic goals and discharge criteria linked to the admission behavior/symptoms will be submitted to the CAMHD Center within ten (10) days of admission. This documentation is required for any reauthorization of CBR2 service.
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 72 hours of service.
    a. Individual/family/group therapy progress notes are placed in the chart.
    b. The psychiatrist shall document at least one monthly face-to-face progress note in the youth's chart
    c. Every nursing contact, including medication administration shall be documented and placed in the youth's chart.
    d. At least once a week progress note by the responsible educational/recreational/occupational specialist are placed in the chart.
    e. Progress notes shall include explicit documentation of the youth progress or impediment toward rectifying sexual deviance specific treatment goals.
3. To ensure continuity of care, the provider is required to provide discharge summaries as described in the general standards within ten (10) days calendar of discharge.
4. Please see Section I General Standards for additional documentation requirements:
    - D. Service/Treatment Planning:
        - Mental Health Treatment Plan including crisis and discharge components. If any major changes occur in the course of treatment, the all components of the MHTP should be updated;
        - Discharge Summary;
    - J. Billing
    - N. Maintenance of Service Records:
        - Progress Notes;

        - Monthly Treatment and Progress Summary
    - O. Additional Reporting Requirements:
        - Attendance and Encounter Records

5. 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.

W. COMMUNITY-BASED RESIDENTIAL 1 (CBR 1)

Definition	Community-Based Residential I (CBR1) program provides twenty-four (24) hour locked care and integrated evidence-based treatment that address the behavioral and emotional problems related to adjudicated 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 1 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. CBR1 programs are required to provide transitional supports to the youth and family in order to facilitate discharge to a "stepped-down," less intensive service. This can include home-based follow-up services for up to 60 days post-discharge (See Transitional Support Service standard).
Services Offered	1. Evidence-based treatment interventions and a supportive milieu to implement the services described above. 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. The treatment is family-centered and includes regular, intensive individual and family therapy (at least three (3) therapy sessions a week). At minimum one (1) of these therapy sessions shall be a modality-driven family therapy session in support of safely transitioning the youth to his/her home/community. In cases where there is no family/guardian to participate in family therapy, discussions with probation officer or care coordinator to support transitioning the youth to his/her home/community is acceptable. 5. Comprehensive psychiatric services to include medical evaluation, medication review, adjustment, and monitoring at least once (1) a month or as indicated by treatment plan.

	Psychiatrist is available for consultation with program staff on treatment as needed. 6. On-site DOE educational program that addresses the youth's educational needs including 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 the youth's plan. 9. A documented MHTP that identifies targets of treatment connected to realistic goals will be developed as part of the initial assessment process and includes information from the pre-admission meeting and CMP. The MHTP will be evaluated and revised as necessary, at least monthly as treatment proceeds and will include the youth, family/guardian and other relevant treatment team members. a. The crisis component of the MHTP identifies the youth's problematic behaviors, setting events, triggers and preferred means of calming or regaining control along with the steps the caregivers will take in the event the behavior escalates out of control. The crisis plan builds on available information from the youth's personal safety plan in the CSP. The crisis plan must focus on early intervention for any problematic behavior to reduce the need to take reactive steps. b. The discharge component of the MHTP 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. Planning begins at the pre-admission meeting and is revised throughout treatment to ensure that any potential obstacles to discharge are recognized and addressed before anticipated discharge date. 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 CBR1 provider will notify any other behavioral health provider(s) of the youth's current status to ensure care is coordinated. 12. The CBR1 program will provide, when clinically indicated, direct transitional support services to facilitate a successful discharge from the program and engagement in the step-down services. This service includes home-based intervention to conclude the family therapy work started while in the residential treatment program. When a youth steps-down to another island, telehealth technology shall be used to deliver these interventions (See Transitional Support Service performance

<table>
<tr><td></td><td>standard).</td></tr>
<tr><td>Admission Criteria</td><td><u>All</u> <u>the following criteria must be met:</u>

1. Males only between the ages of twelve (12) and seventeen (17) years old who meet all the following criteria:
a. Youth has a severe emotional and/or behavioral disorder(s);
b. Youth is known to have sexual behavior problems and has engaged in sexually deviant or aggressive behavior for which he was adjudicated;
c. Youth identified as needing specialized treatment and poses a high risk to others based on specialized assessment; 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;
2. The CMP identifies problem areas and treatment strategies to be addressed within this treatment setting;
3. Family/guardian agree to active involvement in treatment and planning meeting;
4. Youth agrees to active involvement in treatment; and
5. 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 crisis plan and reflected in the realistic discharge criteria along with expectations of family/guardian involvement in the treatment process.</td></tr>
<tr><td rowspan="3">Authorizations</td><td colspan="2">CAMHD LOC code: 30403</td></tr>
<tr><td>Unit = one (1) day</td><td>HCPCS code H0019</td></tr>
<tr><td colspan="2">Clinical Lead may authorize up to thirty (30) units per every thirty (30) days for up to ninety (90) days.</td></tr>
<tr><td>Reauthorization</td><td>Clinical Lead may reauthorize up to thirty (30) units per every thirty (30) days for up to ninety (90) days

<u>Threshold:</u>

Average length of CBR1 is ten (10) months with most youth reaching a point of diminishing progress by the eleventh (11) month.</td></tr>
<tr><td rowspan="4">Additional HCPCS Codes</td><td><u>Therapeutic passes:</u>

Clinical Lead may authorize up to five (5) therapeutic passes. A maximum of three (3) units [three (3) days] at a time may be utilized.</td></tr>
<tr><td>CAMHD LOC code: 30774</td></tr>
<tr><td>Unit = one (1) day | HCPCS code H0019 U4</td></tr>
<tr><td><u>Bed holds:</u>

Clinical Lead may authorize up to three (3) bed holds per episode of care.</td></tr>
</table>

	CAMHD LOC code: 30723	
	Unit = one (1) day	HCPCS code H0019 HA
Continuing Stay Criteria	**All** 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 MHTP 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 MHTP 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 CBR1 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 reoffend 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; 6. Youth has demonstrated minimal or no progress toward treatment goals for a three (3) month period and appropriate	

	modification of MHTP has been made and implemented with no 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 and the Center Clinical Lead has been consulted regularly for assistance; 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 other out-of-home service; 2. Not offered at the same time as Intensive In-Home Therapy, Multisystemic Therapy, Functional Family Therapy, Intensive Independent Living Skills, or Adaptive Behavioral Intervention services *except* where the youth will be transitioned out of the CBR1 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; or 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 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 also 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 program has a QMHP who is experienced in evidence-based treatment for sex offenders. The QMHP is responsible for treatment program and those in care.
3. The program must have a QMHP for on call coverage twenty-four (24) hours per day/seven (7) days a week.
4. Staff providing therapy must be a licensed QMHP or 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/clinical supervisor;
   d. QMHP or MHP therapist;
   e. Licensed Registered Nurse;
   f. CSAC on staff or contracted consultant;
   g. Paraprofessional residential counselor levels 1 or 2;
   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. Program shall have weekly case reviews with all levels of staffing to ensure everyone is knowledgeable about youths' treatment target and interventions to support their progress.
10. Youth that are ill or otherwise unable to attend school must be supervised by an available staff wherever the youth is located.
11. The DOE 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).
12. The CSAC will provide 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 month. The provider must assure that each youth receives the needed psychiatric services either through the agency psychiatrist or private practitioner if the youth is under the care of a private provider. The psychiatrist shall also provide regular consultation to staff around medication, diagnosis and other clinical issues.
14. The psychiatrist is available for medical or 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. If the youth requires hospitalization, the psychiatrist shall be available to assist and 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 also 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 Contractor is cognizant of community safety and risk issues and has policies, procedures, and the mechanisms to effectively assess and manage identified risk.
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 developed in the CSP identifies effective youth self-calming strategies 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 MHTP and crisis plan within the milieu.
8. The MHTP documents targets of treatment that are reflective of the youth's admission behaviors/symptom along with realistic goals and discharge criteria within ten (10) days of admission as part of the initial assessment process and preadmission meeting. The MHTP and crisis 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. The discharge plan component of the MHTP will document 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 is 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 shall 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 shall 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 shall have 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. Requests for police assistance or crisis hotline assistance are 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 Center where the youth is registered to seek approval from the CAMHD Medical Director or designee for such staffing to help stabilize the youth (See Ancillary performance standard for one-on-one Paraprofessional Support).
21. The Contractor must perform a Summary Annual Evaluation for 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).
22. Up to five (5) therapeutic passes are allowed per episode of care for each youth in the program to assist him 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. Up to three (3) 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, adjudicated to the Hawaii Youth Correctional Facility or on elopement status per episode of care.
24. Youth who are discharged from the program due to acute admission, detainment, adjudication or elopement status, will be given priority and expedited readmission if admission is sought within a thirty (30) day period from discharge. This means they shall have priority for any open bed, and a new referral packet shall not be required.
25. Please see Section I General Standards for additional clinical operation requirements:
    - A. Core Components of Current CAMHD System
        - Commitment to Clinical Excellence & Co-management of Care

- E. Referral Process for Contracted Services:
- F. Commitment to Serve All Youth;
- G. Training;
- H. Supervision;
- I. Credentialing;
- L. Service Quality;
- N. Risk Management:
- O. Additional Reporting Requirements
  - Weekly Census Report of Client Status
- P. Youth Rights and Confidentiality
- Q. Bed Holds and Therapeutic Passes

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 MHTP identifying targets of treatment with realistic goals 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 CBR1 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 72 hours of service.
   a. Individual/family/group therapy progress notes are place in the chart.
   b. The psychiatrist shall document at least one monthly face-to-face progress note in the youth's chart.
   c. Every nursing contact, including medication administration shall be documented and placed in the youth's chart.
   d. At least once a week progress note by the responsible educational/recreational/occupational specialist are placed in the chart.
3. To ensure continuity of care, the provider is required to provide discharge summaries as described in the general standards within ten (10) days calendar of discharge.
4. Please see Section I General Standards for additional documentation requirements:
   - D. Service/Treatment Planning:
     - Mental Health Treatment Plan including crisis and discharge components. If any major changes occur in the course of treatment, the all components of the MHTP should be updated;
     - Discharge Summary;
   - J. Billing;
   - N. Maintenance of Service Records:
     - Progress Notes;
     - Monthly Treatment and Progress Summary;
   - O. Additional Reporting Requirements:
     - Attendance and Encounter Records.
5. 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.

The 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.

X. HOSPITAL-BASED RESIDENTIAL (HBR)

Definition	Hospital-based Residential (HBR) offers a high level of intensive psychiatric and nursing intervention 24-hours per day, 7 days a week. HBR service consists of a full range of diagnostic and therapeutic services offered with the 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, including youth with co-occurring mild developmental disabilities who are eligible for CAMHD services. This service is required to provide comprehensive psychiatric and medical evaluation, medication titration, symptom stabilization and intensive brief treatment of up to sixty (60) days. The highly structured program also provides individual, family, and group therapy with integrated service planning through a multi-disciplinary assessment of the youth in a 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 consisting of psychiatry, psychology, social work and nursing. The services include assessment, an intensive structured treatment milieu, evidenced-based therapy and activities designed to improve the functioning of the youth served with integrated service planning and an educational program. 2. A child and adolescent psychiatrist is the lead clinician and provides documented observation, assessments and treatment at least three (3) 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. Psychological services are available for testing and therapy as needed. 4. The treatment is family-centered and includes regular, intensive individual and family therapy (at least three (3) therapy sessions a week). At minimum one (1) of these therapy sessions shall be a modality-driven family therapy session in support of safely transitioning the youth to his/her home/community. In cases where there is no family/guardian to participate in family therapy, discussions with social worker or care. 5. Group therapy at a minimum five (5) times a week. 6. The program maintains an orderly and predictable routine of therapeutic activities consistent with a trauma-informed approach designed to improve behavior and functioning.

	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 assessment, counseling and education as indicated in the youth's plan. 9. A documented MHTP that identifies targets of treatment connected to realistic goals will be developed as part of the initial assessment process and includes information from the pre-admission meeting and CMP. The MHTP will be evaluated and revised as necessary, at least monthly as treatment proceeds and will include the youth, family/guardian and other relevant treatment team members. a. The crisis component of the MHTP identifies the youth's problematic behaviors, setting events, triggers and preferred means of calming or regaining control along with the steps the caregivers will take in the event the behavior escalates out of control. The crisis plan builds on available information from the youth's personal safety plan in the CSP. The crisis plan must focus on early intervention for any problematic behavior to reduce the need to take reactive steps. b. The discharge component of the MHTP 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. Planning begins at the pre-admission meeting and is revised throughout treatment to ensure that any potential obstacles to discharge are recognized and addressed before anticipated discharge date. 10. Treatment is designed to include all members of the family, not just the specific youth through regular family therapy. 11. If the youth is involved in treatment with another behavioral health provider(s) then, with proper consent, the HBR provider will notify any other behavioral health provider(s) of the youth's current status to ensure care is coordinated.
Admission Criteria	**All** the following criteria must be met: 1. **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;

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<tr><td></td><td>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; or
iv. Active hallucinations, bizarre or delusional behavior, or intoxication resulting in danger to self or others;
2. The youth requires intensive, coordinated multi-disciplinary psychiatric intervention within a locked therapeutic milieu;
3. 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;
4. The CMP identifies problem areas and treatment strategies to be addressed within this treatment setting;
5. Family/guardian agree to active involvement in treatment and planning meetings;
6. Youth agrees to active involvement in treatment; and
7. 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 crisis plan and reflected in the realistic discharge criteria along with expectations of family/guardian involvement in the treatment process.</td></tr>
<tr><td rowspan="3">Authorizations</td><td colspan="2">CAMHD LOC code: 31101</td></tr>
<tr><td>Unit = one (1) day</td><td>HCPCS code H0017</td></tr>
<tr><td colspan="2">Clinical Leads shall request HBR pre-authorization at least two (2) calendar days prior to admission. The authorization may be up to fifteen (15) units with review and approval of the CAMHD Medical Director or designee.</td></tr>
<tr><td>Reauthorization</td><td colspan="2">Clinical Lead may request reauthorization of 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 reauthorization period.</td></tr>
<tr><td>Continuing Stay Criteria</td><td colspan="2"><u>All</u> <u>the following criteria are met as determined by clinical review</u>:

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 previously unidentified symptoms/behaviors have emerged that continue to meet admission criteria;</td></tr>
</table>

	b. Symptoms continue despite treatment or a reaction to treatment efforts (psychosocial or medication) has caused a regression or unexpected response; or c. Symptoms and functional impairments continue despite modifications to treatment plan; 2. The documented MHTP and crisis 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 MHTP has been developed in consultation with the Center Clinical Lead and shared with relevant team members; 3. The MHTP 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- HBR 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; 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** (1) of the following criteria: 1. 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; 2. The individual's documented treatment plan goals and objectives have been substantially met; 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	HBR is not considered medically necessary and will not be authorized under the following circumstances:

	1. Not offered at the same time as any other out-of-home services. 2. Not offered at the same time as Intensive In-Home Therapy, Multisystemic Therapy, Functional Family Therapy, Intensive Independent Living Skills, or Adaptive Behavioral Intervention services *except* where the youth will be transitioned out of the HBR 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 used solely for convenience of child protective services housing, as an alternative to incarceration within juvenile justice, as an alternative to specialized schooling or 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 also 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) staff at all times.
2. Staff must be CAMHD credentialed as defined in the general standards.
3. CAMHD will delegate to the HBR programs the credentialing of Qualified Mental Health Professionals only. The Contractor shall follow all CAMHD Credentialing Policies and Procedures related to the credentialing of MHPs and Paraprofessionals level s 1 or 2.
4. The program must be under the direction of a Hawaii licensed ABPN child and adolescent psychiatrist.
5. Psychiatric coverage from a full-time psychiatrist on the unit is required.
6. The program staff ratios need to be adjusted during periods when acuity is high or there is greater activity.
7. Staffing ratios must apply to HBR population and cannot be counted at the same time for staffing of acute or partial populations.

8. 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 also 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 developed in the CSP identifies effective youth self-calming strategies that shall 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 to ensure appropriate and effective MHTP development.
5. Comprehensive multi-disciplinary assessments are performed within forty-eight (48) hours of admission includes consideration of evidence-based treatment options, DSM 5 diagnoses, 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 as needed.
7. The MHTP documents targets of treatment that are reflective of the youth's admission behaviors/symptom along with realistic goals and discharge criteria within ten (10) days of admission as part of the initial assessment process and preadmission meeting. The MHTP and crisis 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. The discharge plan component of the MHTP will document 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 shall 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 HBR services. CAMHD requires a minimum of two (2) day notice prior to admission. No retroactive authorization will be issued if prior authorization was not sought by the provider.
11. The CC and Clinical Lead 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 Lead, 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 Center where the youth is registered to seek approval from the CAMHD Medical Director or designee for such staffing to help stabilize the youth (See Ancillary performance standard for one-on-one Paraprofessional Support).
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 Joint Commission on Accreditation of Healthcare Organizations (JCAHO) guidelines.
16. Therapeutic overnight passes and bed holds are not permitted in HBR programs. Youth are allowed planned therapeutic visits and outing with family members, but these outings are not allowed to be overnight visits.
17. Please see Section I General Standards for additional clinical operation requirements:
    - A. Core Components of Current CAMHD System:
        - Commitment to Clinical Excellence & Co-management of Care;
    - E. Referral Process for Contracted Services;
    - F. Commitment to Serve All Youth;
    - G. Training;
    - H. Supervision;
    - I. Credentialing;
    - L. Service Quality;
    - N. Risk Management:
    - O. Additional Reporting Requirements:
        - Weekly Census Report of Client Status;
    - P. Youth Rights and Confidentiality.

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 admission summary that details the initial diagnosis, mental status, presenting problem, preliminary recommendations and further assessments/testing needed is submitted to the CAMHD Center 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 HBR services.
3. Progress notes should document the course of treatment including a description of the interventions implemented, youth's response, and assessment 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 two (2) 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.
    c. At least one progress note is required per shift throughout the youth's stay.
    d. At least once a week progress note 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. To ensure continuity of care, providers are required to provide discharge summaries as described in the general standards within ten (10) 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 at discharge, statement of status at discharge and any recommended follow-up treatment including medications and follow-up appointments which is given to the parent/guardian at discharge and sent to the referring CAMHD Center.
5. Please see Section I General Standards for documentation requirements including the following:
    - D. Service/Treatment Planning:
        - Mental Health Treatment Plan including crisis and discharge components. If any major changes occur in the course of treatment, the all components of the MHTP should be updated;
        - Discharge Summary;
    - J. Billing;
    - N. Maintenance of Service Records:
        - Progress Notes;
        - Monthly Treatment and Progress Summary;
    - O. Additional Reporting Requirements:
        - Attendance and Encounter Records.

Y. TRANSITIONAL SUPPORT SERVICE (TSS)

Definition	Transitional Support Services are used to help youth who have successfully completed an out-of-home treatment program make a smooth transition out to their family home, DHS-provided resource home, or stepped-down treatment program. This service is provided by a staff member from of the out-of-home program who continues to meet with the youth and family, giving the youth access to support from a known mental health service provider as they cope with the changes involved with shifts in care. A central goal of TSS is to help the youth and family make a smooth transition to a new therapist and a new treatment plan. TSS 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, in the community, at the out-of-home treatment program facility, or via video conferencing/ telehealth technology. The venue for the service should be chosen based on what is preferred by the youth and family.
Services Offered	1. A schedule of regular treatment sessions is planned while the youth is enrolled in the out-of-home program; and goals for these meetings are set with the youth and family as part of discharge planning from the out-of-home program. 2. Usually, the main provider for these transitional sessions will be the youth's primary therapist in the out-of-home program. 3. Interventions may include any of the following: a. Individual work with youth on maintain gains and utilizing skills learned in out-of-home care. This can include relapse prevention and coaching by the therapist to get through stressful times. b. 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 that build on successes achieved in the treatment program. c. 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. Coordinating care with the receiving program and therapist and facilitating transfer of the work to the new provider(s). 4. Development of a Mental Health Treatment Plan (MHTP) that identifies targets of treatment, goals, objectives, and discharge criteria. The planning process will include the youth, family/guardian, and other relevant treatment team members – particularly staff from the receiving step-down program
Admission Criteria	**All** the following criteria must be met: 1. The youth has completed treatment in a CAMHD out-of-home

<table>
<tr><td></td><td>program with at least partial success, and is entering a lower level of care;
2. The youth continues to display behavioral or emotional challenges in the home/community and there is a reasonable likelihood that TSS will lead to specific observable improvements in the youth and family's functioning and/or will help make the new lower level of care more effective;
3. At least one planning meeting is held with the youth, family/guardian, CC, prospective Transitional Support Services therapist, staff of the prospective lower level of care, and other relevant treatment team members to identify treatment targets to be addressed by the TSS prior to discharge from out-of-home program;
4. The family/guardian(s) agree to active involvement in treatment and planning meetings, and the youth is willing to participate.</td></tr>
<tr><td rowspan="3">Authorizations</td><td colspan="2">CAMHD LOC code: 13131</td></tr>
<tr><td>Unit = fifteen (15) minutes</td><td>HCPCS code T1019</td></tr>
<tr><td colspan="2">Clinical Lead may authorize up to eighty (80) units [20 hours] per 30 days.

