



## Revision Table

Revision Date	Sections Revised	Description
7/1/2011	The entire manual	The document was formatted in a similar style with DHSS Medicaid Provider Manual
7/1/2012	Table of Contents	Changed the reference in NOTE to be a hyperlink to the DPBHS Provider Web Page
7/1/2012	1.3.1.1	Changed the section to include exception to requirement of needing parental or legal guardian consent to include substance abuse treatment services for youth age 14 and over. "The only exceptions that do not require consent of the parent or legal guardian are for involuntary psychiatric hospitalizations and substance abuse treatment for youth age 14 and over. "
7/1/2012	1.2.1.1	Mission and Vision have been revised to show the updated Mission and Vision Statements.  Mission: Collaborating to offer effective child and family centered prevention, early intervention and treatment services  Vision: Resilient children and families living in supportive communities.
7/1/2012	1.2.3	Added sentence and hyperlink of where to find DSCYF Operating Guidelines
7/1/2012	1.3.1.3	Updated weblink to incorporate direct hyperlink to website listed
7/1/2012	1.3.2	Added narrative defining licensed staff
7/1/2012	2.2	Maintenance of Records and Documentation - Additional sentence referring to content referenced in Section 6.10.3
7/1/2012	2.2.2	Changed acronym to DPBHS
7/1/2012	2.2.3	Added the following bullets: <ul style="list-style-type: none"> <li>• Assisted in application for insurance, if appropriate</li> <li>• GAIN Short Screener (non-SA Programs for youth in services, age 12+)</li> <li>• GAIN for All SA Services (for more information please see section specific to GAIN)</li> <li>• UCLA administered when clinically appropriate</li> <li>• PCIT used when clinically appropriate</li> <li>• If Level of Care Changed, Revised Treatment Plan</li> <li>• Notes are co-signed</li> <li>• DSCYF Transfer Instruction Sheet</li> </ul> Added "DPBHS Standardized" in front of Assessment, Admission Summary, Treatment Plan, and Discharge



		Summary Reformatted bullet outlining expectations for progress notes so it is bulleted
7/1/2012	3.1.1	DPBHS Consumer Eligibility section – added hyperlinks to the listed Policy and referenced clinical criteria
7/1/2012	3.1.3	Under <i>Outpatient Services</i> , added hyperlinks to listed DPBHS Website.  Under <i>Crisis Services</i> , revised him/herself to read as himself/herself  Under section, <b>IMPORTANT</b> Added the phone number without letters 1-800-969-4357
7/1/2012	3.1.5	Added hyperlink for DHSS Medicaid page
7/1/2012	3.1.6	Added hyperlink to DPBHS Provider Website for the LogistiCare Service Improvement Form
7/1/2012	4.3	<b>References Director of Clinical Services</b> 302-633-2599 – Effective June 4, 2012, the new Director of Intake and Clinical Services Treatment Teams is Julie Leusner
7/1/2012	5.1.2.1	Language has changed from “Prior to the end of the authorization period, a member of the CSMT will call the provider and conduct a progress review” to “Prior to the end of the authorization period, <b>the provider will communicate with CSMT in order to conduct a progress review.</b> ”
7/1/2012	5.3	Added ‘for Routine Outpatient Services’ to Section title
7/1/2012	5.3.1.1	Added a hyperlink to the DPBHS website as referenced in this section
7/1/2012	5.3.2	Form Submission – added a hyperlink to Provider Page as referenced in this section
7/1/2012	5.3.3	Updated the DPBHS Outpatient FAX number to: (302) 424-2960
7/1/2012	5.4.2	Added a hyperlink to the referenced DPBHS website  Updated the DPBHS Outpatient FAX number to (302) 424-2960
7/1/2012	5.5	Updated the phone number for the questions regarding consumer authorization (302) 424-6102
7/1/2012	6.1.5	Added hyperlink to referenced DPBHS website
7/1/2012	6.3	Removed See Appendix reference and updated to DPBHS Provider Page website address/URL
7/1/2012	6.3.1.1.1	Removed referenced to the Moods and Feelings Questionnaire