<u>Billing limits:</u>

Billing for this service must not start until the youth is discharged from the out-of-home program and must not exceed sixteen (16) units [four (4) hours] in any one day. Services shall not be provided during the same hour the youth or family is working with a therapist who is providing another intensive outpatient service such as Intensive In-Home therapy, Independent Living Skills, Adaptive Behavioral Intervention, Multisystemic Therapy or Functional Family Therapy.</td></tr>
<tr><td>Reauthorization</td><td colspan="2">Clinical Lead may reauthorize up to eighty (80) units [20 hours] per 30 days.

<u>Threshold:</u>

This service is transitional in nature and is not expected to last longer than 60 days.</td></tr>
<tr><td>Continuing Stay Criteria</td><td colspan="2"><u>All</u> <u>the following criteria are met as determined by clinical review:</u>
1. All admission criteria continue to be met;
2. The documented MHTP 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 MHTP has been shared with the relevant team members;
3. There is reasonable expectation that continued treatment will enable a smooth transition to the new stepdown service provider or there is reasonable evidence that the youth will decompensate or experience relapse if services are discontinued;</td></tr>
</table>

	4. 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. 5. There is documented evidence of active family involvement in the treatment as required by the MHTP or there is active documented efforts being made to involve them unless contraindicated; and 6. There are documented contacts for coordination of care with the step-down therapist and any other relevant behavioral health providers. 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 and family have begun working well with their stepped-down service provider(s). The new provider has developed a good understanding of what was helpful to the youth/family in the out-of-home treatment and has incorporated the information into the new MHTP; 2. 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; 3. Youth/family has demonstrated minimal or no progress toward treatment goals and clinical review has determined that the youth is not benefiting from this service at this time; 4. 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, despite multiple (at least 3), documented attempts to address the non-participation issues; 5. The youth/family no longer wants to participate in this service and revokes consent.
Service Exclusions	Transitional Support Services are not considered medically necessary and will not be authorized under the following conditions: 1. Not offered at the same time as any hospital or community-based residential treatment service.
Clinical Exclusions	Youth in need of immediate crisis stabilization because of active suicidal, homicidal, or psychotic behavior.

Staffing Requirements:

In addition to the staffing requirements listed in the general standards, these staff requirements must also 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 in most cases this will be the supervising QMHP of the out-of-home program - has oversight and supervision responsibilities for all staff decisions made regarding youth/family

treatment.
2. The TSS Therapist must minimally be credentialed as an MHP with experience working with youth who have serious behavioral or emotional challenges.
3. The Contractor is required to have a QMHP who provides twenty-four (24) hour on-call coverage seven (7) days a week.

Clinical Operations

In addition to the clinical operation 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 clinical operation requirements will supersede the general standards.

1. A planning meeting prior to discharge from the out-of-home program is required to obtain youth, family, CC, Clinical Lead, step-down provider, and other relevant team members' input into symptoms/behavior that are the targets of treatment and reflected in the goals and objectives in the respective MHTPs. The meeting facilitates planning with the receiving stepped-down program provider to ensure the care is coordinated upon release from out-of-home care.
2. The Contractor has process for closing the youth's case in the residential program and opening it in TSS. Contractor also has an established protocol for orienting the youth and family to the TSS.
3. A MHTP that identifies targets of treatment that are reflective of the youth's behaviors/symptom on transfer to TSS 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 MHTP and crisis plan component will be evaluated and revised as necessary as treatment proceeds and will include the youth, family/guardian, CC, and Center Clinical Lead along with other relevant treatment team members.
4. As part of the treatment planning, the discharge component of the MHTP will be developed with the family that specifies realistic indicators that transition to the step-down program is complete including projected timeframe.
5. TSS is 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 relationship with the receiving treatment program develops and their strengths and coping skills increase.
6. Telehealth/video technology may be used when youth and family are on a different island than the residential program provider or when distances are otherwise prohibitive of home visits.
7. The Contractor has policies, which govern the provision of services in natural settings that respects youths' and/or families' right to privacy and confidentiality when services are provided in these settings.
8. 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 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 efforts in the youth's chart.
9. 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.
10. The Contractor has policies and procedures around the use of personal vehicles for

outreach services and for transporting clients when necessary.

11. Please see Section I General Standards for additional clinical operation requirements:
    - A. Core Components of Current CAMHD System
        - Commitment to Clinical Excellence & Co-management of Care
    - E. Referral Process for Contracted Services:
    - F. Commitment to Serve All Youth;
    - G. Training;
    - H. Supervision;
    - I. Credentialing;
    - L. Service Quality;
    - N. Risk Management:
    - O. Additional Reporting Requirements
        - Weekly Census Report of Client Status
    - P. Youth Rights and Confidentiality

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 MHTP identifying targets of treatment with realistic goals, objectives and discharge criteria linked to the admission behavior/symptoms will be submitted to the Center with ten (10) calendar days of admission. This documentation is required for any reauthorization of TSS.
2. TSS Therapists must provide a written progress note for each face-to-face or telehealth contact with the youth and/or family and for planning contacts with the CC or the receiving program's therapist 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 MHTP 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 seventy-two (72) hours of service.
3. A discharge summary is submitted to the Center with ten (10) calendar days of discharge.
4. Please see Section I, General Standards for additional documentation requirements:
    - D. Service/Treatment Planning:
        - Mental Health Treatment Plan including crisis and discharge components. If any major changes occur in the course of treatment, the all components of the MHTP should be updated;
        - Discharge Summary;
    - J. Billing
    - N. Maintenance of Service Records:
        - Progress Notes;
        - Monthly Treatment and Progress Summary

SECTION III:

APPENDIX

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Note: Templates, forms and planning documents will be available for download at http://health.hawaii.gov/camhd/ click on Provider Relations and then form to begin downloads.

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.)

STATE OF HAWAII
DEPARTMENT OF HEALTH
CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
3627 KILAUEA AVENUE ROOM 101
HONOLULU, HAWAII 96816

Policy Number:	**80.600**
Name of Policy:	**Non-Discrimination Policy-Lesbian Gay Bisexual Transgender (LGBT)**
Section: VI	Consumers/Programs/Services/Standards of Practice
Supersedes:	New
Units Affected:	CAMHD-Wide; D Central Administration Office; D Administrative Services; D Clinical Services Office; D Performance Management; D Management Information Systems; D Family Guidance Centers/FCLB
Author(s):	Safe Spaces Committee & Quality Steering Committee
Stakeholders:	r /J
Approved By:	1A _ -
Approval Date:	NOV - 2 20\5
Effective Date:	NOV ..,;,2 2015
Last Revision:	
	For** a revision history, please see **the tracking** Jonn **included with the original P&P manual.
Archived By:	*NIA*
Archive Date:	*NIA*

PURPOSE:

In accordance with state and federal laws, each youth served by the Child and Adolescent Mental Health Division (CAMHD) has the right to receive services in an environment free of harassment and discrimination. The CAMHD is committed to providing a healthy and accepting setting for all youth placed in its care by training and evaluating staff, instituting policies, and educating youth to respect each other. The CAMHD does not tolerate discrimination or harassment by or toward employees, volunteers, contracted providers, or youth.

The purpose of these policy and practice guidelines is to establish operational practices that reinforce our commitment to respect the dignity of Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, lntersex, Asexual, 2 Spirit, Mah.ii (LGBTQIA2SM, aka. LGBT) and gender non-conforming youth and create a safe environment for all members of the CAMHD community,

and ensure 'that all people have equal access to all available services, placement, care, treatment, and benefits provided by the CAMHD.

DEFINITIONS:

For purposes of the policy and practice guidelines, the following definitions apply:

Ally: A heterosexual and/or cisgender person who supports equal civil rights, gender equality, LGBT social movements, and challenges homophobia, biphobia and transphobia.

Asexual: The lack of sexual attraction to anyone, or low or absent interest in sexual activity. It may be considered the lack of a sexual orientation, or one of the four variations thereof, alongside heterosexuality, homosexuality, and bisexuality.

Bisexual: A person who is emotionally, romantically, and sexually attracted to both males and females.

Cisgender: A person whose gender identity corresponds with their sex assigned at birth; not transgender.

Contractor: Any person who is employed directly by an agency or organization that has a contract or Memorandum of Understanding with the CAMHD.

Employee: Any person who is employed directly by the CAMHD (i.e., student interns, trainees, employees, volunteers, and contracted providers).

Discrimination: Any act, policy, or practice that, regardless of intent, has the effect of subjecting any youth to differential treatment as a result of that youth's actual or perceived sexual orientation or gender identity.

Gay: A person who primarily is emotionally, romantically, and sexually attracted to individuals of the same sex, typically in reference to boys or men.

Gender Expression: The manner in which a person expresses his or her gender through clothing, appearance, behavior, speech, etc. Gender expression is a separate concept from sexual orientation and gender identity.

Gender Identity: A person's internal, deeply felt sense of being male or female, regardless of the person's sex at birth.

Gender Dysphoria (GD): A DSM-5 diagnosis in which there is a marked difference between the individual's expressed/experienced gender and the gender others would assign him or her, continuing for at least six months. This condition is only diagnosed when the individual experiences clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Harassment: Includes, but is not limited to: name-calling; disrespectful gestures, jokes, or comments; inappropriate touching; threats of physical or emotional harm or negative consequences (including religious condemnation); physical abuse; sexual abuse, including unwanted sex acts, touching, pantomime, and threats; emotional abuse, such as shunning or isolation; bullying; and cyber-bullying. Attempting to change a youth's sexual orientation or gender identity is also a form of harassment.

Intersex: A variation in sex characteristics including chromosomes, gonads, or genitals that do not allow an individual to be distinctly identified as male or female.

Lesbian: A girl or woman who primarily is emotionally, romantically, and sexually attracted to girls or women.

Mahii: In modern day Hawai'i it is a commonly used slang word for transvestite and transgender persons.

Protected Categories: A characteristic of a person which, by law and/or policy, cannot be targeted for discrimination. For the purpose of this policy the following are protected categories: race, ethnicity, sex, immigration status, disability, national origin, sexual orientation, or gender. identity or expression.

Queer: An umbrella term for sexual and gender minorities that are not heterosexual or cisgender. Queer may be used by those who reject traditional gender identities as a broader, less conformist, and deliberately ambiguous alternative to LGBT.

Questioning: A term used to describe those who are in the process of discovery and exploration about their sexuality orientation or gender identity.

Sexual Orientation: A person's emotional, romantic, and sexual attraction, to individuals of the same sex or of a different sex.

Transgender: A person whose gender identity (their understanding of themselves as male or female) does not correspond with their sex assigned at birth. A transgender girl is a girl whose birth sex was male but who understands herself to be female. A transgender boy is a boy whose birth sex was female but who understands himself to be male.

Youth: Any person ages 3 through 22 receiving services from the CAMHD, referred to the CAMHD for eligibility determination, or receiving services from its contracted providers.

2 Spirit: A modern umbrella term used by some indigenous North Americans to describe or label gender-variant individuals in their communities.

POLICY:

- It shall be the policy of the CAMHD to provide the highest quality of services to youth regardless of their actual or perceived race, ethnicity, sex, immigration status, disability, national origin, sexual orientation, or gender identity or expression.
- All youth served under the CAMHD and its contracted providers shall receive fair and equal treatment, without bias and in a professional and confidential manner based on principles of sound professional practice.
- Employees, volunteers, and contractors that offer services to youth served by the CAMHD shall not discriminate against or harass any youth in their care based on their protected class, including a youth's actual or perceived sexual orientation, gender identity or expression.
- The CAMHD employees and contracted providers shall protect youth from discrimination, physical and sexual harassment or assault, and verbal harassment by other youth, based on a youth's actual or perceived sexual orientation, gender identity or expression, or other protected categories.
- The CAMHD will take all reasonable steps within its control to meet the diverse needs of all youth, employees, and contractors and provide an environment in which all individuals are treated with respect and dignity, regardless of protected categories, including sexual orientation, gender identity or expression.

General Operations

- All youth need to feel safe in their surroundings in order to fully benefit from mental health services. The CAMHD shall establish and maintain a culture where the dignity of every youth is respected and all youth feel safe. Employees shall create opportunities for dialogue with youth and staff about all forms of diversity to increase tolerance and respect.
- The CAMHD will promote the positive adolescent development of all youth in its care. Actions that support positive adolescent development include: modeling desired behavior such as demonstrating respect for all youth; reinforcing respect for differences amongst youth, encouraging the development of healthy self-esteem in youth, and helping youth manage the stigma sometimes associated with difference.
- Employees should model positive behavior when interacting with LGBT youth and remind all youth that anti-LGBT threats of violence, actual violence, or disrespectful or suggestive comments or gestures, will not be tolerated.
- The CAMHD intends to provide a safe and non-discriminatory environment where youth can learn and grow. Employees of the CAMHD and its contracted providers shall not prohibit or discourage communication or interaction between youth of the same sex that is not also prohibited or discouraged between youth of different sexes. Expressions of romantic or emotional attraction between youth of the same sex that do not include sexual activity are not prohibited and shall not result in punishment.
- The CAMHD shall provide LGBT youth with access to educational, rehabilitative, recreational, and other programming on the same basis as other youth. Youth shall not be denied qualification for or access to programming based on sexual orientation or gender identity or expression.

Confidentiality

- Employees shall not disclose a youth's sexual orientation or gender identity to other youth at the facility or to outside parties, individuals, or agencies, such as health care or social service providers or a youth's family and friends, without the youth's permission, unless such disclosure is necessary to comply with state or federal law.
- Any disclosure of confidential information related to a youth's LGBT identity shall be limited to information necessary to achieve the specific beneficial purpose of the disclosure.
- This confidentiality restriction does not prevent individuals working at the CAMHD from discussing a youth's needs or services with other staff members or when resolving a grievance.

Intake

- Staff should be aware that LGBT youth are in various stages of awareness and comfort with their sexual orientation and gender identity. Youth intake interviewers shall sensitively inquire about fears the youth may have, but intake workers should not directly ask youth if they are LGBT. Some youth will disclose that they are LGBT. If a youth discloses their sexual orientation or gender identity, the intake worker should talk with the youth about it in an open and non-judgmental fashion and determine if the youth has particular concerns or needs related to being LGBT.

Youth Placement

- Placement decisions for LGBT youth shall occur as soon as possible after intake. All classification and placement decisions for youth shall be individualized, based on good practices, and shall prioritize the youth's physical and emotional well-being.

Names and La.nguage

- The CAMHD employees, volunteers, and contractors, shall use respectful language and terminology that does not further stereotypes about LGBT people.
- Employees, volunteers, and contractors of the CAMHD, in the course of their work, shall not refer to youth by using derogatory language in a manner that conveys bias towards or hatred of LGBT people. In particular, employees of the CAMHD and its contractors shall not imply to or tell LGBT youth that they are abnormal, deviant, or sinful, or that they can or should change their sexual orientation or gender identity.
- Transgender youth shall be referred to by their preferred name and the pronoun that reflects the youth's gender identity, even if their name has not been legally changed. All written documentation about a transgender youth shall use the youth's preferred name as well note the youth's legal name recognized by the court.

Clothing and Gender Presentation

- Youth shall be allowed to dress and present themselves in a manner consistent with their gender identity.
- Grooming rules and restrictions, including rules regarding hair, make-up, shaving, etc., shall be the same in male and female units. Transgender girls shall not be required to have a male haircut, or to wear masculine clothing. Transgender boys shall not be required to maintain a female hairstyle, to wear make-up, or to wear feminine clothing.

Medical and Mental Health Care

- If the youth requests assessment or treatment, the **CAMHD** shall provide transgender youth with access to medical and mental health care providers who are knowledgeable about the health care needs of transgender youth. The CAMHD will provide all recommended transgender-related treatments in accordance with the medical and mental health assessments performed by the youth's health care provider and will provide transportation for the youth to receive such treatments, if necessary.
- In accordance with accepted health care practices which recognize that attempting to change a person's sexual orientation or gender identity is harmful, the CAMHD and its contracted providers shall not employ or contract with mental health providers who attempt to change a youth's sexual orientation or gender identity.
- All sex offender treatment shall not discriminate based on sexual orientation and gender identity and shall not criminalize or pathologize LGBT identity.

PROCEDURES:

Training of Employees, Volunteers,* & *Contractors

- In order for employees, volunteers, and contractors to have the awareness and capacity to effectively work with LGBT youth, all CAMHD administrators, employees, volunteers, and contractors are required to attend training on working with LGBT youth. This training should teach participants: 1) the goals and requirements of the Nondiscrimination Policy and Practice Guidelines Regarding LGBT Youth; 2) how to work with LGBT youth in a respectful and non-discriminatory manner; and 3) how to recognize, prevent, and respond to harassment against LGBT youth.
- All employees and administrators of the CAMHD shall receive training about LGBT youth during their orientation and as part of their continuing education requirements. These trainings shall be taught by a qualified trainer with expertise in working with LGBT youth.
- All new administrators, employees, volunteers, and contractors shall receive a copy of the Policy and Practice Guidelines with their orientation materials. Current administrators, employees, volunteers, and contractors shall receive a copy of the Policy and Practice Guidelines before it is to go into effect.

Responsibilities of Employees and Contractors to Respond to and Report Harassment

- Contractors of the **CAMHD** shall promptly and appropriately intervene when a youth physically, verbally, or sexually abuses or harasses another youth based on the youth's actual or perceived sexual orientation or gender identity, when youth are in the contractors' custody or care.
- All employees and contractors shall be required to report all incidents in violation of this policy in accordance with Sentinel Event and Reportable Incident procedures. Failure to report an incident may result in disciplinary actions or other consequences.
- The CAMHD employees and contracted providers have an obligation to report conduct by other employees and contractors that may be in violation of this policy to the other individual's supervisor and the CAMHD administration (Performance Management).

Reporting Procedures for Youth
Youth shall be able to report violations of this policy following established agency and/or CAMHD grievance procedures. Grievance procedures shall protect confidentiality of youth and contain other measures to prevent retaliation.

Enforcement
Supervisory and management staff shall treat all reports of violations of this policy seriously. The CAMHD administration shall promptly and effectively respond to grievances filed by youth and shall take swift action according to established procedures when employees or contractors report violations.

SCOPE:

This policy shall apply to all employees of the CAMHD, to employees or representatives of any agency providing services on behalf of youth at the CAMHD, including but not limited to the Department of Health, Department of Human Services, Department of Education, their contractors, volunteers, and any other relevant agencies or departments which have contact with youth served by the CAMHD.

Severability
The provisions of the Policy and Practice Guidelines shall be severable. If any provision or portion of this policy or its application to any person or circumstance is held invalid, the remainder of this policy or the application of the provision to other persons or circumstances is not affected.

References		
Source	**Number**	**Area**
CAMHD Policy		
Federal Law		
Hawaii Law		
Contract Requirements		
Other		

Attachments
A.
B.

SAFETY PLAN - CRISIS PREVENTION PLAN

Youth's name: **Date:**

PROBLEM BEHAVIORS: These are behaviors I sometimes show, especially when I'm stressed:

- ☐ Losing control
- ☐ Injuring myself
- ☐ Assaulting people
- ☐ Attempting suicide
- ☐ Feeling suicidal
- ☐ Threatening others
- ☐ Running away
- ☐ Using alcohol
- ☐ Using other drugs
- ☐ Feeling unsafe
- ☐ **Other (please describe)**

TRIGGERS: When these things happen, I am more likely to feel unsafe and upset:

- ☐ Not being listened to
- ☐ Loud noises
- ☐ Darkness
- ☐ Contact with family
- ☐ Feeling pressured
- ☐ Feeling lonely
- ☐ Being stared at
- ☐ Particular person:
- ☐ Being touched
- ☐ Arguments
- ☐ Being teased
- ☐ **Other (please describe)**
- ☐ Lack of privacy
- ☐ Not having control
- ☐ Particular time of day:
- ☐ People yelling
- ☐ Being isolated
- ☐ Particular time of year

WARNING SIGNS: These are things other people may notice me doing if I begin to lose control:

- ☐ Sweating
- ☐ Red faced
- ☐ Acting hyper
- ☐ Being Rude
- ☐ Eating more
- ☐ Singing inappropriately
- ☐ Breathing hard
- ☐ Wringing hands
- ☐ Swearing
- ☐ Pacing
- ☐ Eating less
- ☐ **Other (please describe)**
- ☐ Racing heart
- ☐ Loud voice
- ☐ Bouncing legs
- ☐ Crying
- ☐ Not taking care of myself
- ☐ Clenching teeth
- ☐ Sleeping a lot
- ☐ Rocking
- ☐ Squatting
- ☐ Isolating/avoiding people
- ☐ Clenching fists
- ☐ Sleeping less
- ☐ Can't sit still
- ☐ Hurting things
- ☐ Laughing loudly/giddy

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
- ☐ Talking with friends
- ☐ Exercising
- ☐ Taking a hot shower
- ☐ Ripping paper
- ☐ Bouncing a ball
- ☐ Drawing
- ☐ Being around others
- ☐ Calling family (who?)
- ☐ Listening to music
- ☐ Talking with an adult
- ☐ A cold cloth on face
- ☐ Taking a cold shower
- ☐ Screaming into pillow
- ☐ Male staff support
- ☐ Being read a story
- ☐ Doing chores/jobs
- ☐ **Other (please describe):**
- ☐ Reading a book
- ☐ Coloring
- ☐ Writing in a journal
- ☐ Playing cards
- ☐ Holding ice in my hand
- ☐ Female staff support
- ☐ Making a collage
- ☐ Cold water on hands
- ☐ Sitting with staff
- ☐ Molding clay
- ☐ Punching a pillow
- ☐ Video Games
- ☐ Getting a hug
- ☐ Deep breathing
- ☐ Crying
- ☐ Drinking hot herb tea
- ☐ Pacing
- ☐ Humor
- ☐ Hugging a stuffed animal
- ☐ Lying down
- ☐ Using the gym
- ☐ Speaking w/ my therapist
- ☐ Snapping bubble wrap
- ☐ Using a rocking chair

THINGS THAT MAKE IT WORSE: These are things that do NOT help me calm down or stay safe:

- ☐ Being alone
- ☐ Being disrespected
- ☐ Being reminded of the rules
- ☐ Being around people
- ☐ Loud tone of voice
- ☐ Being touched
- ☐ Humor
- ☐ Being ignored
- ☐ **Other (please describe)**
- ☐ Not being listened to
- ☐ Having staff support
- ☐ Peers teasing
- ☐ Talking to an adult

STATE OF HAWAII
DEPARTMENT OF HEALTH
CHILD AND ADOLESCENT MENTAL HEALTH DIVISION

Initial Mental Health Evaluation

Name of Youth:	DOB:
Youth CR#:	Date of Assessment:
Gender Identity:	Age at Assessment: y m
School:	Grade:
Guardians:	Education Status: ☐General Education ☐IDEA ☐504
Collateral Contacts:	Examiner:

I. Referral Source:
☐Parent ☐Department of Human Services (DHS) ☐Department of Education (DOE)
☐Court/Probation ☐Physician ☐Self ☐Other

II. Reason for Referral/Chief Complaint:
History of current problem:

III. Current Problems in functioning—Interview Participant(s):

A. Describe current issues in each domain, then use this information to complete the Child and Adolescent Functional Assessment Scale (CAFAS)
(Describe and rate most severe level for past 30 days using CAFAS manual):

1. School:
   CAFAS item number:
   Impairment: ☐none (0) ☐mild (10) ☐moderate (20) ☐severe (30)
2. Home:
   CAFAS item number:
   Impairment: ☐none (0) ☐mild (10) ☐moderate (20) ☐severe (30)
3. Community:
   CAFAS item number:
   Impairment: ☐none (0) ☐mild (10) ☐moderate (20) ☐severe (30)
4. Behavior to Others:
   CAFAS item number:
   Impairment: ☐none (0) ☐mild (10) ☐moderate (20) ☐severe (30)
5. Moods/Emotions:
   CAFAS item number:
   Impairment: ☐none (0) ☐mild (10) ☐moderate (20) ☐severe (30)
6. Self-Harm:
   CAFAS item number:

SAMPLE

Impairment: ☐none (0) ☐mild (10) ☐moderate (20) ☐severe (30)

7. Substance Abuse:
   CAFAS item number:
   Impairment: ☐none (0) ☐mild (10) ☐moderate (20) ☐severe (30)
8. Thinking:
   CAFAS item number:
   Impairment: ☐none (0) ☐mild (10) ☐moderate (20) ☐severe (30)
   Total CAFAS score:
9. Other noteworthy problems/concerns:

B. Developmental history:

1. Pregnancy and birth: ☐uncomplicated ☐complicated pregnancy ☐complicated birth ☐wasn't assessed

2. Prenatal exposure to substances: ☐denied ☐suspected ☐known/confirmed ☐wasn't assessed

3. Any abnormalities in development: ☐none ☐motor delays ☐cognitive delays ☐wasn't assessed

4. Pubertal development: ☐ pre-pubertal ☐currently in puberty ☐ post puberty
   For girls - Age at menarchy: ☐ not applicable

5. Issues related to sexuality: ☐ none reported ☐ yes - describe: f
6. Other issues:

C. Medical history:

1. Primary Care Physician:
2. Date of last physical:
3. Any hospitalizations or surgeries: ☐no ☐yes

4. Any head injury or loss of consciousness: ☐no ☐yes

5. Significant medical issues in the youth's past or present: ☐no ☐yes

6. Allergies/drug allergies: ☐no ☐yes

7. Any current problems with:
   i. Eating/appetite ☐no ☐yes
   ii. Sleeping ☐no ☐yes
   iii. Bowel/Bladder control ☐no ☐yes

8. Current medications: ☐no ☐yes

9. Other medical concerns: ☐no ☐yes

D. Psychosocial history:

SAMPLE

1. Youth lives with: ☐birth parent(s) ☐adoptive parent(s) ☐relatives ☐foster family ☐Other:
   Describe any custody/visitation issues:
2. Birth parents' names:

3. Identify everyone living in the current home:

4. Culture/ethnicity of the youth (check all that apply):
   ☐African American ☐Caucasian ☐Chinese
   ☐Filipino ☐Japanese ☐Korean ☐Micronesian
   ☐Native American ☐Native Hawaiian ☐Pacific Islander
   ☐Other
5. Adult employment and household income:

6. Transportation:

E. Factors that have contributed to the youth's difficulties (including ACES scale) - check those that apply and describe:
1. ☐ Emotional abuse:

2. ☐ Physical abuse:

3. ☐ Sexual abuse:

4. ☐ Physical neglect:

5. ☐ Lack of feeling loved and supported:

6. ☐ Breakdown of family (parents separated or divorced):

7. ☐ Violence between intimate partners in the home:

8. ☐ Incarceration of parent figure:

9. ☐ Current or previous substance abuse by parent figure:

10. ☐ Current or previous serious mental health problem in parent figure:

11. ☐ Family poverty/financial problems:

12. ☐ Out-of-home placements:

13. ☐ Multiple moves, multiple schools:

14. ☐ Other difficult events/experiences:

15. ☐ Current instability of parent figures and family setting:

16. ☐ Child Welfare Services involvement -☐ present and/or ☐ past: Reason:

SAMPLE

ACES score [total number of checks on items 1-10]:

F. Family psychiatric and substance abuse history, present or past (if yes, describe):
   1. Mother: ☐no ☐yes ☐unknown
   2. Father: ☐no ☐yes ☐unknown
   3. Youth: ☐no ☐yes ☐unknown
   4. Other Important Family Member: ☐no ☐yes ☐unknown

G. Family strengths/Informal supports:
   1. Youth's interests, strengths:

H. Family Court involvement, and charges/reason:

   Name of probation officer:

IV. Review of Systems *(For Psychiatrists)*
- Psychiatric:
- Constitutional:
- Neurologic:
- Musculoskeletal:
- Other organ systems reviewed:

V. Youth Interview:

A. Youth's view of the presenting problem/chief complaint:

B. Mental Status exam (complete checklist, attached)

SAMPLE

Mental Status Checklist:

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

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

Associations:
- ☐ intact
- ☐ loose
- ☐ circumstantial
- ☐ tangential
- ☐ unable to assess
- ☐ other:

Fund of Knowledge:
- ☐ age appropriate
- ☐ limited
- ☐ impaired
- ☐ unable to assess
- ☐ other:

Memory-Short Term:
- ☐ intact
- ☐ impaired
- ☐ unable to assess
- ☐ other:

Memory-Long Term:
- ☐ intact
- ☐ impaired
- ☐ unable to assess
- ☐ other:

Insight:
- ☐ good
- ☐ fair
- ☐ inconsistent
- ☐ poor
- ☐ unable to assess
- ☐ other:

Judgment:
- ☐ good
- ☐ fair
- ☐ inconsistent
- ☐ poor
- ☐ unable to assess
- ☐ other:

Intelligence:
- ☐ average
- ☐ above average
- ☐ borderline
- ☐ below average
- ☐ unable to assess
- ☐ other:

Comments:

Communication:

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

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

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

Comments:

SAMPLE

General Appearance:

Body Type:
- ☐ age appropriate
- ☐ appears younger than stated age
- ☐ appears older than stated age
- ☐ unable to assess
- ☐ other

Weight:
- ☐ within normal limits
- ☐ underweight
- ☐ overweight
- ☐ unable to assess
- ☐ other:

Hygiene:
- ☐ well-groomed
- ☐ fair
- ☐ disheveled
- ☐ poor
- ☐ unable to assess
- ☐ other:

Eye Contact:
- ☐ good
- ☐ fair
- ☐ poor
- ☐ unable to assess
- ☐ other:

Comments:

Motor:

Fine Motor:
- ☐ advanced
- ☐ normal range
- ☐ mild delays
- ☐ significant delays
- ☐ unable to assess
- ☐ other:

Gross Motor:
- ☐ advanced
- ☐ normal range
- ☐ mild delays
- ☐ significant delays
- ☐ unable to assess
- ☐ other:

Comments:

Regulation:

Attention:
- ☐ intact
- ☐ limited
- ☐ severely impaired
- ☐ unable to assess
- ☐ other:

Activity Level:
- ☐ normal range
- ☐ overactive
- ☐ impulsive
- ☐ agitated
- ☐ lethargic
- ☐ unable to assess
- ☐ other:

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

Transitions:
- ☐ normal response
- ☐ anxious
- ☐ disorganized
- ☐ uncooperative
- ☐ unable to assess
- ☐ other:

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

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

Comments:

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

Comments:

Cognition/Thought Processes:

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

SAMPLE

VI. Additional individuals interviewed:

VII. Additional Assessment Data

A. Assessment Tools used:

B. Results: If assessment tools were used, provide information about test results:

VIII. Motivation for treatment

A. How open is the youth/family to participating in mental health treatment?

B. What does the family and/or the youth hope to get out of mental health Treatment?

IX. Clinical Formulation:

- **Primary Problems to be Addressed:**
  Problem 1:
  Problem 2:
  Problem 3:

X. Diagnostic Impression including DSM-5/ICD10 codes:

Symptoms noted that support this diagnosis:

XI. Clinical Recommendation for CAMHD Services:

Recommend youth be declared: ☐ Eligible ☐ Potentially Eligible Outlier ☐ Not Eligible

Recommended Management Plan for Problem 1:

Recommended Treatment Targets to Begin Services:

Externalizing Behaviors	Internalizing Behaviors	Positive Behaviors	Other Targets
☐ Aggression	☐ Anxiety	☐ Academic Achievement	☐ Cognitive Functioning
☐ Anger	☐ Avoidance	☐ Activity Involvement	☐ Eating/Feeding Prblms
☐ Attention Problems	☐ Depressed Mood	☐ Assertiveness	☐ Enuresis/Encopresis
☐ Fire Setting	☐ Grief	☐ Community Involvement	☐ Health Management
☐ Hyperactivity	☐ Phobia or Fears	☐ Contentment/Happiness	☐ LD/Underachievement
☐ Oppositionality	☐ School Refusal/Truancy	☐ Empathy	☐ Medication Adherence
☐ Peer/Sibling Conflict	☐ Self-Esteem	☐ Peer Involvement	☐ Personal Hygiene
☐ Runaway/Elopement	☐ Self-Injurious Behaviors	☐ Positive Family Fxing	☐ Treatment Engagement
☐ Sexual Misconduct	☐ Suicidality	☐ Positive Peer Interaction	
☐ Substance Use	☐ Traumatic Stress	☐ Positive Thinking	
☐ Willful Misconduct		☐ School Involvement	
		☐ Self-Management/Control	
		☐ Social Skills	
		☐ Treatment Engagement	

SAMPLE

Recommended Management Plan for Problem 2:

Recommended Treatment Targets to Begin Services:

Externalizing Behaviors	Internalizing Behaviors	Positive Behaviors	Other Targets
☐ Aggression	☐ Anxiety	☐ Academic Achievement	☐ Cognitive Functioning
☐ Anger	☐ Avoidance	☐ Activity Involvement	☐ Eating/Feeding Prblms
☐ Attention Problems	☐ Depressed Mood	☐ Assertiveness	☐ Enuresis/Encopresis
☐ Fire Setting	☐ Grief	☐ Community Involvement	☐ Health Management
☐ Hyperactivity	☐ Phobia or Fears	☐ Contentment/Happiness	☐ LD/Underachievement
☐ Oppositionality	☐ School Refusal/Truancy	☐ Empathy	☐ Medication Adherence
☐ Peer/Sibling Conflict	☐ Self-Esteem	☐ Peer Involvement	☐ Personal Hygiene
☐ Runaway/Elopement	☐ Self-Injurious Behaviors	☐ Positive Family Fxing	☐ Treatment Engagement
☐ Sexual Misconduct	☐ Suicidality	☐ Positive Peer Interaction	
☐ Substance Use	☐ Traumatic Stress	☐ Positive Thinking	
☐ Willful Misconduct		☐ School Involvement	
		☐ Self-Management/Control	
		☐ Social Skills	
		☐ Treatment Engagement	

Recommended Management Plan for Problem 3:

Recommended Treatment Targets to Begin Services:

Externalizing Behaviors	Internalizing Behaviors	Positive Behaviors	Other Targets
☐ Aggression	☐ Anxiety	☐ Academic Achievement	☐ Cognitive Functioning
☐ Anger	☐ Avoidance	☐ Activity Involvement	☐ Eating/Feeding Prblms
☐ Attention Problems	☐ Depressed Mood	☐ Assertiveness	☐ Enuresis/Encopresis
☐ Fire Setting	☐ Grief	☐ Community Involvement	☐ Health Management
☐ Hyperactivity	☐ Phobia or Fears	☐ Contentment/Happiness	☐ LD/Underachievement
☐ Oppositionality	☐ School Refusal/Truancy	☐ Empathy	☐ Medication Adherence
☐ Peer/Sibling Conflict	☐ Self-Esteem	☐ Peer Involvement	☐ Personal Hygiene
☐ Runaway/Elopement	☐ Self-Injurious Behaviors	☐ Positive Family Fxing	☐ Treatment Engagement
☐ Sexual Misconduct	☐ Suicidality	☐ Positive Peer Interaction	
☐ Substance Use	☐ Traumatic Stress	☐ Positive Thinking	
☐ Willful Misconduct		☐ School Involvement	
		☐ Self-Management/Control	
		☐ Social Skills	
		☐ Treatment Engagement	

XII. Evaluator:

Comments:

Other Recommendations:

The assessment formulation is based on the information provided at the time of this report. Any new or additional information may alter the diagnostic impression. Please contact the Evaluator with any questions or comments:

Evaluator Name:	Contact Phone:
Evaluator Agency:	Contact Email:

Respectfully submitted,

Date:

SAMPLE

To be completed with the youth and care givers when safety is a prominent concern. The completed plan should be distributed to treatment team members by the Mental Health Care Coordinator from the Family Guidance Center. Copies should be given to the youth and caregivers for reference.

Youth's name: **Date:**

Part 1. Crisis Prevention Plan – how to keep safe

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):**

SAMPLE

☐ 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:

==========

Part 2: Crisis Intervention Plan - Strategies to use if the prevention and support strategies (Part 1) are not effective.

SIGNS THAT I MAY NOT BE ABLE TO STAY SAFE: Thoughts, feelings, actions that indicate loss of control

- _____
- _____
- _____
- _____
- _____
- _____

SAMPLE

SUPPORT PEOPLE: People I can call or have someone call when I have these thoughts, feelings, or actions.

If you cannot reach the first person go down the list until you reach someone.

NAME	RELATIONSHIP TO YOUTH	PHONE NUMBER

Help Statement: This is my clear and specific statement to let my support person know what I need:

_____

Crisis Support: If all of my coping strategies have not worked and I cannot reach a support person, I will call crisis support:

Crisis Line: 1-800-753-6879 Suicide Prevention Line: 800-273-TALK (8255) Crisis Text Line: 741741 Dial 911 or go to the Emergency Room	TELL THE CRISIS WORKER: 1) If you plan to harm yourself or someone else or already have – BE SPECIFIC 2) How long you will be able to remain safe 3) Where you are and with whom (if anyone)

Youth Signature: _____ Date: _____

Parent Signature: _____ Date: _____

Staff/Therapist Signature: _____ Date: _____

SAMPLE

STATE OF HAWAII
DEPARTMENT OF HEALTH
CHILD AND ADOLESCENT MENTAL HEALTH DIVISION

Summary Annual Evaluation – Template

Name of Evaluator:		Date of Summary:
Role of the Evaluator: ☐ Treating clinician ☐ CAMHD Clinical Lead ☐ Other		
Name of Child:		DOB:
Gender: ☐ Male ☐ Female ☐ Other:	Age at Time of Summary: y m	
School:	Grade:	
Guardians:	Education Status: ☐ Regular Ed ☐ IDEA ☐ 504	
Collateral Contacts who provided information:		

I. Current CAMHD Primary Type of Care: Case Management only
Describe current services:

II. Chief complaint/reason for treatment:

III. Current Problems in Functioning
(Describe and rate most severe level for past 30 days using CAFAS manual):

1. Home:
CAFAS item number:
Impairment: ☐ none 0 ☐ mild 10 ☐ moderate 20 ☐ severe 30
2. School:
CAFAS item number:
Impairment: ☐ none 0 ☐ mild 10 ☐ moderate 20 ☐ severe 30
3. Community:
CAFAS item number:
Impairment: ☐ none 0 ☐ mild 10 ☐ moderate 20 ☐ severe 30
4. Behavior to Others:
CAFAS item number:
Impairment: ☐ none 0 ☐ mild 10 ☐ moderate 20 ☐ severe 30
5. Moods/Emotions:
CAFAS item number:
Impairment: ☐ none 0 ☐ mild 10 ☐ moderate 20 ☐ severe 30
6. Self-Harm:
CAFAS item number:
Impairment: ☐ none 0 ☐ mild 10 ☐ moderate 20 ☐ severe 30
7. Substance Abuse:
CAFAS item number:
Impairment: ☐ none 0 ☐ mild 10 ☐ moderate 20 ☐ severe 30
8. Thinking:
CAFAS item number:
Impairment: ☐ none 0 ☐ mild 10 ☐ moderate 20 ☐ severe 30

SAMPLE

Total CAFAS score:

9. Other noteworthy problems/concerns:

A. Family information:
   1. Child resides with: ☐birth parent(s) ☐adoptive parent(s) ☐relatives ☐foster family ☐Other:
      Describe any custody/visitation issues:
   2. Who do you consider to be the youth's primary parent/caregiver currently?
      Name:
      Relationship: ☐ birth parent ☐ adoptive parent ☐ grandparent ☐ hanai parent/other relative ☐ other – please describe:
   3. Current involvement of the primary parent(s)/caregiver(s) in the youth's mental health services:
      ☐Fully engaged in treatment;
      ☐Cooperative and supportive, but only partially engaged;
      ☐Somewhat supportive but minimally engaged;
      ☐Detached from treatment;
      ☐Hostile toward treatment
      ☐ Other:
      Describe how the family is interacting with treatment providers currently:

B. Which of the following adverse experiences have happened to the youth ***during the past year***? Check those that apply and describe:
   1. ☐ Emotional abuse:
   2. ☐ Physical abuse:
   3. ☐ Sexual abuse:
   4. ☐ Physical Neglect:
   5. ☐ Lack of feeling loved and supported (emotional neglect):
   6. ☐ Breakdown of family (parents separated or divorced):
   7. ☐ Violence between intimate partners in the home:
   8. ☐ Incarceration of parent/s:
   9. ☐ Current substance abuse by parent figure:
   10. ☐ Current serious mental health problem in parent figure:
   11. ☐ Family Poverty/financial problems:
   12. ☐ Out-of-home placements:
   13. ☐ Family move

SAMPLE

14. ☐ Change in schools:

15. ☐ Current instability of parent figures and family setting:

16. ☐ CWS involvement during past year:
    Reason: Describe:
17. ☐ Other difficult events/experiences:

18. Has any past traumatic experience come to light in the past year that was previously unknown to service providers? ☐ No ☐ Yes please describe:
19. Please describe important changes over the past year in:
    a. Youth's physical health/development:
    b. Psychotropic medications:
    c. Youth's school behavior/education:
    d. Youth's family situation:
    e. Youth's legal situation:

IV. Current Risk Assessment (based on interviews with the child and adult informants)

Suicide:
Overall level of concern: No Evidence of Need Comments:
Self-Harm:
Overall level of concern: No Evidence of Need Comments:
Violence toward others/assaultive behavior:
Overall level of concern: No Evidence of Need Comments:
Sexual Behavior issues:
Overall level of concern: No Evidence of Need Comments:
Child Abuse or Neglect:
Overall level of concern: No Evidence of Need Comments:
Substance Use/Abuse:
Overall level of concern: No Evidence of Need Comments:
Runaway/Elopement:
Overall level of concern: No Evidence of Need Comments:

V. Describe progress made by the youth/family over the past year:

Overall Progress rating: Deterioration from baseline

VI. Diagnostic Impression including DSM-5/ICD10 codes:
Current Diagnoses of Record: 1) 2) 3)
Does this diagnosis still apply?
☐ Yes - Symptoms noted that support this diagnosis

☐ Consider changing or adding a diagnosis - Signs/symptoms noted recently that suggest a need for further assessment or change in diagnosis:

SAMPLE

Mental Status Checklist:

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:

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:

Comments:

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

Comments:

Cognition/Thought Processes:

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

SAMPLE

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:

SAMPLE

Recommendations:

Respectfully Submitted:

Evaluator Date

Supervising QMHP (if applicable) Date

Clinical Management Plan

Youth: Name	CRN: 123456	DOB: m/d/yy	Age: #y #m	Gender Identity: select or enter text here
School: XYZ Intermediate	Grade: #	Education Status: select		FGC: select
Care Coordinator: Name	MHS1: Name			Clinical Lead: Name
Diagnoses: From IMHE				

Date of Initial Plan: select

A. Treatment Focus Areas & Treatment Targets

Treatment Focus Area 1	*Treatment Target 1a*	*Treatment Target 1b*	*Treatment Target 1c*
From IMHE…	Externalizing Behaviors Internalizing Behaviors Positive Behaviors More Targets Other	Externalizing Behaviors Internalizing Behaviors Positive Behaviors More Targets Other	Externalizing Behaviors Internalizing Behaviors Positive Behaviors More Targets Other
Date: select *Status:* select			
Treatment Focus Area 2	*Treatment Target 2a*	*Treatment Target 2b*	*Treatment Target 2c*
From IMHE…	Externalizing Behaviors Internalizing Behaviors Positive Behaviors More Targets Other	Externalizing Behaviors Internalizing Behaviors Positive Behaviors More Targets Other	Externalizing Behaviors Internalizing Behaviors Positive Behaviors More Targets Other
Date: select *Status:* select			
Treatment Focus Area 3	*Treatment Target 3a*	*Treatment Target 3b*	*Treatment Target 3c*
From IMHE…	Externalizing Behaviors Internalizing Behaviors Positive Behaviors More Targets Other	Externalizing Behaviors Internalizing Behaviors Positive Behaviors More Targets Other	Externalizing Behaviors Internalizing Behaviors Positive Behaviors More Targets Other
Date: select *Status:* select			

B. Additional Recommendations for Other Assessments

Mental Health Assessment: From IMHE…

Other Assessment or Medical Consult: From IMHE…

SAMPLE

C. Treatment Services & Transition / Step-Down Plans

Treatment Services

	Date	*Authorized Service*	*Anticipated Duration*	*Comments*	*End Date*
1)	select	select	# months	Comments…	select

Transition / Step-Down Plans

	Date	*CAMHD Services*							*Other Services*		
1)	select	☐ABI	☐FEP	☐FFT	☐IIH	☐IILS	☐IOH	☐MST ☐TSS	☐AMHD	☐CCS	☐OP Med Mgmt
		☐CBR		☐HBR		☐TFH		☐TRH	☐OP Therapy	☐SBBH	☐Other
		☐Case Mgmt		☐Kaeru		☐Kealahou		☐Med Mgmt ☐PSS	☐Other	☐Other	☐Other

Comments…

D. Additional Comments / Information / Considerations / Notes / Tasks

Comments…

Completed by:

Name _____ Role / Title _____ _____ Date _____

Signature

SAMPLE

Case Review

Youth: Name	CRN: 123456	DOB: m/d/yy	Age: #y #m	Gender Identity: select or enter text here
School: XYZ Intermediate	Grade: #	Education Status: select		FGC: select
Care Coordinator: Name	MHS1: Name			Clinical Lead: Name
Diagnoses: From IMHE				

Date of Case Review: select

A. Relevant Updates

Family ..... Enter text here or select No Update
Community Supports ..... Enter text here or select No Update
Care Coordination ..... Enter text here or select No Update
Mental Health ..... Enter text here or select No Update
Primary Care ..... Enter text here or select No Update
School ..... Enter text here or select No Update
Court ..... Enter text here or select an option
Child Welfare ..... Enter text here or select an option
Transition to Adulthood ..... Enter text here or select an option
Upcoming Transitions ..... Enter text here or select No Update
Upcoming Meetings ..... Enter text here or select No Update

B. Treatment Services

Current treatment is medically necessary: select *Plan:* select *Progress Status:* select

Comments…

C. Follow-Up Tasks / Activities *Date of Next Review:* select

Clinical Lead: Task… *Care Coordinator:* Task…

SAMPLE

Coordinated Service Planning

Current Situation	Contact	Status	Primary Goal(s)	Supports	Plan
Family	**Guardian**: **Home Phone**: (808) **Work**: (808) **Cell**: (808) **Other**: (808) **E-mail**: **Mailing Address** **Primary Caregiver if different from above**:	**Living Situation** ☐ **At home with:** ☐ **In DHS Foster Home** ☐ **In Tx Placement:** ☐ **Other:**		**Strengths**: **Resources/Informal Supports**: **Incentives**: **HFAA involved** ☐ **No** ☐ **Yes**	**HFAA Family Improvement Plan**: ☐ **N/A** ☐ **No** ☐ **Yes (date of plan):** **Comments**: **Date Plan Requested**:
Care Coordination	**Name**: **Phone**: (808) **Fax**: (808) **E-mail**: **Mailing Address**	**Type of Eligibility:** ☐ **SEBD** **(and/or)** ☐ **ES**	☐ **Family Engagement** ☐ **Needs Assessment** ☐ **Clinical Review and Formulation** ☐ **Authorize Clinically Appropriate Services** ☐ **Monitor Progress** ☐ **Other**	☒ **Intensive Case Management** ☐ **Referrals** ☐ **Coordinate/Facilitate Meetings** ☐ **System-education** ☐ **Interpersonal Support** ☐ **Psycho-education** ☐ **Coordinate Travel** ☐ **Other**	**Coordinated Service Plan & Crisis Plan**: **Date:** **Comments**:

SAMPLE

Current Situation	Contact	Status	Primary Goal(s)	Supports	Plan
Mental Health 1 **LOC:** **Agency:** **Start Date:** **End Date:** ☐ **N/A** **Date Revised:**	**Name**: **Title**: **Phone**: (808) **Fax**: (808) **E-mail**: **Mailing Address**	**Type of Eligibility**: ☐ **SEBD** **(and/or)** ☐ **ES** ☐ **Insurance** **MHA:** ☐ **No** ☐ **Yes (date of MHA):** **Current Dx**: **Assessor:** **Comments**:	**Reason for Referral**: **CMP**: ☐ **No** ☐ **Yes (date of CMP):** **Comments**: **Treatment Targets on CMP:** **Treatment Targets on recent TPS:**	**Current Services/Strategies**: **Current Medications**:	**MHTP**: ☐ **No** ☐ **Yes (date of plan):** ☐ **Not a CAMHD Provider** **Comments**: **Date Plan Requested**: **Interventions on MHTP:** **Interventions on recent TPS:**

SAMPLE

Mental Health 2 **LOC:** **Agency:** **Start Date:** **End Date:** ☐ **N/A** **Date Revised:**	**Name**: **Title**: **Phone**: (808) **Fax**: (808) **E-mail**: **Mailing Address**	**Type of Eligibility**: ☐ **SEBD** **(and/or)** ☐ **ES** ☐ **Insurance** **MHA:** ☐ **No** ☐ **Yes (date of MHA):** **Current Dx**: **Assessor:** **Comments**:	**Reason for Referral**: **CMP**: ☐ **No** ☐ **Yes (date of CMP):** **Comments**: **Treatment Targets:** **Treatment Targets on recent TPS:**	**Current Services/Strategies**: **Current Medications**:	**MHTP**: ☐ **No** ☐ **Yes (date of plan):** ☐ **Not a CAMHD Provider** **Comments**: **Date Plan Requested**: **Interventions:** **Interventions on recent TPS:**

SAMPLE

Current Situation	Contact	Status	Primary Goal(s)	Supports	Plan
Primary Care Physician	**Name:** **Phone:** (808) **Fax:** (808) **E-mail:** **Mailing Address**	**Insurance Carrier:** **Member#:**	**Medical Conditions Being Treated:** ☐ **None** **or:**	**Current Medications or Medical Treatments:** ☐ **None** **or:**	
School ☐ **N/A** ☐ **Graduated** ☐ **GED** ☐ **4140** ☐ **College** **Date Revised:**	**Primary Contact**: **Title of Contact:** **Phone**: (808) **Fax**: (808) **E-mail**: **Mailing Address**	**School Attending**: **Grade:** **Select One:** ☐ **IDEA** ☐ **504** ☐ **Regular Ed** ☐ **Other:** ☐ **GED Prep Course** ☐ **Adult Education** ☐ **Community Based Education**	**Academic, Behavioral, and/or Other Goals:**	**Are any supports / services being provided through DOE?** ☐ **No** ☐ **Yes (list below):** ☐ **FBA** ☐ **EBA** ☐ **BSP** ☐ **SBBH** ☐ **School Counseling** ☐ **School SW** ☐ **Surrogate Parent** ☐ **Other**	**Type of Plan**: ☐ **IEP** **Date of Plan:** **DOH/Family Guidance Center written into IEP:** ☐ **No** ☐ **Yes** ☐ **504 Plan** **Date of Plan:** ☐ **BSP** **Date of Plan:** ☐ **N/A** **Date Plan Requested**:

SAMPLE

Current Situation	Contact	Status	Primary Goal(s)	Supports	Plan
Court ☐ **N/A** **Date Revised:**	**Name**: **Phone**: (808) **Fax**: (808) **E-mail**: **Mailing Address** **Is OYS youth's custodian?** ☐ **No** ☐ **Yes**	**Select:** ☐ **Informal Adjustment** ☐ **Counsel and Release** ☐ **Probation** ☐ **Drug Court** ☐ **School Non-Attendance** ☐ **Parole** ☐ **HYCF** **Incarceration date:** **Anticipated Release Date:** ☐ **Other** ☐ **Charges:**		**Are any supports / services being provided through OYS / Judiciary?** ☐ **No** ☐ **Yes (list below)**	**Are there Conditions of Probation?** ☐ **No** ☐ **Yes (date of conditions):**

SAMPLE

Current Situation	Contact	Status	Primary Goal(s)	Supports	Plan
Child Welfare ☐ **N/A** **Date Revised:**	**Name**: **Phone**: (808) **Fax**: (808) **E-mail**: **Mailing Address**	**Legal Status:** ☐ **Pending Investigation** ☐ **Voluntary FC** ☐ **Temporary FC** ☐ **Foster Custody** ☐ **Permanent Custody** ☐ **Family Supervision** ☐ **Other:** **FC-S** ☐ **No** ☐ **Yes**	**Select:** ☐ **Child Safety** ☐ **Reunification** **Are parents fully informed of their role in reunification?** ☐ **No** ☐ **Yes** ☐ **Guardianship** ☐ **Adoption** ☐ **Other**	**Are any supports / services being provided through CWS?** ☐ **No** ☐ **Yes (list below)** ☐ **FSS** ☐ **VCM** ☐ **VFC** ☐ **TFC** ☐ **GAL** ☐ **Other**	**Service Plan:** ☐ **No** ☐ **Yes (date of plan):** **Are parents aware of and do they understand what is expected of them in their service plan?** ☐ **No** ☐ **Yes**
Other Supports and Services ☐ **N/A** **Date Revised:**					

SAMPLE

Current Situation	Responsible Domain	Describe Transition	Primary Goal(s)	Timeline	Supports Needed
Upcoming Transitions ☐ **N/A** **Date Revised:**					
Transition to Adulthood (16 yrs. and older) ☐ **N/A** **Date Revised:**					☐ **Housing** ☐ **Medical Insurance** ☐ **Employment** ☐ **Transportation** ☐ **Primary Care Physician** ☐ **Mental Health** ☐ **Dental** ☐ **Other**

SAMPLE

SAFETY PLAN - CRISIS PREVENTION PLAN

Youth's name: **Date:**

PROBLEM BEHAVIORS: These are behaviors I sometimes show, especially when I'm stressed:

- ☐ Losing control
- ☐ Injuring myself
- ☐ Assaulting people
- ☐ Attempting suicide
- ☐ Feeling suicidal
- ☐ Threatening others
- ☐ Running away
- ☐ Using alcohol
- ☐ Using other drugs
- ☐ Feeling unsafe
- ☐ **Other (please describe)**

TRIGGERS: When these things happen, I am more likely to feel unsafe and upset:

- ☐ Not being listened to
- ☐ Loud noises
- ☐ Darkness
- ☐ Contact with family
- ☐ Feeling pressured
- ☐ Feeling lonely
- ☐ Being stared at
- ☐ Particular person:
- ☐ Being touched
- ☐ Arguments
- ☐ Being teased
- ☐ **Other (please describe)**
- ☐ Lack of privacy
- ☐ Not having control
- ☐ Particular time of day:
- ☐ People yelling
- ☐ Being isolated
- ☐ Particular time of year

WARNING SIGNS: These are things other people may notice me doing if I begin to lose control:

- ☐ Sweating
- ☐ Red faced
- ☐ Acting hyper
- ☐ Being Rude
- ☐ Eating more
- ☐ Singing inappropriately
- ☐ Breathing hard
- ☐ Wringing hands
- ☐ Swearing
- ☐ Pacing
- ☐ Eating less
- ☐ **Other (please describe)**
- ☐ Racing heart
- ☐ Loud voice
- ☐ Bouncing legs
- ☐ Crying
- ☐ Not taking care of myself
- ☐ Clenching teeth
- ☐ Sleeping a lot
- ☐ Rocking
- ☐ Squatting
- ☐ Isolating/avoiding people
- ☐ Clenching fists
- ☐ Sleeping less
- ☐ Can't sit still
- ☐ Hurting things
- ☐ Laughing loudly/giddy

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
- ☐ Talking with friends
- ☐ Exercising
- ☐ Taking a hot shower
- ☐ Ripping paper
- ☐ Bouncing a ball
- ☐ Drawing
- ☐ Being around others
- ☐ Listening to music
- ☐ Talking with an adult
- ☐ A cold cloth on face
- ☐ Taking a cold shower
- ☐ Screaming into pillow
- ☐ Male staff support
- ☐ Being read a story
- ☐ Doing chores/jobs
- ☐ Reading a book
- ☐ Coloring
- ☐ Writing in a journal
- ☐ Playing cards
- ☐ Holding ice in my hand
- ☐ Female staff support
- ☐ Making a collage
- ☐ Cold water on hands
- ☐ Sitting with staff
- ☐ Molding clay
- ☐ Punching a pillow
- ☐ Video Games
- ☐ Getting a hug
- ☐ Deep breathing
- ☐ Crying
- ☐ Drinking hot herb tea
- ☐ Pacing
- ☐ Humor
- ☐ Hugging a stuffed animal
- ☐ Lying down
- ☐ Using the gym
- ☐ Speaking w/ my therapist
- ☐ Snapping bubble wrap
- ☐ Using a rocking chair

SAMPLE

☐ 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)**

_____

SAMPLE

Mental Health Treatment Plan

Youth: Name	CRN: 123456	DOB: mm/dd/yy	Age: #y #m	Gender Identity: ☐ Female ☐ Male ☐ Other
School: XYZ Elementary		Grade: #		Education Status: select
Guardian(s): Name	Care Coordinator: Name			FGC: select
Therapist: Name	Provider Agency: Org Name			Date of Plan: select ☐ Initial Plan ☐ Updated Plan
Diagnoses: 314.01 (F90.2)				

I. Youth & Family Information

a. Description: Youth is a…

b. Strengths: Parent and teachers report…

c. Barriers to Treatment & Plans to Address Barriers: History of elopement…

II. Treatment Plan

a. Anticipated Treatment Format, Sessions Per Week, Hours Per Session, and Provider(s)

	Intervention Format	*Sessions per week*	*Hours (Units) per session*	*Provider(s)*
1)	select Other / Notes	select / week	select / session	Name
	Additional Comments…			

b. Treatment Focus Areas, Targets, and Practice Elements / Strategies

Treatment Focus Area 1: *(from CMP or Referral Form)*

How will this be addressed in the milieu: *(for out-of-home services only)*

1a. *Treatment Target* *(select 1)*

Externalizing Behaviors
Internalizing Behaviors
Positive Behaviors
More Targets
Other

Practice Elements for Treatment Target *(select 1 practice element per column – up to 3 total)*

Behavior Management	Behavior Management	Behavior Management
Coping/Self-Control	Coping/Self-Control	Coping/Self-Control
Core Practices	Core Practices	Core Practices
More Practices	More Practices	More Practices
Other	Other	Other

Status: select

Measurable Goal / Outcome: Mood rating will increase / decrease…

Projected End Date: select

Start Date: select

End Date: select

SAMPLE

III. Discharge Plan

a. Important Indicators / Criteria for Discharge: Youth and family…

b. Anticipated Barriers to Discharge: Work schedule, childcare needs…

c. Recommended Continued Services – Preferred Option — *Probable Timeframe:* select

CAMHD Services:							*Services Outside CAMHD:*		
☐ABI	☐FEP	☐FFT	☐IIH	☐IILS	☐IOH	☐MST ☐TSS	☐AMHD	☐CCS	☐OP Med Mgmt
☐CBR		☐HBR		☐TFH		☐TRH	☐OP Therapy	☐SBBH	☐Other
☐Case Mgmt		☐Kaeru		☐Kealahou		☐Med Mgmt ☐PSS	☐Other	☐Other	☐Other

Additional Comments…

d. Alternative Option — *Probable Timeframe:* select

CAMHD Services:							*Services Outside CAMHD:*		
☐ABI	☐FEP	☐FFT	☐IIH	☐IILS	☐IOH	☐MST ☐TSS	☐AMHD	☐CCS	☐OP Med Mgmt
☐CBR		☐HBR		☐TFH		☐TRH	☐OP Therapy	☐SBBH	☐Other
☐Case Mgmt		☐Kaeru		☐Kealahou		☐Med Mgmt ☐PSS	☐Other	☐Other	☐Other

Reason(s) alternative might be utilized: If situation worsens…

SAMPLE

Service Acronyms:
Adaptive Behavioral Intervention (ABI), Adult Mental Health Div. (AMHD), Case Management (Case Mgmt), Community-Based Residential (CBR), Community Care Services (CCS), First Episode Psychosis (FEP), Functional Family Therapy (FFT), Hospital-Based Residential (HBR), Intensive In-Home (IIH), Intensive Independent Living Skills (IILS), Intensive Outpatient Hospital (IOH), Medication Management (Med Mgmt), Multi-Systemic Therapy (MST), Outside Provider / Outpatient (OP), Parent Support Service (PSS), School-Based Behavioral Health (SBBH), Transitional Family Home (TFH), Therapeutic Respite Home (TRH), Transition Support Service (TSS)

IV. Crisis Prevention Plan & Crisis Intervention Plan

a. Crisis Prevention Plan (Based on the full Safety Plan)

PROBLEM BEHAVIORS – These are unsafe behaviors I show when I'm stressed, that I am trying to avoid:

- • •

TRIGGERS / WARNING SIGNS – When these things happen, I may need help to avoid a crisis:

- • •

INTERVENTIONS – These are things to try to help me calm down and keep myself safe when I'm feeling upset:

- • •

b. Crisis Intervention Plan (Strategies to use if the prevention supports above are not effective) ☐ N/A Reason if checked

SIGNS THAT I MAY NOT BE ABLE TO STAY SAFE – Thoughts, feelings, and/or actions that indicate loss of control:

- • •

SUPPORT PEOPLE – People I can call or have someone call when I have these thoughts, feelings, or actions:

1) Name Relationship to youth Phone

** If you cannot reach the first person, go down the list until you reach someone.*

HELP STATEMENT – This is my clear and specific statement to let my support person know what I need:

I feel out of control…

CRISIS SUPPORT – If all of my coping strategies have not worked and I cannot reach a support person, contact crisis support:

- Crisis Line: 832-3100 (Oahu) / 1-800-753-6879 (Neighbor Islands)
- Crisis Text Line: 741741
- Suicide Prevention Line: 1-800-273-TALK (8255)
- Dial 911 or go to the Emergency Room

TELL THE CRISIS WORKER:

1. If you plan to harm yourself / someone else or already have - BE SPECIFIC
2. How long you will be able to remain safe
3. Where you are and with whom (if anyone)

SAMPLE

V. Signatures

	Name	*Role*	*Signature*	*Date*
1)	Name	Client		
2)	Name	Parent / Guardian		
3)	Name	Therapist		
4)	Name	Care Coordinator		
5)	Name	Role		

SAMPLE

CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
POLICY AND PROCEDURE MANUAL

SUBJECT: Referral Acceptance Protocol	**Number:**	**80.614**
	Page:	I of6
REFERENCE: Hawaii Revised Statutes, and Hawaii Administrative Rules for Chapter 103F	**APPROVED:**	
	Si1mature on File	11/15/05
	Chief	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 I 03F 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 (MHCC) 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.

REVISION HISTORY: 4 Oct 05 (formerly Consumer Access to CAMHD Services)
Initial Effective Date: 04 Feb 03
Biannual Review Date:

File Ref:
A7504

CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
POLICY AND PROCEDURE MANUAL

SUBJECT: Referral Acceptance Protocol	**Number:**	**80.614**
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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 Reporf'* 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

I. 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.

C. Mental Health Only (MHO) services which are available to youth, not eligible for ES or SEBD Health Plan services, but deemed to be in need of mental health services. The CAMHD Medical Director shall determine MHO eligibility.

2. CAMHD Branches shall assign a Mental Health Care Coordinator (MHCC) in accordance with *CAMHD Policy & Procedure 80.702, Care Coordination and Policy &*

CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
POLICY AND PROCEDURE MANUAL

SUBJECT: Referral Acceptance Protocol	**Number:**	**80.614**
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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.(CA.l\1HMIS);

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 an MHCC 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 MHCC 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 MHCC will contact the Provider to determine the reason for the delay and to provide any necessary assistance.

REVISION HISTORY: 4 Oct 05 (formerly Consumer Access to CAMHD Services)
Initial Effective Date: 04 Feb 03
Biannual Review Date:

File *Ref:*
A7504

CHILD AND ADOLESCENT MENTAL HEALTH DIVISION AND PROCEDURE

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5. If the youth is accepted but the program beds are at capacity, the MHCC 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 MHCC 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 MHCC. The MHCC 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 MHCC 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 ofCAMHD 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.

REVISION HISTORY: 4 Oct 05 (formerly Consumer Access to CAMHD Services)
Initial Effective Date: 04 Feb 03
Biannual Review Date:

File *Ref:* A7504

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4. The MHCC will copy the CS0 Resource Management (RM) Supervisor on any rejection letters or rejection indicated on the *"Acceptance of Referral Form".* The CS0 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 ofrejections and ejections to CAMHD on a designated form. The Branches will verify this information by completing the ***"FGC Data Verification Tracking Tool" (See Attachment DJ.***

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 MHCC and the Provider are expected to work closely together while the youth is in the Provider's program. The MHCC 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 CS0 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 CS0. The CS0 will fax its approval or disapproval to the Provider within three (3) business days of the receipt of the form.

      I. 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.

REVISION H1STORY: 4 Oct 05 (fonnerly Consumer Access to CAMHD Services) File Ref:

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CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
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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 ofCAMHD 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 MHCC 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

B. Waitlisted Youth Form

C. CAMHD Independent Psychiatrist Consultation Form

D. FGC Quality Indicator Tracking Tool

REVISION HISTORY: 4 Oct 05 (foJ;lllerly Consumer Access to CAMI-ID Services) File Ref:

Initial Effective Date: 04 Feb 03 A7504
Biannual Review Date:

CAMHD Referral Form

YOUTH INFORMATION

Name	123456	Select
Youth	Youth Registration Number	LOC / Service Requested

Gender	#y #m	mm/dd/yy	#
Gender	Age	DOB	Grade

Insurance	Policy #
Insurance Plan	Insurance Number

#	Service	Living Sit
Latest CAFAS Score	Current Level of Care / Service	Living Situation

☐ *Youth has a court order affecting treatment.* Explain

EMERGENCY CONTACTS

Name	Relation to Youth	Phone
Name	Relation to Youth	Phone

TREATMENT FOCUS AREAS

Treatment Focus Area 1: From IMHE

Treatment Focus Area 2: From IMHE

Treatment Focus Area 3: From IMHE

This application is true and complete to the best of my knowledge.

Name	Title	Select
Completed By	Title	Family Guidance Center

first.last@doh.hawaii.gov	(808) 123-4567	(808) 123-4567
Email	Phone	Fax

	Select
Signature	Date

ATTACHMENTS

Required Documents for all Services

- ☐ Coordinated Service Plan
- ☐ Mental Health / Emotional Behavioral Assessment
- ☐ Other
- ☐ Clinical Management Plan (if available)
- ☐ Individualized Education Plan (if applicable)
- ☐ Other

Additional Required Documents for Out-of-Home Services

- ☐ TB Clearance Certificate (within 12 months) ***or*** ☐ Will be provided at intake
- ☐ Proof of Physical Exam (within 12 months) ***or*** ☐ Will be provided at intake
- ☐ Immunization Record (for youth under age 12) ***or*** ☐ Will be provided at intake

SAMPLE

Referral Acceptance Form

SECTION 1: To be completed by the Family Guidance Center (FGC) Care Coordinator (CC).

Name Youth Name	CRN Youth Registration Number	LOC LOC Requested
FGC Family Guidance Center	(808) 123-4567 FGC Phone Number	(808) 123-4567 FGC Fax Number
Agency Provider Agency	Name Agency Contact Person	
(808) 555-1212 Agency Phone Number	(808) 555-2323 Agency Fax Number	Select Date Referral Sent to Agency

SECTION 2: To be completed by the Provider Agency and returned to the FGC within two (2) working days of receipt of the referral packet.

Printed Name of Agency Contact Person	Signature of Agency Contact Person	
Date Referral Packet Received	Date Referral Accepted	Anticipated Admit / Start Date

WAITLIST ☐ No Beds Available ☐ No Therapist Available

Date Waitlisted	Waitlist Number

SECTION 3: To be completed by the Care Coordinator (CC) and faxed to the Provider Agency.

☐ Youth is receiving treatment with another agency – please remove from waitlist.

Date

SECTION 4: To be completed by the Provider Agency and returned to the FGC.

Should you believe the youth is not appropriate for this service / level of care, please return this form with written justification, signed by your Agency's Clinical Director, within two (2) working days of receipt of the referral packet.

Additionally, your Agency's Clinical Director must contact the Center Clinical Lead to discuss your concerns.

PLEASE NOTE: Contact the CC assigned to the case to discuss any delays in returning this form within the two (2) working days as required.

☐ **REFERRAL REJECTED** ☐ Signed Justification Attached

Printed Name of Agency Clinical Director	Signature of Agency Clinical Director	Date

SAMPLE

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
K	Kauai	**M**	Maui	**EH**	Hawaii	**WH**	Hawaii

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

A7504-B P&P 80.614 Attachment B rev. 23 Feb 2006

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	**WO**	Windward Oahu	**LO**	Leeward Oahu	**HNL**	Honolulu, Oahu		
FCLB	Family Court Liaison Branch	**K**	Kauai	**M**	Maui	**EH**	East Hawaii	WH	West Hawaii

WAIT LIST	
***Yes** ☐	**No** ☐
** If Yes, Enter details below*	

A	B	C	E	F	G	H	I	J	K
Date of Admission	Patient Name LN, FN	Gender M or F	Referring Agency (FGC)	Projected Date of Discharge	Actual Date of Discharge	Wait Listed Date	Projected Date of Admission	Screen Date	Comments

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

Credentialing forms and templates can be downloaded from the CAMHD website under Provider Relations Forms tab here:
http://health.hawaii.gov/camhd/provider-relations-forms/

Competency Assessment for Paraprofessionals in Residential Programs

Instructions: The primary supervisor should complete these ratings based on her/his direct observations of the Paraprofessional worker and input from other supervisors/clinical leaders. Checking any description that fits the individual well. Any endorsement of a description in the "deficient" column should lead to the development of a supervision plan to address that area inclusive on of training.

1. Knowledge of Individualized Treatment Plan		
Deficient (0)	Satisfactory (1)	Proficient (2)
☐ Does not know the youth's mutually agreed upon goal ☐ May know general issues that youth is dealing with but nothing specific. ☐ Has different goals than identified in the plan.	☐ Knows the youth's primary mutually agreed upon goal in general terms. ☐ Has general ideas on how to support the youth in reaching this goal.	☐ Knows the youth's specific mutually agreed upon goal in solvable and/or measureable terms. ☐ Can articulate specific methods to support this goal. ☐ Has discussed this youth's goals and support strategies with clinician.
2. Trauma Informed Care		
Deficient (0)	Satisfactory (1)	Proficient (2)
☐ Uses consequences or threats of consequences as initial response to problem behaviors. ☐ Responds in a negatively emotionally charged manner. ☐ Feels betrayed by youth who break rules.	☐ Able to establish trust and demonstrates advocacy with youth s/he works with. ☐ Encourages youth's voice regarding goals, daily activities, coping, recreation, education, etc. ☐ Demonstrates consistency with youth and promotes consistency amongst staff.	☐ Employs specific trauma-informed principles such as increasing predictability in the environment; reducing known triggers; using validation; increasing a sense of personal control; establishing a sense of safety etc. ☐ Has an understanding of how trauma is exhibited in different youth.
3. Strength-based Intervention		
Deficient (0)	Satisfactory (1)	Proficient (2)
☐ Views relapses as failures of treatment, program or youth. ☐ Attempts to teach and enforce while youth is dysregulated. ☐ Engages in power struggles.	☐ Welcomes visiting families as a valuable resource to the youth. ☐ Responds to youth in an encouraging and non-judgmental manner. ☐ Is working to more regularly incorporate crisis prevention	☐ Uses specific Motivational Interviewing techniques. ☐ Uses functional strengths identified by team to promote health. ☐ Looks for what is being communicated by youth in problematic behaviors.

☐ When youth are in crisis or experiencing emotional dysregulation, does not attempt to de-escalate youth before resorting to hands-on redirection or restraints.	techniques in job performance.	☐ Communicates with clinician and family (when appropriate) on progress being made in milieu. ☐ Utilizes de-escalation techniques regularly before resorting to hands-on re-direction/restraints.
4. Therapeutic Knowledge Base		
Deficient (0)	Satisfactory (1)	Proficient (2)
☐ Pathologizes or moralizes all problematic behaviors. ☐ Does not see a difference between adolescents and adults. ☐ Does not incorporate trainings, techniques or new knowledge to improve job performance or understanding of youth.	☐ Views some defiance as developmentally appropriate behavior. ☐ Is aware of developmental trauma and trauma informed care. ☐ Sometimes incorporates new training and techniques to improve job performance and increase understanding of population served.	☐ Has an understanding of differences in the treatment needs of male and female youth. ☐ Can articulate some of the risk factors that make the youth we serve vulnerable. ☐ Can articulate some of the protective factors that we support in the youth we serve. ☐ Has a basic understanding of child and adolescent development. ☐ Regularly incorporates new training and techniques to improve job performance and expand understanding of youth.
5. Professional Behavior		
Deficient (0)	Satisfactory (1)	Proficient (2)
☐ Overly rigid boundary that prevents engagement with youth and family. ☐ Has interactions with youth or family members outside of work hours or regarding non-programmatic matters. ☐ Treats youth as one would treat a peer.	☐ Does not communicate with the youth or family outside of work hours or for non-programmatic matters. ☐ Does not disclose personal information that is not already public, not relevant nor unresolved. ☐ Speaks respectfully to youth and family.	☐ Is capable of appropriate use of self-disclosure to engage and facilitate progress with youth in a manner that does not blur professional boundaries or place youth or family in a vulnerable position. ☐ Discusses the limits of the relationship with the youth and family when a boundary is challenged.

☐ Youth interacts with particular staff as though they were a peer. ☐ Discusses other youth or other staff issues with youth. ☐ Staff behavior has been interpreted as demeaning, inciting or intimidating by youth. ☐ Regularly misses supervision sessions. ☐ Takes professional advice/constructive criticism as a personal attack.	☐ Regularly attends supervision and meetings. ☐ Incorporates constructive criticism into improved performance.	☐ Seeks out supervision, clarification and consultation.
6. Programmatic Knowledge		
Deficient (0)	Satisfactory (1)	Proficient (2)
☐ Does not know or follow policies and procedures.	☐ Understands and adheres to policies and procedures (most notably for crisis responses).	☐ Is viewed as a leader and is often sought after for accurate programmatic information. ☐ Contributes to programmatic development (procedural, operational, therapeutic activities, educational etc.)

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	1 Mar 2004
	Chief	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 CAMHD's contracted agencies' staff.

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

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SUBJECT: Child Abuse and Neglect Check	Number:	80.406
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environment, withholding of medical or necessary treatments, lack of appropriate supervision, and any other instance as defined by the DHS.

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 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, CAMHD's Credentialing Specialist or designee will inform the contracted agencies of those personnel that have been cleared.

5. CAMHD's Credentialing Specialist will notify contracted agencies or of employees with confirmed CAN histories as perpetrators involving criteria "a" through "f" of policy #1, or any other criteria deemed to be of high-risk by the Credentialing Committee, without divulging specifics relative to the nature of the history. Likewise, the Credentialing Specialist will inform the immediate clinical supervisor of any CAMHD staff with a confirmed CAN history.

6. 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.

7. 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.

8. 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:

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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.

9. 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.

10. The Credentialing Committee will inform the agency in writing, under CAMHD Chief's approval and signature, of CAMHD's decision, basis for the decision, and recommendations that may include:

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SUBJECT: Child Abuse and Neglect Check	Number:	80.406
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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

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POLICY AND PROCEDURE MANUAL

SUBJECT: Delegation of Credentialing Primary Source Verification	**Number:**	**80.308.3**
	Page:	1 of 8
REFERENCE: CAMHD Credentialing Policies and Procedures for Licensed and Unlicensed Providers; NCQA, BBA	**APPROVED:** Chief	4/9/06 Eff. Date

PURPOSE

To provide guidelines and timelines for the delegation of credentialing activities by CAMHD to CAMHD contracted provider agencies (Agency/ies) providing mental health services. The policy also provides guidelines for monitoring the delegated activities of the CAMHD Agencies.

DEFINITIONS

See Glossary of Credentialing Terms **(See Attachment A)**

POLICY

1. The CAMHD is responsible and will be held accountable to ensure that all delegated credentialing functions and activities are performed in accordance with the specifications outlined in this policy.
2. The CAMHD shall evaluate a prospective delegate's ability to provide the intended delegated credentialing functions.
3. The CAMHD shall review and approve all descriptions of delegated credentialing activities prior to the approval of a delegation agreement.
4. The CAMHD shall monitor delegated activities regularly using the formal, systematic processes outlined within this policy to assess the delegate's compliance.

PROCEDURE

PRE-DELEGATION ASSESSMENT

1. Prior to the delegation of credentialing activities and functions the CAMHD will pre-assess an Agency or credentials verification service contractor to determine its ability to perform the activities and functions as outlined in the "CAMHD Pre-Delegation Assessment Tool." **(See Attachment B)**
2. The results of the pre-assessment audit will be reported to the CAMHD Credentialing Committee for review and decision.

RESPONSIBILITIES AND ACCOUNTABILITY OF THE DELEGATE

1. Initial Credentialing:

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SUBJECT: Delegation of Credentialing Primary Source Verification	Number:	80.308.3
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A. The CAMHD Agency or credentials verification service contractor shall obtain initial credentialing primary source verifications using methodology and times frames as outlined in the "*CAMHD Licensed Provider Initial Credentialing Checklist*" **(See Attachment C)**, the "*CAMHD MHP and Paraprofessional Initial Background Verification Checklist*" **(See Attachment D)**

B. The CAMHD Agency will obtain credentialing and background verification approval for all practitioner (licensed or unlicensed) from CAMHD prior to serving CAMHD consumers. Services provided prior to this CAMHD approval will not be reimbursed.

1. The CAMHD Agency credentialing specialist or a primary source verification service representative must do the following:

   a. Obtain a completed credentialing application form from the practitioner;

   b. Create an agency credentialing file for each provider applicant;

   c. Obtain necessary consents to conduct credentialing primary source verifications;

   d. Conduct primary source verifications as outlined in the "CAMHD Licensed Provider Initial Credentialing Checklist" and "CAMHD MHP and Paraprofessional Initial Background Verification Checklist";

   e. Conduct a pre-audit of primary source verified documents to ensure they meet CAMHD requirements – using the "CAMHD Licensed Provider Initial Credentialing Checklist" and the "CAMHD MHP and Paraprofessional Initial Background Verification Checklist" as guides;

   f. Maintain the original primary source verification documents in the practitioner's file at the CAMHD Agency. Existence of the originals will be verified during delegation onsite audit visits;

   g. Create a duplicate credentialing file for the applicant with all the primary source verification;

   h. Tab primary source verifications with numbers to match the numbers on the "Licensed Provider Initial Credentialing Checklist and the MHP and Paraprofessional Initial Background Verification Checklists";

i. Send a duplicate file to the CAMHD Credentialing department; and

j. Keep current in the file all documents that have expiration dates such as licenses and malpractice insurance.

2. **Re-credentialing:**

A. The CAMHD Agency will conduct the re-credentialing primary source verifications as outlined in the "*CAMHD Licensed Provider Re-credentialing Checklist*" **(See Attachment E)** and the "*CAMHD MHP and Paraprofessional Background Re-verification Checklist.*" **(See Attachment F)** The primary source verification requirements must follow primary source verification methodology and time frames as outlined in the "*CAMHD Licensed Provider Re-credentialing Policies and Procedures*" and the "*CAMHD MHP and Paraprofessional Background Re-verification Policies and Procedures.*"

B. The CAMHD Agency will obtain re-credentialing and background re-verification approval for all practitioners (licensed or unlicensed) from CAMHD ***prior*** to expiration of original credentialing dates. ***Services provided in the time period between the end of the original credentialing end date and the start of the re-credentialing period will not be reimbursed.***

C. The CAMHD Agency credentialing specialist or a primary source verification service representative must do the following:

1) Obtain a completed credentialing re-application or background re-verification form from the practitioner;

2) Obtain necessary consents to conduct re-credentialing or background re-verification primary source verifications;

3) Obtain primary source as outlined in the "CAMHD Licensed Provider Initial Re-recredentialing Checklist" and the "CAMHD MHP and Paraprofessional Background Re-verification Checklist";

4) Conduct a pre-audit of obtained primary source documents to ensure they meet CAMHD requirements – use the "CAMHD Licensed Provider Re-credentialing Checklist" and the "CAMHD MHP and Paraprofessional Background Re-verification Checklist" as guides;

5) Maintain original primary source re-verifications in the clinician file at the CAMHD Agency. Existence of the originals will be verified during delegation onsite audit visits;

6) Create a duplicate file for the applicant with all the primary source re-verifications;

7) Tab primary source re-verifications with numbers to match the numbers on the "CAMHD Licensed Provider Re-credentialing Checklist" and the "CAMHD MHP and Paraprofessional Background Re-verification Checklist";

8) Send a duplicate file to the CAMHD Credentialing Department; and

9) Keep current in the file all documents that expire such as licenses and malpractice insurance.

3. **Operational Requirements:**

A. The CAMHD Agency shall ensure that the CAMHD requirements as outlined in *the "CAMHD Contracted Agency Credentialing Systems Audit Tool"* are in place. **(See Attachment G)**

B. The CAMHD Agency shall have documented processes in place to monitor the activities of their credentialing department. The supervisor for their credentialing specialist must have knowledge of the current CAMHD credentialing requirements in order for them to efficiently implement them and monitor the performance of their staff. A yearly evaluation of CAMHD Credentialing Staff must be conducted in order for CAMHD Agency management to be fully aware of performance issues that may hinder its ability to perform CAMHD delegated functions. Other operational requirements are outlined in the *"CAMHD Contracted Agency Credentialing Systems Audit Tool"* must be followed.

4. **Delegate's Accountability to CAMHD**

The delegate is accountable to ensure that all activities set forth in this delegation policy and procedures and in the delegation agreement are completed in accordance with CAMHD requirements within the specified timelines.

TIMEFRAME OF DELEGATED ACTIVITIES

The delegated activities and functions described in this policy will be effective as of the date of signature of the CAMHD delegation agreement with the delegate.

MONITORING OF DELEGATED ACTIVITIES

1. **Schedule and Location:**

Onsite monitoring of delegated activities and credentialing operations/systems will be conducted at least annually at the CAMHD Agency office where the credentialing files

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are kept. CAMHD has the right to conduct additional on-site visits as indicated by program quality issues that may arise.

REVISION HISTORY:
Initial Effective Date: 15 July 03
Biannual Review Date:

File Ref:
A6798

2. **Audit Tools and Thresholds:**

   A. The tool to be used will be the "Licensed Provider CAMHD Contracted Agency Credential File Audit Form" **(See Attachment H)** and / or the "MHP and Paraprofessional CAMHD Contracted Agency Credential File Audit Form." **(See Attachment I)** The existence of the originals of previously submitted primary source verifications will be checked. The date of primary source verifications that were originally submitted to CAMHD for review will be pre-listed on these tools.

   B. The CAMHD Agency must provide original documents for the audit. Absent original documents will be noted as such if they cannot be found by the conclusion of the on-site audit. The CAMHD Agency must complete, at a minimum, 85% of the requirement listed in the tool to demonstrate substantial compliance with this activity.

   C. The "CAMHD Contracted Agency Credentialing Systems Audit" tool will be used to evaluate other delegated credentialing functions and requirements. The threshold score of 85% is required to demonstrate substantial compliance. See Delegate Evaluation Scoring Compliance Scale **(See Attachment J)**

3. **Sample Size:**

   A. The sample Agency credential files that will be audited is selected through random sampling from the CAMHD Contracted Agencies' monthly report of employees and subcontractors. Names listed on the licensed and unlicensed monthly reports are arranged alphabetically. Each year a number is chosen. For example, the number five (5) is chosen and then every 5th name on the lists will be selected for the sample until 25% or 20 files, whichever is lesser, is selected.

   B. CAMHD will provide the CAMHD Agency with the sample for the agency credential files audit no later than two (2) days before the audit.

   C. The sample size will be at least 25% or twenty (20) files, whichever is lesser, for each category (licensed and unlicensed) of the clinician files inclusive of all psychiatrists.

4. **Technical Assistance / Additional Training:**

   A. Technical assistance is provided by the CAMHD Credentialing Specialist to all agencies on areas that they have not scored 100%. This includes reviewing the agencies' current credentialing processes.

   B. A suggestion on how activities could be improved in order for agency to achieve 100% performance on all aspects of credentialing.

C. Agencies that have managed to show improvement in their credentialing processes including aspects that are not technically part of the delegated activities, such as human resource functions, are recognized for their efforts and are encouraged to partner with other CAMHD Credentialing Specialist who continue to struggle in order to promote mentoring as part of the overall plan to create a successful delegation program.

REPORTING OF ONSITE AUDIT FINDINGS AND CORRECTIVE ACTION REQUESTS AND RESPONSES

1. **Reporting of Findings to the Delegate**

A. At the close of the visit the CAMHD auditor will conduct an exit interview with the CAMHD Agency credentialing specialist and any other pertinent personnel. The CAMHD auditor will go over findings and items that would be requested in a corrective action plan, if any.

B. A copy of the following will be provided to the agency staff at the completion of the audit to allow delegate ample time to submit any corrective actions:

- Licensed Provider CAMHD Contracted Agency Credential File Audit Form
- MHP and Paraprofessional CAMHD Contracted Agency Credential File Audit Form
- CAMHD Contracted Agency Credentialing Systems Audit Tool
- The Delegation Audit Corrective Action Form
- The CAMHD Contract Agencies' Specialists will be asked to acknowledge receipts of audit results by signing the Agency Receipt of Delegated Corrective Action Plan.

2. **Reporting of Findings to the CAMHD Credentialing Committee**

A. A copy of the Delegation Audit Corrective Action Form will be presented to the CAMHD Credentialing Committee at the meeting following the completion of the onsite visit. The Credentialing Committee will review the results and make additional recommendations for CAP that they feel should be included in the final corrective action report sent to the CAMHD Agency.

B. The CAMHD Credentialing Committee will report these findings to the CAMHD Performance Improvement Steering Committee for review and recommendations as applicable.

3. **Corrective Action Activities**

The CAMHD Agency' corrective action plans and any supporting documents must be submitted to the CAMHD Credentialing Specialist no later than thirty (30) days from the CAMHD Agency's receipt of the onsite audit report (the date of the actual onsite audit). CAMHD shall respond as appropriate.

4. **Follow-up On-site Visit**

CAMHD reserves the right to conduct a follow up on-site visit to ensure corrective activities stated in the corrective action plan are in fact being implemented by the agency, with a one-week notice prior to the visit provided to the agency.

SUSPENSION OR REVOCATION OF DELEGATION

CAMHD retains the authority to suspend or revoke delegated activities upon the CAMHD Agency's continued inability to implement corrective action activities resulting in a score lower than the established threshold of 85% in any of the evaluated sections after the third on-site visit or at any time the delegate fails to fulfill its delegated obligations.

RESPONSIBILITIES OF CAMHD

A. CAMHD will review submitted files and either approve or disapprove the files within thirty (30) working days of receipt of file.

B. In the event that a file is not approved, CAMHD will notify the CAMHD Agency via telephone or electronic mail of the deficiencies. The agency will be advised that the file will be kept in the CAMHD Credentialing office for thirty (30) days.

C. Files that are not presented to the CAMHD Credentialing Committee after thirty (30) days of deficiency notification will be returned to the CAMHD Agency.

D. CAMHD retains the authority to conduct monitoring reviews as described above to ensure that delegated credentialing functions and operational systems are being performed in accordance to CAMHD standards and expectations.

E. CAMHD retains the right to suspend or revoke delegated activities as described the in the "Suspension or Revocation" section of this policy.

ATTACHMENTS:

A. Glossary of Credentialing Terms

B. CAMHD Pre-Delegation Assessment Tool, Version:

C. CAMHD Licensed Provider Initial Credentialing Checklist, Revised:

D. CAMHD MHP and Paraprofessional Initial Background Verification Checklist, Version: 3-06

E. CAMHD Licensed Provider Recredentialing Checklist, Revised: 3-06

F. CAMHD MHP and Paraprofessional Background Re-Verification Checklist, Revised: 3-06

G. CAMHD Contracted Agency Credentialing Systems Audit. Version: 10/1/04

H. CAMHD Contracted Agency Licensed Providers Credential File Audit Form, Version: 3-06

I. CAMHD Contract Agency MHP and Paraprofessional Credential File Audit Form, Version: 3-06

J. Delegate Evaluation Scoring Compliance Scale

Glossary of Credentialing Terms

Applicant: Any practitioner applying for credential approval with CAMHD.

Attestation Letter – A letter from a representative of the Agency attesting that they have obtained primary source verification documents from the primary source and that originals of these documents are maintained in the Agency credential file.

BBA - Balanced Budget Act, 42 CFR.

Client- Youth with emotional and/or behavioral challenges receiving intensive mental health services from CAMHD.

Contracted Provider Agency - Agency under contract with CAMHD to provide mental health services to CAMHD clients.

Credentialing The systematic process of assessing the qualifications of CAMHD and CAMHD Agencies' qualified licensed mental health professional (QMHP), direct care personnel and clinical supervisors. The credentialing process ensures that staff has the required primary source verified credentials, licenses, certificates, malpractice coverage and other pertinent background to provide services to the consumers of CAMHD.

Credentialing Committee - standing The Credentialing Committee is a standing Child and Adolescent Mental Health Division (CAMHD) committee is designated to provide oversight over CAMHD's credentialing processes in accordance with the Credentialing Committee Policy and Procedures. Membership shall be representative of various disciplines from CAMHD's various sections with preference given, but not limited to licensed professionals.

Delegation- Authority assigned by the CAMHD to another / other organization to conduct functions and activities in CAMHD's behalf according to CAMHD expectations and standards in such a manner that benefits CAMHD. The organization is identified as a "*delegate*".

DCCA - Department of Commerce and Consumer Affairs, professional and vocational licensing division of the State of Hawaii

ECMFG: The Educational Commission for Foreign Medical Graduates that evaluates foreign medical graduates' medical school curriculum to ensure that it is in alignment with the United States' medical school standards.

NCQA - National Commission of Quality Assurance

PISC - Performance Improvement and Steering Committee, standing CAMHD committee

Primary Source Verification - The process of verifying an individual professional's verbal or documented claims of professional and legal standing through direct contact with officials at the primary sources of education, licensing, prior employment, insurance carriers, etc.

Practitioner: Any QMHP.

Qualified Mental Health Professional (QMHP): The following State of Hawaii Licensed clinicians fall under this category: Medical Doctor (M.D.) Licensed Social Worker (LSW), Licensed Marriage and Family Therapist (LMFT), Licensed Psychologist (Ph.D or Psy.D); Advanced Practice Registered Nurse (APRN) and Osteopathic Doctor (D.O.)

Recredentialing A re-verification process of primary source information that may have changed since last reviewed, such as licenses and malpractice claims information

Termination: Voluntary or involuntary end of contract or employment with CAMHD or a CAMHD Contracted Provider Agency.

CAMHD Pre-Delegation Assessment Tool
Part 1

AGENCY NAME: _____

DATE AUDITED: _____

AUDITOR'S NAME: _____

REQUIRED ELEMENTS	PRESENT	
	YES	NO
CREDENTIALING POLICIES AND PROCEDURES		
• Required primary source verifications clearly listed		
• Clearly states that clinician is not allowed to treat CAMHD clients prior to being approved by the CAMHD Credentialing Committee		
• Clearly states the clinician is not allowed to provide supervision to another credentialed clinician prior to being approved by the CAMHD Credentialing Committee		
• States the methodology of submitting copies of primary source verification documents to CAMHD		
• A statement ensuring confidentiality of all information gathered during the credentialing process		
• A statement to maintain current all documents that expire such as license and malpractice insurance.		
• A statement assuring CAMHD that the agency will have a trained Credentialing Specialist back-up		
• A statement outlining the communication process between the Contracted Provider Agency Credentialing Specialist and the Billing Specialist		
HUMAN RESOURCES PROCEDURES		
• Mechanism in place to verify at least 2 employment references conducted prior to start date of clinician; as applicable		
VERIFICATION OF EXPIRED DOCUMENTS		
• Tracking system that would allow tracking of malpractice insurance expiration dates		
• Tracking system that would allow tracking of licenses		

CAMHD Pre-Delegation Assessment Tool
Part 1

Continuation

REQUIRED ELEMENTS	PRESENT	
	YES	NO
AGENCY CREDENTIALING SPECIALIST		
• Credentialing Specialist on staff		
• Trained Credentialing back - up		
• Presence of email address for Credentialing Specialist		
• Telephone number for Credentialing Specialist		
INFORMATION SYSTEMS		
• Credentialing Tracking Database		
• Ability to query expiration dates documents & produce reports		
BILLING SYSTEMS		
• Written communication system between the Credentialing Department and the Billing Department		
• Written billing rejection troubleshooting manual		
REPORTING REQUIREMENTS		
• Monthly report templates on computer		
CREDENTIALING STAFF REVIEWS		
• Established processes for Evaluation of Credentialing Specialist Performance yearly		

CAMHD Pre-Delegation Assessment Tool
Part 2
MHP and Paraprofessional
Credential File Set Up

AGENCY NAME: _____

DATE AUDITED: _____

AUDITOR'S NAME: _____

PRIMARY SOURCE DOCUMENTS	TABS FOR THESE REQUIREMENTS PRESENT IN THE CHART?	
	YES	NO
Copy of Attestation letter sent to CAMHD on file		
Original Background Verification Application on file		
Original Transcript or Education Verification on file		
Original Hawaii Justice Center Check printout or letter on file		
Original CAN check results on file		
TOTAL SCORE		

CAMHD Pre-Delegation Assessment Tool
Part 3
Licensed Providers Credential File Set Up

PROVIDER NAME: _____

DATE AUDITED: _____

AUDITOR'S NAME: _____

PRIMARY SOURCE DOCUMENTS	TABS FOR THESE REQUIREMENTS PRESENT IN THE CHART?	
	YES	NO
Copy of Attestation letter sent to CAMHD on file		
Original Credentialing Application		
Original Dated Resume		
Original Transcript / or letter verifying education		
Original Residency Verification or Original Internship Verification or Original Fellowship Verification		
Original ECMFG Verification; as applicable		
Copy of submitted DEA certificate		
Copy of submitted State certificate		
Original current malpractice coverage verification		
Original prior malpractice coverage No Claims verification		
Original DCCA license verification		
Original other state license verification		
Original Medicare / Medicaid Sanction verification		
Original Hawaii Justice Center Check		
Original NPDB verification *(for MDs, PHDs, PsyDs, Dos and APRNs)*		
Original CAN check results		
Original Board Verification		
Original letter of good standing from hospital		
TOTAL SCORE		

Credentialing forms and templates can be downloaded from the CAMHD website under Provider Relations Forms tab here:
http://health.hawaii.gov/camhd/provider-relations-forms/

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

5. **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.

6. **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.

7. **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.

8. **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.

9. **Confidentiality Policy**. The CAMHD holds all practitioner data and information that is obtained through the credentialing/recredentialing process in strict confidence.

10. **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.

11. **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 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 <u>initially credentialed</u> 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

Glossary of Credentialing Terms

Alias: An assumed or additional name.

Applicant: Any practitioner applying for credential approval with CAMHD.

Attestation Letter: A letter from a representative of the Agency attesting that they have obtained primary source verification documents from the primary source and that originals of these documents are maintained in the Agency credential file.

BBA: Balanced Budget Act, 42 CFR.

Client: Youth with emotional and/or behavioral challenges receiving intensive mental health services from CAMHD.

Contracted Provider Agency: Agency under contract with CAMHD to provide mental health services to CAMHD clients.

Complete Application: All blanks on the application form are filled in and necessary additional explanations provided; 2) All requested attachments and information have been submitted; 3) Verification of the information is complete and was done through primary sources when required; 4) All information necessary to properly evaluate the applicant's qualifications has been received and is consistent with the information provided in the application.

Credentialing: The systematic process of assessing the qualifications of CAMHD and CAMHD Agencies' qualified licensed mental health professional (QMHP), direct care personnel and clinical supervisors. The credentialing process ensures that staff has the required primary source verified credentials, licenses, certificates, malpractice coverage and other pertinent background to provide services to the consumers of CAMHD.

Credentialing Committee - standing The Credentialing Committee is a standing Child and Adolescent Mental Health Division (CAMHD) committee is designated to provide oversight over CAMHD's credentialing processes in accordance with the Credentialing Committee Policy and Procedures. Membership shall be representative of various disciplines from CAMHD's various sections with preference given, but not limited to licensed professionals.

Delegation- Authority assigned by the CAMHD to another / other organization to conduct functions and activities in CAMHD's behalf according to CAMHD expectations and standards in such a manner that benefits CAMHD. The organization is identified as a "*delegate*".

Department of Commerce and Consumer Affairs (DCCA): Professional and vocational licensing division of the State of Hawaii

The Educational Commission for Foreign Medical Graduates (***ECFMG)***: Evaluates foreign medical graduates' medical school curriculum to ensure that it is in alignment with the United States' medical school standards.

Mental Health Professional (MHP): Unlicensed, Board Ineligible Psychiatrist; Psychiatric Resident; Unlicensed, Ph.D or Psychologist (Psy D); Registered Public Nurse (RPN), Licensed with Masters Degree; Unlicensed, Masters Psychology; Licensed, Masters Social Work; Unlicensed Masters Social Work (MSW); Unlicensed Marriage & Family Therapist (MFT); Unlicensed, Masters Certified Counselor; Unlicensed, Masters Degree.

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 must 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. CAMHD requires an NPI for all QMHPs and MHPs, and all paraprofessionals providing and billing for 13101 (Intensive In-Home therapy) services.

National Commission of Quality Assurance (***NCQA)*** is an independent 501(c)(3) non-profit organization in the United States designed to improve health care quality. NCQA manages voluntary accreditation programs for individual physicians and medical groups. Health plans seeking accreditation measure performance through the Healthcare Effectiveness Data and Information Set (HEDIS).

Paraprofessional (PARA): Certified Substance Abuse Counselor (CSAC); Registered Public Nurse (RPN) Bachelors, Licensed; RPN Associate, Licensed; Licensed Practical Nurse (LPN); Bachelors, Psychology; Bachelors, Social Work; Bachelors, Counseling; Bachelors, Other; Associates, Other; High School Graduate or GED.

Primary Source Verification - The process of verifying an individual professional's verbal or documented claims of professional and legal standing through direct contact with officials at the primary sources of education, licensing, prior employment, insurance carriers, etc.

Practitioner: Any QMHP, MHP or Paraprofessional.

Qualified Mental Health Professional (QMHP): Medical Doctor (M.D.) Licensed Social Worker (LSW), Licensed Marriage and Family Therapist (LMFT), Licensed Psychologist (Ph.D or Psy.D); Advanced Practice Registered Nurse (APRN) and Osteopathic Doctor (D.O.)

Recredentialing A re-verification process of primary source information that may have changed since last reviewed, such as licenses and malpractice claims information

Termination: Voluntary or involuntary end of contract or employment with CAMHD or a CAMHD Contracted Provider Agency.

Credentialing forms and templates can be downloaded from the CAMHD website under Provider Relations Forms tab here:
http://health.hawaii.gov/camhd/provider-relations-forms/

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
   - 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.

    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:

D. 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.

E. 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.

F. 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.

G. 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 File
- Entry 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.

H. 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.

I. 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.

J. 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.

K. 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.

L. 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.

M. 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.

N. 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.

O. 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.

P. 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.

Q. 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.

R. 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.

S. 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.

T. 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.

B. 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

Glossary of Credentialing Terms

Alias: An assumed or additional name.

Applicant: Any practitioner applying for credential approval with CAMHD.

Attestation Letter: A letter from a representative of the Agency attesting that they have obtained primary source verification documents from the primary source and that originals of these documents are maintained in the Agency credential file.

BBA: Balanced Budget Act, 42 CFR.

Client: Youth with emotional and/or behavioral challenges receiving intensive mental health services from CAMHD.

Contracted Provider Agency: Agency under contract with CAMHD to provide mental health services to CAMHD clients.

Complete Application: All blanks on the application form are filled in and necessary additional explanations provided; 2) All requested attachments and information have been submitted; 3) Verification of the information is complete and was done through primary sources when required; 4) All information necessary to properly evaluate the applicant's qualifications has been received and is consistent with the information provided in the application.

Credentialing: The systematic process of assessing the qualifications of CAMHD and CAMHD Agencies' qualified licensed mental health professional (QMHP), direct care personnel and clinical supervisors. The credentialing process ensures that staff has the required primary source verified credentials, licenses, certificates, malpractice coverage and other pertinent background to provide services to the consumers of CAMHD.

Credentialing Committee - standing The Credentialing Committee is a standing Child and Adolescent Mental Health Division (CAMHD) committee is designated to provide oversight over CAMHD's credentialing processes in accordance with the Credentialing Committee Policy and Procedures. Membership shall be representative of various disciplines from CAMHD's various sections with preference given, but not limited to licensed professionals.

Delegation- Authority assigned by the CAMHD to another / other organization to conduct functions and activities in CAMHD's behalf according to CAMHD expectations and standards in such a manner that benefits CAMHD. The organization is identified as a "*delegate*".

Department of Commerce and Consumer Affairs (DCCA): Professional and vocational licensing division of the State of Hawaii

The Educational Commission for Foreign Medical Graduates (***ECFMG)***: Evaluates foreign medical graduates' medical school curriculum to ensure that it is in alignment with the United States' medical school standards.

Mental Health Professional (MHP): Unlicensed, Board Ineligible Psychiatrist; Psychiatric Resident; Unlicensed, Ph.D or Psychologist (Psy D); Registered Public Nurse (RPN), Licensed with Masters Degree; Unlicensed, Masters Psychology; Licensed, Masters Social Work; Unlicensed Masters Social Work (MSW); Unlicensed Marriage & Family Therapist (MFT); Unlicensed, Masters Certified Counselor; Unlicensed, Masters Degree.

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 must 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. CAMHD requires an NPI for all QMHPs and MHPs, and all paraprofessionals providing and billing for 13101 (Intensive In-Home therapy) services.

National Commission of Quality Assurance (***NCQA)*** is an independent 501(c)(3) non-profit organization in the United States designed to improve health care quality. NCQA manages voluntary accreditation programs for individual physicians and medical groups. Health plans seeking accreditation measure performance through the Healthcare Effectiveness Data and Information Set (HEDIS).

Paraprofessional (PARA): Certified Substance Abuse Counselor (CSAC); Registered Public Nurse (RPN) Bachelors, Licensed; RPN Associate, Licensed; Licensed Practical Nurse (LPN); Bachelors, Psychology; Bachelors, Social Work; Bachelors, Counseling; Bachelors, Other; Associates, Other; High School Graduate or GED.

Primary Source Verification - The process of verifying an individual professional's verbal or documented claims of professional and legal standing through direct contact with officials at the primary sources of education, licensing, prior employment, insurance carriers, etc.

Practitioner: Any QMHP, MHP or Paraprofessional.

Qualified Mental Health Professional (QMHP): Medical Doctor (M.D.) Licensed Social Worker (LSW), Licensed Marriage and Family Therapist (LMFT), Licensed Psychologist (Ph.D or Psy.D); Advanced Practice Registered Nurse (APRN) and Osteopathic Doctor (D.O.)

Recredentialing A re-verification process of primary source information that may have changed since last reviewed, such as licenses and malpractice claims information

Termination: Voluntary or involuntary end of contract or employment with CAMHD or a CAMHD Contracted Provider Agency.

Credentialing forms and templates can be downloaded from the CAMHD website under Provider Relations Forms tab here:
http://health.hawaii.gov/camhd/provider-relations-forms/

CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
POLICY AND PROCEDURE MANUAL

SUBJECT: Sentinel Events and Reportable Incidents	**Number: 80.805**
	Page: 1 of 3
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] 2-24-14 Chief Eff. Date

PURPOSE

To establish uniform guidelines for a reporting system that is designed to track and document the occurrence of sentinel events and reportable incidents as reported by contracted provider agencies and the Child and Adolescent Mental Health Division (CAMHD) Family Guidance Centers (hereinafter referred to as "Providers").

DEFINITIONS

Sentinel Event - an unexpected occurrence involving death or serious physical and/or psychological injury, or the risk thereof, requiring immediate investigation and/or administrative response. Serious injury specifically includes loss of limb or function. The phrase "or the risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome.

Reportable Incident - an unexpected occurrence involving serious challenging behavior or an injury that does not pose a significant risk of harm or death.

Critical Sentinel Event - an event resulting in death.

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 strategies the organization will 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.

POLICY

1. 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.
2. Providers shall document and report all sentinel events and reportable incidents to the CAMHD Performance Management Office as well as the applicable Family Guidance Center where the youth is registered.
3. The Provider will review sentinel events to determine:
   A. Antecedents, triggers, and contributing factors; and
   B. Potential root causes.

REVISION HISTORY:	March 31, 2003; May 1, 2014	File Ref:
Initial Effective Date:	July 1, 2001	A6432
Biannual Review Date:		

CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
POLICY AND PROCEDURE MANUAL

SUBJECT: Sentinel Events and Reportable Incidents	**Number: 80.805**
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4. Provider agencies are required to track and analyze the occurrence of both sentinel events and reportable incidents as part of their quality improvement program to identify areas of need in general operations, program, staffing, training, and supervision. Results of these analyses shall be reported in the *Quarterly Quality Assurance Summary*.
5. The CAMHD reporting system shall allow for clinical and administrative oversight as well as the provision of data utilized towards preventive interventions.
6. The Provider shall complete a written report for all sentinel events and reportable incidents; sentinel event reports will include:
   A. A detailed assessment and analysis of the sentinel event, including the identification of precipitating and contributing factors;
   B. Post-event details; and
   C. Programmatic adjustments when necessary.

PROCEDURE

1. Providers must notify appropriate parties of all sentinel events and reportable incidents as follows:
   A. Sentinel events* must be verbally reported **within twenty-four (24) hours** to:
      1) the CAMHD Sentinel Event Line (733-9356);
      2) the assigned Care Coordinator; and
      3) the youth's legal guardian.
      *Critical sentinel events must be reported **within two (2) hours** to the CAMHD Administrator and the CAMHD Medical Director, in addition to the above.
   B. Reportable incidents must be verbally reported **within twenty-four (24) hours** to:
      1) the assigned Care Coordinator; and
      2) the youth's legal guardian.
2. Providers shall submit a written account of all sentinel events and reportable incidents as follows:
   A. Sentinel events must be submitted in writing using CAMHD's *Sentinel Event Form* (See Attachment A) **within three (3) business days.**
   B. Reportable incidents shall be submitted in writing using CAMHD's *Reportable Incident Form* (See Attachment B) **within five (5) business days.**
   C. Forms must be transmitted via an approved secure web server[1] or confidential fax[2] to:
      1) the Performance Management Office; and
      2) the assigned Care Coordinator.
3. The Performance Management Office will request or conduct an investigation of events involving:
   A. Death;
   B. Allegations of abuse; and
   C. Other occurrences deemed concerning.

[1] Secure web server such as HHIE must be mutually agreed upon by the agency and the CAMHD.
[2] Fax transmissions containing protected health information must follow protocol pursuant to *CAMHD P&P 80.402, "Confidentiality, FAX Transmission"*

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CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
POLICY AND PROCEDURE MANUAL

SUBJECT: Sentinel Events and Reportable Incidents	Number: 80.805
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4. A Root Cause Analysis (RCA) will be conducted for all critical sentinel events.
   A. The CAMHD Performance Manager and Medical Director shall assemble a team of CAMHD professionals and others to conduct the RCA. Members of the team may include:
      1) a licensed clinical mental health professional;
      2) Performance Management staff; and
      3) Other staff experienced in or having special knowledge of compliance with CAMHD, federal, and state guidelines and laws.
   B. Providers shall participate in the RCA and provide all relevant information requested by the team as appropriate.
   C. The Performance Manager will prepare a written report of the investigation and its findings, including the RCA and the Provider's Action Plan, for review by CAMHD leadership and the CAMHD Safety and Risk Management (SARM) Committee.
   D. The Performance Manager will prepare a final written report of the findings and recommendations that will be distributed to all applicable CAMHD sections.
   E. Performance Management staff will monitor agency follow-through as well as the adequacy and effectiveness of implemented corrective actions.
5. Provider agencies shall maintain a database of sentinel events and reportable incidents in order to generate reports and track trends.
   A. Aggregate data, analyses, and planned or implemented adjustments shall be reported in the *Quarterly Quality Assurance Summary*.
   B. The Performance Management Office may inspect a Providers' database and tracking system during special investigations and/or annual licensing and program reviews.
6. The Performance Management Office will maintain a call-log of all sentinel events to determine whether further information is necessary in instances where immediate action by the Provider and/or CAMHD is warranted.
7. The Performance Management Office will track the timeliness and adequacy of all submitted forms and will consult with the Performance Manager and/or Provider as necessary.
8. The Performance Management Office will maintain an electronic database of all sentinel events and reportable incidents. Reports will be generated quarterly and reviewed by the Performance Manager as well as Quality Assurance Specialists at each Family Guidance Center.

ATTACHMENTS

A. CAMHD Sentinel Event Form
B. CAMHD Reportable Incident Form
C. Sentinel Event and Reportable Incident Category Definitions

REVISION HISTORY:	March 31, 2003; May 1, 2014	File Ref:
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Sentinel Event Categories & Qualifiers

SE01 Abuse of Client
- Any act upon youth that results in a CPS/CWS report (made by the service provider)

SE02 Death of Client
- Result of an accident or natural events; occurs while youth is receiving services from your agency

SE03 Elopement (high-risk for harm to self or others)
- Youth away from home/program without permission; whereabouts unknown; gone overnight

SE04 Homicide
- A deliberate & unlawful death; youth either perpetrator or victim

SE05 Injury
- Result of an accident or intentional act; requires medical attention (emergency dept. or hospital visit)

SE06 Medication Error/Substance Intoxication
- Accidental misuse of medication; intentional abuse of medication/substance seeking intoxication; requires medical attention (emergency dept. or hospital visit)
  NOT SUICIDE ATTEMPT

SE07 Physical Assault
- Youth is either the perpetrator or victim of physical attack that results in an injury requiring medical attention (emergency dept. or hospital visit)

SE08 Psychiatric Hospitalization
- Unplanned admission to either the acute or inpatient psych unit

SE09 Refusal of Life-Preserving Medical Treatment
- Refusal of recommended or necessary life-saving treatment

SE10 Restraint or Seclusion (longer than 5 minutes)
- Impeding or restricting movement by physical or mechanical force as a safety measure; performed by staff

SE11 Self-Inflicted Potentially Lethal Injury
- Non-fatal, deliberate self-injury; with or without suicidal intent; requires medical attention

SE12 Sexual Assault
- Engaging in a non-consensual sex act through coercion or force; sexual contact with an individual under the age of 14; youth either perpetrator or victim

SE13 Suicide
- Intentional, self-inflicted harm/injury resulting in death

SE14 Suicidal Threat
- Expression of intent with a serious plan, and/or means, and/or an act of harm

SE15 Other
- Uncommon but SERIOUS events
  - Possession of a weapon; Fire-setting; Homicidal threat
- Potentially life-threatening behaviors
- Several low-moderate level risk factors combined produce a more serious situation

Reportable Incident Categories & Qualifiers

RI01 Elopement
- Youth away from TFH or CAMHD residential program without permission; whereabouts unknown; gone overnight
  Elopement from Mainland facility considered SE03

RI02 Physical Assault
- Youth is either the perpetrator or victim of physical attack that results in an injury but does not require medical attention
  Does not apply to IIH, MST, or FFT level of care

RI03 Restraint or Seclusion
- Impeding or restricting movement by physical or mechanical force as a safety measure; performed by staff; duration does not exceed 5 minutes; not repeated

RI04 Self-Harm
- Deliberate, intentional self-injury (cutting, burning, hitting) without suicidal intent

RI05 Suicidal Threat
- Plausible expression of thoughts or intent without a plan, and/or means, and/or an act of harm

RI06 Other
- Significant, warrants follow-up or further assessment
  - Unfounded allegations; Inappropriate sexual behavior
- Disrupts treatment
  - CWS/CPS removal (service provider not involved)
  - Potentially dangerous behaviors

Not SE/RI but MHCC Notification Required

While the following circumstances do not qualify as SE/RI, it is still important to notify the MHCC and Treatment Team members of these situations within 24-hours.

- × Runaway/Truancy
- × Drug/Alcohol Use
- × Theft
- × Arrests, Police Called for Assistance
- × Property Damage
- × Minor Injuries
- × Fights, Altercations, Arguments w/ Peers & Family
- × Consensual, Age-Appropriate Sexual Behavior
- × Frequently Encountered Challenging Behaviors
- × Taken to ER but Not Admitted (Crisis Plan)

All sentinel events must be verbally reported to the CAMHD Sentinel Event Line, Care Coordinator, and legal guardian **within 24-hours of the event**. This form is to be completed by staff and approved by the program QMHP **within 3 business days of the event**.

Sentinel Event - *an unexpected occurrence involving death or serious physical and/or psychological injury, or the risk thereof, requiring immediate investigation and/or administrative response. Serious injury specifically includes loss of limb or function. The phrase "or the risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome.*

Agency: Select **Service:** Select **Island:** Select

Youth: Last Name First Name **DOB:** Select

CR#: 123456 **MHCC:** Name **FGC:** Select

Event Date: Select **Event Time:** 10:00 PM **R / S Duration:** # minutes

Staff Involved: Name Name

Name Name Name

Event Description

Event description…

Precipitating & Contributing Factors

Contributing factors…

Post-Event Details

Post-event details…

Programmatic Adjustments

Program or treatment adjustments…

Additional Information

More info…

Event Category

SE01 ☐ **Abuse of Client** **if staff involved, program must complete an internal investigation*

SE02 ☐ **Death of Client**

SE03 ☐ **Elopement** (high-risk for harm to self or others)

SE04 ☐ **Homicide**

SE05 ☐ **Injury** (requiring emergency dept. or hospital visit)

SE06 ☐ **Medication Error / Substance Intoxication** (requiring emergency dept. or hospital visit)

SE07 ☐ **Physical Assault** (requiring emergency dept. or hospital visit)

SE08 ☐ **Psychiatric Hospitalization**

SE09 ☐ **Refusal of Life Preserving Medical Treatment**

SE10 ☐ **Emergency Intervention(s)** (restraint / seclusion lasting longer than 5 minutes, emergency med)

☐ **Restraint** ☐ **Seclusion** ☐ **Medication** (administered IM)

SE11 ☐ **Self-Harm** (requiring emergency dept. or hospital visit)

SE12 ☐ **Sexual Assault**

SE13 ☐ **Suicide**

SE14 ☐ **Suicidal Threat / Attempt** (serious – with a plan to harm / act of harm)

SE15 ☐ **Other** serious event not described above

Completed by: _____ **Date:** _____

Approved by: _____ **Date:** _____

All reportable incidents must be verbally reported to the Care Coordinator and legal guardian **within 24-hours**. This form is to be completed by staff and approved by the program QMHP **within 5 business days**. Reportable incidents should also be documented with a clinical note in the treatment record.

Reportable Incident - *an unexpected occurrence involving serious challenging behavior or an injury that does not pose a significant risk of harm or death.*

Agency: Select **Service:** Select **Island:** Select

Youth: Last Name First Name **DOB:** Select

CR#: 123456 **MHCC:** Name **FGC:** Select

Event Date: Select **Event Time:** 10:00 PM **R / S Duration:** # minutes

Staff Involved: Name Name

Name Name Name

Incident Description

Incident description…

Incident Category

RI01 ☐ **Elopement** (from CAMHD out-of-home placement)

RI02 ☐ **Physical Assault** (not requiring emergency dept. or hospital visit)

RI03 ☐ **Restraint or Seclusion** (less than 5 minutes, not repeated, performed by program staff)

RI04 ☐ **Self-Harm**

RI05 ☐ **Suicidal Threat** (without a plan to harm or act of harm)

RI06 ☐ **Other** significant incident not described above

Completed by: _____ **Date:** _____

Approved by: _____ **Date:** _____

SUBJECT: Grievances and Grievance Appeals	**Number:**	**80.603**
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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."*

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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.

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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).

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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

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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.

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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.);

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-
- 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.

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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)

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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;

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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;

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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

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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.

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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

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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:

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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)

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REFERENCE: Child Health Act, Public Law No. 106-310; 42 CFR Parts 441 and 483; CMS; American Academy of Child and Adolescent Psychiatry Policy Statement; AHA, "Guiding Principles on Restraint and Seclusion for Behavioral Health Services," Feb.'99; CAMHD Sentinel Event Policy.	**APPROVED:** *Signature on File* 03/13/07
	Chief Eff. Date

PURPOSE

To provide a uniform set of standards and guidelines, conducive with Centers for Medicare and Medicaid Services (CMS) requirements, for the use of restraint or seclusion for youth in out-of-home placements in Child and Adolescent Mental Health Division (CAMHD)-contracted programs.

DEFINITIONS

Emergency safety situation*:* when unanticipated youth behavior places the youth or others at serious threat of violence or injury if no intervention occurs and calls for an emergency safety intervention as defined in this section.

Emergency safety intervention*:* Intervention or action performed in a manner that is safe, proportionate, appropriate to the severity of the behavior, and the youth's chronological and developmental age, size, gender, physical, medical, psychiatric condition and personal history (including any history of physical or sexual abuse) to ensure the safety of the youth and others.

Seclusion*:* The ***involuntary*** confinement of 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 the unlocked seclusion room).

Serious occurrence: A youth's death, serious injury or suicide attempt.

Restraint*:* The restriction of freedom of movement through personal, drug or mechanical means in order to protect the individual from injury to self or to others. There are no distinguishing time limits among any form of restraint.

Mechanical Restraint: Any device attached or adjacent to the youth's body (***e.g.,*** four- point bed restraint) that restricts a youth's movement.

Personal (Physical))Restraint: Involves any use of physical force to restrict a youth's freedom of movement. Personal escorts where the youth is willfully cooperating with the escort is not considered a restraint until such time as the youth no longer intends to follow or be escorted (e.g., youth struggles with staff).

Drug (Chemical) Restraint: Any drug that:

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1. Is administered to manage a youth's behavior in a way that reduces the safety risk to the youth or others;
2. Has the temporary effect of restricting the youth's freedom of movement; and
3. Is not a standard treatment for the youth's medical or psychiatric condition.

Time Out: The removal of youth from peers or rewarding situations that does not involve seclusion. Time Out is not used as a primary purpose to confine the youth, only to separate the youth from others. Such a restriction requires constant monitoring by staff. The individual is not physically prevented from leaving the designated time-out area.

Serious Injury: Any significant impairment of the physical condition of the youth as determined by qualified medical personnel, including, but not limited to, burns, lacerations, bone fractures, substantial hematoma, and injuries to internal organs, whether self-inflicted or inflicted by someone else.

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:

- any inappropriate sexual contact between youth, or credible allegation thereof;
- any inappropriate, intentional physical contact between youth that could reasonably be expected to result in bodily harm, or credible allegation thereof;
- any physical mistreatment of a youth by staff, or credible allegation thereof;
- 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;
- medication errors and drug reactions;
- any fire, spill of hazardous materials, or other environmental emergency requiring the removal of youth from a facility; or
- any incident of elopement by a youth.

POLICY

1. Each client has the right to be free from restraint or seclusion of any form that is used as a means of coercion, discipline, convenience, or retaliation. For CAMHD-contracted providers providing intensive home and community-based intervention services, the CAMHD recognizes that seclusion and restraint are not available or practicable at these

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levels of care and therefore, are not generally used in such settings. Mental health professionals providing intensive home and community-based intervention services who might encounter potentially dangerous or otherwise unsafe situations in the community should be knowledgeable about resources and be sufficiently trained to recognize when police, mobile outreach, or emergency services are needed and then be able to assist in accessing the appropriate intervention.

2. 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 plan to anticipate and manage a youth's unsafe behavior and must be clearly documented that such non-aversive strategies were the first course of action.

3. Evidence of the use of non-aversive interventions and positive behavior supports is the expectation of all levels of care.

4. Uses of restraint or seclusion are safety interventions ***of last resort*** and only in situations where risk of danger to the youth or others is reasonably imminent. Restraint or seclusion:

   A. Is not used as a treatment intervention.

   B. Must terminate when the emergency safety situation has ended and the safety of all can be ensured, even if the order has not expired.

   C. Is prohibited from the simultaneous use.

   D. 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 under 9 years of age.

   E. Must not involve the use of mouth coverings.

   F. Must not result in harm or injury to the youth.

   G. Standing orders and as-needed (PRN) orders are prohibited.

PROCEDURE

1. CAMHD shall contractually require that each contracted provider agency must have policies and procedures regarding the use of restraint or seclusion. The policies and procedures must include, but are not limited to, the following:

   A. 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;

   B. Reviewing and updating restraint and seclusion policies and procedures regularly based on clinical outcomes;

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C. Agency-wide priority to use restraint or seclusion appropriately, safely and in accordance the agency's restraint and seclusion policies and procedures;

D. Adequate allocation of resources to prevent the frequent use of restraint or seclusion; and

E. Appropriate decision-making guidelines for when the use of restraint or seclusion is necessary.

2. Restraint or Seclusion Orders

A. Drug restraints 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 period of the emergency safety intervention.

B. Only a board-certified psychiatrist, licensed psychologist, or physician licensed to practice medicine with specialized training and experience in the diagnosis and treatment of mental diseases, may order the use of restraint or seclusion.

1. 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.

2. Each order must include:

a. The name and signature of the staff issuing the order;

b. The date and time the order was issued; and

c. The type of emergency safety intervention order, including the length of time authorized.

3. For Hospital-Based Facilities: A board-certified psychiatrist, licensed psychologist, or physician licensed to practice medicine with specialized training and experience in the diagnosis and treatment of mental diseases who issued the order 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***.

4. 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 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***.

5. All assessments will include, but are not limited to:

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a. The youth's physical and psychological status;

b. The youth's behavior;

c. The appropriateness of the intervention measures; and

d. Any complications resulting from the intervention.

6. The board-certified psychiatrist, licensed psychologist, or physician licensed to practice medicine with specialized training and experience in the diagnosis and treatment of mental diseases issuing the order must be available to staff for consultation, at least by telephone, throughout the period of the emergency safety intervention.

7. 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 staff, such as a licensed practical nurse, must immediately contact the person who issued the order to receive further instructions.

8. In the absence of a board-certified psychiatrist, licensed psychologist, or physician licensed to practice medicine with specialized training and experience in the diagnosis and treatment of mental diseases, verbal orders must be received by a registered nurse at the time the emergency safety intervention is initiated by staff and the physician must be available to staff for consultation, at least by telephone, throughout the period of the emergency safety intervention.

   Each order must include:

   a. The name of the staff issuing the order;

   b. The date and time the order was obtained;

   c. The type of emergency safety intervention ordered, including the length of time authorized; and

   d. The signature of the staff issuing the order that verifies the verbal order within ***twenty-four (24) hours of the order.***

C. If the youth's treatment team psychiatrist is available, only he or she can order restraint or seclusion.

D. If the treatment team psychiatrist is not the person issuing the order, he or she must be consulted as soon as possible and informed of the situation that required the restraint or seclusion. The date and time of this action must be documented. The program must document attempts to establish contact within 24 hours.

E. Written orders are never issued as standing orders or *as-needed* basis.

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3. Monitoring of the Youth:

   A. 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 duration of the emergency safety intervention.

   B. 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:

      1. Allow staff full view of the youth in all areas of the room; and

      2. Be free of potentially hazardous conditions such as unprotected light fixtures and electrical outlets.

4. Parental Notification

   A. At admission, parents or legal guardians and youths are informed of the program's policy regarding the use of restraint or seclusion during an emergency safety situation that may occur. The policy is communicated in a language understood by the youth and his/her parents or legal guardians.

   B. Each youth and/or his legal guardian shall be provided with a copy of the program's policy. The policy will inform them of the grievance procedure if they feel that this right has been violated.

   C. The youth and/or parents/legal guardian (if the youth is a minor) will acknowledge in writing that they have been informed of and understand the facility's policy. This written acknowledgement will be filed in the youth's record.

   D. 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 file. The program must document attempts to establish contact within twenty-four (24) hours.

5. Post-Intervention Debriefings

   A. Within twenty-four (24) hours after the use of restraint or seclusion, the youth and all staff (except when the presence of a particular staff person may jeopardize the well-being of the resident) involved in the emergency safety intervention must have a face-to-face discussion.

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B. 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 resulting in 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.

C. 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 that includes, at a minimum, a review and discussion of:

1. The emergency safety situation that required the intervention, including a discussion of the ***precipitating factors*** that led up to the intervention;

2. Alternative techniques that 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; and

4. The outcome of the intervention, including any injuries that may have resulted from the use of restraint or seclusion.

D. 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 treatment plan that resulted from the debriefings.

6. Medical Treatment

A. Staff must immediately obtain medical treatment from qualified medical personnel for a youth injured as a result of an emergency safety intervention.

B. The program must have affiliations or written transfer agreements with one or more hospitals approved for participation under the Medicaid program that reasonably ensure that:

1. A youth will be transferred to a hospital and admitted in a timely manner when a transfer is medically necessary for medical care or acute psychiatric care;

2. Medical and other information needed for care of the youth will be exchanged between the institutions in accordance with State medical privacy law, including any information needed to determine whether the appropriate care can be provided in a less restrictive setting; and

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3. Services are available to each youth twenty-four (24) hours a day, seven (7) days a week.

C. Staff must document in the youth's record, all injuries that occur as a result of an emergency safety intervention, including injuries to staff resulting from that intervention. Staff must also document any indications or allegations of injury or misconduct made by the youth along with the program's determination of appropriate follow-up.

D. Staff involved in an emergency safety intervention that results in an injury to a resident or staff must meet with supervisory staff and evaluate the circumstances that caused the injury and develop a plan to prevent future injuries.

7. Facility/Program Reporting

A. Each agency must record, maintain, and track, any use of seclusion and restraint following the use of the most recent and current Centers for Medicare and Medicaid Services accreditation requirements. At a minimum, reporting information shall include:

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

B. A sentinel event telephone call is made to CAMHD within twenty-four (24) hours of the occurrence of the restraint or seclusion. A complete documentation of the episode will follow in the CAMHD seventy-two (72) hour Sentinel Event Report, including (1) a review of the less restrictive alternatives that were considered, and (2) a reference to the debriefing with all staff involved in the event.

C. Psychiatric residential treatment facilities must report each serious occurrence to both the state Medicaid agency and the state protection and advocacy system no later than close of business the next business day after a serious occurrence.

1. Serious occurrences include: Youth's death; serious injury (refer to definition, page 2 of this policy), and youth's suicide attempt.

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2. Staff must document in the youth's record that the serious occurrence was reported and the name of the person to whom it was reported. ***A copy of this report must be maintained in the incident and accident report logs kept by the facility.***

3. The report must include the name of the resident, description of the occurrence, and the name, street address, and telephone number of the facility.

4. The facility must notify the youth's parent or legal guardian as soon as possible, but no later then twenty-four (24) hours after the serious occurrence.

8. Education and Training

A. The facility must require staff to have ongoing education, training, and demonstrated knowledge of:

1. Techniques to identify staff and resident behaviors, events, and environmental factors that may trigger emergency safety situations;

2. The use of nonphysical intervention skills, such as de-escalation, mediation conflict resolution, active listening, and verbal and observational methods, to present emergency safety situations; and

3. The safe use of restraint and the safe use of seclusion, including the ability to recognize and respond to signs of physical distress in youths that are restrained or in seclusion.

B. The facility must require or adhere to:

1. Staff certification in the use of cardiopulmonary resuscitation, including annual re-certification;

2. Individuals who are qualified by education, training, and experience must provide staff training;

3. Staff training must include training exercises in which staff successfully demonstrates in practice the techniques they have learned for managing emergency safety situations;

4. Trained staff who have demonstrated competency before participating in an emergency safety intervention;

5. Documentation in individual personnel records certifying successful training and demonstration of competency. Documentation must include the date training was completed and the name of the persons certifying the completion of training;

CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
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6. Initial training must be a minimum of eight (8) hours in duration. Staff must receive at least eight (8) hours of training in crisis intervention annually. At least two (2) times a year, a staff person must safely demonstrate the safe use of restraint or seclusion techniques; and

7. The availability of all training programs and materials for review by CMS, State Medicaid agency, and CAMHD.

ATTACHMENT: None

REVISION HISTORY: 07/08/03
Initial Effective Date: 02/17/02
Biannual Review Date:

File Ref:
A6762

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**

Service Principles

The following is a summary of the CAMHD Service System Principles. A complete version can be found in the *Child & Adolescent Mental Health Performance Standards* (pg. 202). http://health.hawaii.gov/camhd/files/2013/07/Orange-Book.pdf

1. Services will be child and family centered and will respect the culture of the family.
2. Services will address all needs such as health, feelings, behaviors, school, community, and each stage of growing up.
3. The main goal is to help the family get stronger and healthier, and stay together.
4. Services may take place in the home or where the child and family feel most comfortable and will match the child and family needs.
5. Sometimes a child needs to receive services away from home. All other choices will be considered before a child is placed out of the home. Services will short-term and focused on reuniting the family or finding a permanent placement.
6. Services will be helpful and should match the child's individual needs, even if their needs change.
7. Families and caregivers will be included in making treatment decisions and plans.
8. As children get older, they can take part in planning and making decisions about the services they receive.
9. Helping a child as soon as possible is important. Problems at home and school or with friends and family should be addressed early on to reduce the need for more serious services later.
10. It is important to protect and speak up for the rights of children.

How to File a Grievance

A grievance is a formal complaint about a person or service. If you are not happy with the services you have received or feel your rights or your child's rights have been violated, you can file a grievance.

There are two (2) ways to file a grievance:

1. Contact your Care Coordinator or the Quality Assurance Specialist at your Family Guidance Center; or
2. Call the CAMHD Grievance Office at: (808) 733-9352.

The Hawaii Department of Health
Child & Adolescent Mental Health Division

Service Principles and Consumer Rights & Responsibilities

Your Responsibilities

Parent participation makes a difference; your child is more likely to succeed if you are involved in the treatment. Here are some ways you can show your commitment to helping your child:

- Keep scheduled appointments. If you are going to miss an appointment, please call the person you are supposed to meet as soon as possible and ask them for a new appointment.
- Answer questions openly so we can provide the best care.
- Take an active role in the treatment.
- Attend and participate in the Coordinated Service Plan meetings.
- Ask questions if something is unclear or confusing.

Confidentiality

Information about your child is private. If someone needs your child's information they have to get your permission first. However, the CAMHD may share information about your child *without* your permission in the following situations:

- If there is a very serious emergency (like a car accident).
- If we believe that your child will hurt themselves or someone else.
- If the court orders us to provide information.
- If there are signs of child abuse or neglect.
- If there is a Med-QUEST audit.

Your child's information may be shared with service providers (doctors, teachers, social workers). These people will not give the information to anyone who is not involved in helping your child.

The CAMHD obeys the following State and Federal Laws:

- The Civil Rights Act, 1964
- The Age Discrimination Act, 1975
- The Vocational Rehabilitation Act, 1973
- The Americans with Disabilities Act
- The Health Insurance Portability and Accountability Act (HIPAA)
- 42 CFR – Confidentiality of Substance Abuse Patient Records
- The Individuals with Disabilities Education Act (IDEA)

Your Rights

People who receive services and other supports have certain rights and legal protections. Understanding these rights can help you make decisions about your child's treatment, solve problems, and stand up for yourself, child, and family.

1. You have the right to be treated with respect.
2. You and your child have the right to privacy.
3. You have the right to treatment regardless of your:
   - Race
   - Ethnicity
   - Sex
   - Religion
   - Nationality
   - Sexual Orientation
   - Disability
   - Primary Language
   - Gender Identity
4. You have the right to know about the CAMHD, the services you can receive and who will provide the services. You also have the right to know your treatment and service choices.
5. You have the right to know all your rights and your responsibilities. You have the right to get help from the CAMHD in understanding your services.
6. You are free to use your rights. You will not be treated differently and your services will not be changed because you use your rights.
7. You have the right to receive information and services in a timely manner.
8. You have the right to be 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.
9. You have the right to ask for a different provider. If you want a different provider, we will try to find another one to work with you.
10. You have the right to refuse treatment.
11. You have the right to get services in a way that respects your culture and beliefs.
12. You have the right to request and receive special accommodations such as interpretive services and assistance for the visually impaired.
13. 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.
14. You have the right to complain about your services and expect that no one will try to get back at you. If you complain, your services will not stop unless you want them to. *See "How to File a Grievance" on the back page for more information.*
15. You have the right to be free from being restrained or secluded unless an allowed doctor or psychologist approves. If that happens, it will only be to protect you or others from harm. Seclusion and restraint can never be used to punish you or 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.

Transitional Family Home Profile Form

1. Agency Name:
2. Agency Contact Name & Number: Date:
3. Foster Family Name:
4. Transitional Family geographic location:
5. Transitional Family preference or exclusions for youth (if any including age, gender, diagnosis, etc):
6. Transitional Family length of experience as TFH:
7. Transitional Family current number, age and sex of foster youth:
8. Transitional Family current number, age and sex of biological youth:
9. Transitional Family, maximum number of foster youth willing to take:
10. Transitional Family strengths:
11. Transitional Family weaknesses:

Comments:

Ohio Mental Health Consumer Outcomes System
Ohio Youth Problem, Functioning, and Satisfaction Scales

Y

Youth Rating – Short Form (Ages 12-18)

Name: _____ Date: _____ Grade: _____ ID#: _____ Completed by Agency

Date of Birth: _____ Sex: D Male D Female Race: _____

Instructions: Please rate the degree to which you have experienced the following problems in the past 30 days.	Not at All	Once or Twice	Several Times	Often	Most of the Time	All of the Time
1. Arguing with others	0	1	2	3	4	5
2. Getting into fights	0	1	2	3	4	5
3. Yelling, swearing, or screaming at others	0	1	2	3	4	5
4. Fits of anger	0	1	2	3	4	5
5. Refusing to do things teachers or parents ask	0	1	2	3	4	5
6. Causing trouble for no reason	0	1	2	3	4	5
7. Using drugs or alcohol	0	1	2	3	4	5
8. Breaking rules or breaking the law (out past curfew, stealing)	0	1	2	3	4	5
9. Skipping school or classes	0	1	2	3	4	5
10. Lying	0	1	2	3	4	5
11. Can't seem to sit still, having too much energy	0	1	2	3	4	5
12. Hurting self (cutting or scratching self, taking pills)	0	1	2	3	4	5
13. Talking or thinking about death	0	1	2	3	4	5
14. Feeling worthless or useless	0	1	2	3	4	5
15. Feeling lonely and having no friends	0	1	2	3	4	5
16. Feeling anxious or fearful	0	1	2	3	4	5
17. Worrying that something bad is going to happen	0	1	2	3	4	5
18. Feeling sad or depressed	0	1	2	3	4	5
19. Nightmares	0	1	2	3	4	5
20. Eating problems	0	1	2	3	4	5

(Add ratings together) Total _____

Instructions: Please circle your response to each questions.

1. Overall, how satisfied are you with your life right now?
    1. Extremely satisfied
    2. Moderately satisfied
    3. Somewhat satisfied
    4. Somewhat dissatisfied
    5. Moderately dissatisfied
    6. Extremely dissatisfied
2. How energetic and healthy do you feel right now?
    1. Extremely healthy
    2. Moderately healthy
    3. Somewhat healthy
    4. Somewhat unhealthy
    5. Moderately unhealthy
    6. Extremely unhealthy
3. How much stress or pressure is in your life right now?
    1. Very little stress
    2. Some stress
    3. Quite a bit of stress
    4. A moderate amount of stress
    5. A great deal of stress
    6. Unbearable amounts of stress
4. How optimistic are you about the future?
    1. The future looks very bright
    2. The future looks somewhat bright
    3. The future looks OK
    4. The future looks both good and bad
    5. The future looks bad
    6. The future looks very bad

Total:_____

Ohio Mental Health Consumer Outcomes System
Ohio Youth Problem, Functioning, and Satisfaction Scales

P

Parent Rating – Short Form

Child's Name: _____ Date: _____ Child's Grade: ___ ID#: _____ Completed by Agency

Child's Date of Birth: _____ Child's Sex: ☐ Male ☐ Female Child's Race: _____

Form Completed By: ☐ Mother ☐ Father ☐ Step-mother ☐ Step-father ☐ Other: _____

Instructions: Please rate the degree to which your child has experienced the following problems in the past 30 days.	Not at All	Once or Twice	Several Times	Often	Most of the Time	All of the Time
1. Arguing with others	0	1	2	3	4	5
2. Getting into fights	0	1	2	3	4	5
3. Yelling, swearing, or screaming at others	0	1	2	3	4	5
4. Fits of anger	0	1	2	3	4	5
5. Refusing to do things teachers or parents ask	0	1	2	3	4	5
6. Causing trouble for no reason	0	1	2	3	4	5
7. Using drugs or alcohol	0	1	2	3	4	5
8. Breaking rules or breaking the law (out past curfew, stealing)	0	1	2	3	4	5
9. Skipping school or classes	0	1	2	3	4	5
10. Lying	0	1	2	3	4	5
11. Can't seem to sit still, having too much energy	0	1	2	3	4	5
12. Hurting self (cutting or scratching self, taking pills)	0	1	2	3	4	5
13. Talking or thinking about death	0	1	2	3	4	5
14. Feeling worthless or useless	0	1	2	3	4	5
15. Feeling lonely and having no friends	0	1	2	3	4	5
16. Feeling anxious or fearful	0	1	2	3	4	5
17. Worrying that something bad is going to happen	0	1	2	3	4	5
18. Feeling sad or depressed	0	1	2	3	4	5
19. Nightmares	0	1	2	3	4	5
20. Eating problems	0	1	2	3	4	5

(Add ratings together) Total _____

Instructions: Please circle your response to each question.

1. Overall, how satisfied are you with your relationship with your child right now?
    1. Extremely satisfied
    2. Moderately satisfied
    3. Somewhat satisfied
    4. Somewhat dissatisfied
    5. Moderately dissatisfied
    6. Extremely dissatisfied
2. How capable of dealing with your child's problems do you feel right now?
    1. Extremely capable
    2. Moderately capable
    3. Somewhat capable
    4. Somewhat incapable
    5. Moderately incapable
    6. Extremely incapable
3. How much stress or pressure is in your life right now?
    1. Very little
    2. Some
    3. Quite a bit
    4. A moderate amount
    5. A great deal
    6. Unbearable amounts
4. How optimistic are you about your child's future right now?
    1. The future looks very bright
    2. The future looks somewhat bright
    3. The future looks OK
    4. The future looks both good and bad
    5. The future looks bad
    6. The future looks very bad

Total: _____

Mental Status Checklist:

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

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

Associations:
- ☐ intact
- ☐ loose
- ☐ circumstantial
- ☐ tangential
- ☐ unable to assess
- ☐ other:

Fund of Knowledge:
- ☐ age appropriate
- ☐ limited
- ☐ impaired
- ☐ unable to assess
- ☐ other:

Memory-Short Term:
- ☐ intact
- ☐ impaired
- ☐ unable to assess
- ☐ other:

Memory-Long Term:
- ☐ intact
- ☐ impaired
- ☐ unable to assess
- ☐ other:

Insight:
- ☐ good
- ☐ fair
- ☐ inconsistent
- ☐ poor
- ☐ unable to assess
- ☐ other:

Judgment:
- ☐ good
- ☐ fair
- ☐ inconsistent
- ☐ poor
- ☐ unable to assess
- ☐ other:

Intelligence:
- ☐ average
- ☐ above average
- ☐ borderline
- ☐ below average
- ☐ unable to assess
- ☐ other:

Comments:

Communication:

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

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

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

Comments:

General Appearance:

Body Type:
- ☐ age appropriate
- ☐ appears younger than stated age
- ☐ appears older than stated age
- ☐ unable to assess
- ☐ other

Weight:
- ☐ within normal limits
- ☐ underweight
- ☐ overweight
- ☐ unable to assess
- ☐ other:

Hygiene:
- ☐ well-groomed
- ☐ fair
- ☐ disheveled
- ☐ poor
- ☐ unable to assess
- ☐ other:

Eye Contact:
- ☐ good
- ☐ fair
- ☐ poor
- ☐ unable to assess
- ☐ other:

Comments:

Motor:

Fine Motor:
- ☐ advanced
- ☐ normal range
- ☐ mild delays
- ☐ significant delays
- ☐ unable to assess
- ☐ other:

Gross Motor:
- ☐ advanced
- ☐ normal range
- ☐ mild delays
- ☐ significant delays
- ☐ unable to assess
- ☐ other:

Comments:

Regulation:

Attention:
- ☐ intact
- ☐ limited
- ☐ severely impaired
- ☐ unable to assess
- ☐ other:

Activity Level:
- ☐ normal range
- ☐ overactive
- ☐ impulsive
- ☐ agitated
- ☐ lethargic
- ☐ unable to assess
- ☐ other:

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

Transitions:
- ☐ normal response
- ☐ anxious
- ☐ disorganized
- ☐ uncooperative
- ☐ unable to assess
- ☐ other:

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

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

Comments:

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

Comments:

Cognition/Thought Processes:

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

Life Skill Shopping List

Building Relationships Skills

W	D		W	D	
		Knowing when I can trust someone			Accepting help
		Getting close and staying close			Difficulty sharing about myself "letting people in"
		Helping/supporting others			Supporting yourself
		Expressing gratitude			Giving compliments
		Making new friends or contacts			Able to talk story
		Understanding how others feel			Identifying a non-parent adult support (i.e. Uncle/Aunty, coach, kumu, clergy etc.)
		Accepting "no" as an answer			Accepting compliments
		Handling rejection			Being anxious or nervousness around people
		Knowing when someone is taking advantage of you			managing romantic or sexual feelings
		Other:			

Managing Joint Decisions & Managing Interpersonal Conflict

W	D		W	D	
		Dealing someone else's different opinion			Accepting disappointment
		Deciding on how much to self-sacrifice			Thinking out-of-the-box for interpersonal problems
		Recognizing and choosing reasonable solutions			Problem solving
		Negotiating			Asserting yourself
		Picking your battles			Forgiving others
		Other:			

W=want to learn
D=Did it!

Dealing with frustration and unfavorable events

W	D		W	D	
		Handling frustration			Handling one's own mistakes and failures
		Feeling appropriate fear in a dangerous situation			Telling whether a situation is dangerous
		Feeling appropriate guilt when you've done wrong			Tolerating one's own feelings or thoughts
		Handling thoughts or impulses that I shouldn't do			Dealing with second person's getting something that one wants for oneself
		Suicidal thoughts			Thoughts of self-harm
		Dealing with being apart from a loved one			Other:

Celebrating good things, feeling pleasure, leisure time

W	D		W	D	
		Accepting approval, compliments and positive attention			Enjoying exploration, discovery and the unknown
		Feeling pleasure from doing kind, loving acts			Feeling gratitude
		Celebrating and feeling the blessing of luck			Playing, being silly, carefree
		Rewarding oneself for one's own accomplishments			Finding constructive use of time
		Relaxing			Enjoying humor
		Other:			

W=want to learn
D=Did it!

Developing the capacity for delayed gratification

W	D		W	D	
		Denying myself something I want right now			Following rules, obeying
		Persisting on tasks even when discouraged			Maintaining healthy habits (smoking, drugs etc.)
		Being honest and dependable			Developing skills that bring approval from people (work, school, recreation)
		Saving instead of spending			Concentration and attending
		Working towards a long-term goal			Understanding “deliberate” practice
		Tracking your own progress and hard work			Scheduling and prioritizing meaningful activities and healthy habits
		Other:			

Cognitive processing through words, symbols and images

W	D		W	D	
		Using words to understand the world			Recognizing and talking about your feelings
		Correctly seeing how other people feel			Deciding how much control you have over different events
		Decision making; defining a problem, gathering info, generating options, predicting and evaluating consequences, making choices			Thinking before acting
		Organizing and planning			Realistically looking at your own skills and abilities
		Seeing the skills and character of others			Being able to use imagination as a tool
		Identifying problem thoughts			Changing problem thoughts
		Re-thinking the meaning of past events			Other:

W=want to learn
D=Did it!

Transition Shopping List

Education

W	D		W	D	
		Obtain High School Diploma			Complete Personal Statement
		Apply for College			Search For Scholarship
		Complete Financial Aid Forms			Complete/Submit Scholarship App.
		Enter Another Educational/Cert. Program			Go On A Campus Tour
		Other:			

Employment

W	D		W	D	
		Find A Job			Learn Basic Computer Skills
		Write A Resume; Complete Job Appl.			Learn How To Read A Paycheck Stub
		Learn To Read A Job Ad			Get A Social Security Card
		Get A State Of Hawaii ID			Get An Official Birth Certificate
		Open a Checking/Savings Account			Learn About Building Credit & Savings

Living Situation

W	D		W	D	
		Learn About Tenant And Landlord Rights			Learn How To Cook Five Good Meals
		Understand A Lease Agreement			Learn About Nutrition and Diet
		Learn How To Do Your Own Laundry			Learn How To Use A Stove, Oven, etc.
		Learn How To Clean A Kitchen/Bathroom			Find An Affordable Safe Place To Live
		Other:			

Life skills:

W	D		W	D	
		Get A Driver's Permit			Get Medical Insurance
		Get A Driver's License			Get Auto Insurance
		Balance My Checkbook			Understand My Medications
		Learn How To Shop For The Best Deals			Learn How To Protect Myself From ID Theft
		Learn The Local Bus System			Find 5 New Ways To Have Fun
		Learn How To Manage Stress			Find A Workout System That I Enjoy
		Understand Birth Control And STDs			Gain or Lose _____ lbs.
		Make New Friends			Volunteer In The Community
		Find A Good Doctor You Can Visit			Learn How To file Taxes
		Find A Good Counselor You Can Visit			Find A Good Dentist You can Visit

W=Want to Do It
D=Did it!

Caregiver Skills Menu

Caregiver name:

W	D		W	D	
		Giving Praise			Providing incentives to my child
		Giving Rewards			Expectations and monitoring
		Setting limits & giving consequences			Learning to really hear what my child is saying
		Teach problem solving			Improve my communication skills
		Manage my own anger			Depression management (for self)
		Managing my own stress			Identifying what is already working
		Help my child calm down			Responding to depression (of youth)
		Develop routines (meals, homework etc.)			Supporting my anxious child
		Practicing and supporting therapeutic interventions given to youth			Using family meetings to maintain order, consistency and clear expectations
		Supporting school achievement			Conflict resolution skills
		Learning about the thinking-feeling-doing triangle			Learning about parenting organizations and resources
		Learning about youth organizations and resources			How to promote family members supporting each other
		What to do when my child runs away			What to do when my child threatens suicide
		What to do when my child threatens me or a family members			Understanding my child's crisis plan
		Developing family goals			Find a non-caregiver reliable adult support for youth
		Other:			

W=want to learn
D=Did it!