7/1/2012	6.3.4	Revised reference to Section 5 below to read as “section 6.5”
7/1/2012	6.6	Revised section numbers for <i>For behavioral intervention and crisis requirements see #6.6.1 (‘Integrated Behavioral Intervention Program Activity Plan) or #6.6.2 (Crisis Services Plan for Safety) within this section.</i>
7/1/2012	6.9.3	Added hyperlink to this section which references DPBHS website
7/1/2012	6.9.4	Added fax number in which the Transfer Instruction Sheet is to be submitted
7/1/2012	7.1.2.6	Removed the requirement for “Licensed clinical staff providing direct treatment services must document, at minimum, one hour of supervision per month.”
7/1/2012	7.5.1	Added hyperlinks to referenced policies
7/1/2012	7.6	Added hyperlink to referenced DPBHS Handbook
7/1/2012	7.7.2.3.2	Added language for After Hours Coverage
7/1/2012	7.8	Added hyperlink to the DPBHS Provider Website
7/1/2012	7.8.2.1	Added hyperlink to “The Professional’s Guide to Reporting Abuse and Neglect”
7/1/2012	7.8.2.2	Added hyperlink to section <i>If the provider does not deliver services in Delaware</i>
7/1/2012	8.1.2.2	Updated fax number for outpatient clinical reports to (302) 424-2960
7/1/2012	<b>SCHEDULE OF DOCUMENT DELIVERABLES – ADMINISTRATIVE INFORMATION</b>	Updated person to contact for any change in documentation status, to the DPBHS Manager of Quality Improvement and the fax number: 302-622-4475
7/1/2012	9	Reimbursement – Revised Timeframe Identified for Timely Submission
7/1/2012	9.2	Submission of Electronic Billing – contact information has been updated to the current Billing Manager’s phone number 302-633-2695
7/1/2012	9.2.3	Added content: <b>For a more comprehensive review of the DPBHS acceptable billing practices and instructions on how to bill, please refer to the DPBHS Treatment Provider Billing Manual</b>
7/1/2012	9.3	Direct Deposit contact number has been updated to Karen Connell 302-892-4533
7/1/2012	10	Division Seclusion and Restraint Philosophy Statement –



		Corrected Division Acronym to DPBHS
7/1/2012	11	Under NOTE, added hyperlinks to the identified website addresses

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NOTE: This Manual, including the forms referenced within, and much of the information referred throughout can be viewed via the DPBHS internet site: <http://www.kids.delaware.gov/pbhs/pbhs.shtml>



## Division of Prevention and Behavioral Health Services Provider Manual

**THIS MANUAL CONTAINS INFORMATION FOR SUCCESSFUL DPBHS/PROVIDER RELATIONS AND IS ATTACHED BY REFERENCE TO THE PROVIDER CONTRACT.**

### 1.0 Introduction

The Delaware Department of Services for Children, Youth, and their Families' (DSCYF) Division of Prevention and Behavioral Health Services (DPBHS) enters into contracts with provider agencies for the purchase of treatment services furnished to eligible consumers. This Manual has been developed to set forth the general policies and procedures for provider participation. For reimbursement of services by DPBHS, providers shall comply with requirements stated in this Manual.

This Manual is a reference document for provider agencies, Department program and contract administrators and staff. It contains the necessary conditions and requirements for continued participation in and reimbursement of treatment services.

#### 1.1 Legal Basis

Legislative Mandate - In 1983, 29 Delaware Code, Chapter 90 established the Department of Services for Children, Youth and Their Families (DSCYF). DSCYF is made up of four Divisions which focus on specific child and family needs. Each Division has a legal mandate to provide certain aspects of treatment/intervention for children and families involved with the Department:

1.1.1 The Division of Family Services (DFS) provides intervention services for abused, neglected, and dependent children and adolescents and their families.

1.1.2 The Division of Youth Rehabilitative Services (DYRS) provides treatment/habilitation/rehabilitation for youth, both pre- and post- adjudication.

1.1.3 The Division of Management Support Services (DMSS) provides fiscal, personnel and other general services for the Department. DMSS is also responsible for coordinating and/or providing education services for residential and day treatment programs.

1.1.4 The Division of Prevention and Behavioral Health Services (DPBHS) is mandated to provide a comprehensive continuum of treatment services for children, youth, and their families in the least restrictive and most community-based service appropriate.

#### 1.2 Purpose and Scope of DPBHS

1.2.1 The purposes of DPBHS:

1.2.1.1 **Mission - Collaborating to offer effective child and family centered prevention, early intervention and treatment services.**

**Vision – Resilient children and families living in supportive communities.**

1.2.1.2 DPBHS provides services to children and families in accordance with Systems of Care principles:

1.2.1.2.1 Values:

Effective: July 1, 2012



- child-centered and family focused with the needs of the child and family dictating the types and mix of services provided.
- community-based services, integrated with intensive care management.
- culturally competent, with services that are responsive to the cultural, racial and ethnic differences of the population served.

#### 1.2.1.2.2 Guiding Principles:

- comprehensive service array to meet individual child and family needs.
- individualized service planning.
- least restrictive, most normative setting which is clinically appropriate.
- families and surrogate families should be full participants in all aspects of the planning and delivery of services.
- intensive care management to ensure coordination and integration of services.
- early identification and intervention for children is key.
- smooth transitions to adult services at age 18.
- rights of children and their families should be protected.
- effective advocacy for children and their families should be promoted.

1.2.2 Commitment to Evidence-Based Practices - DPBHS encourages services which can be empirically supported in literature for specific target populations and presenting problems. These practices may include: positive behavioral support, cognitive behavioral therapy, multi-systemic therapy, Cannabis Youth Treatment (CYT), etc.

1.2.3 This Document - This document is a supplement to the Department of Services for Children Youth and Their Families (DSCYF) Operating Guidelines for Service Providers, which sets forth the minimum standards expected for DSCYF providers. **The DSCYF Operating Guidelines is available at: [http://kids.delaware.gov/mss/mss\\_contracts.shtml](http://kids.delaware.gov/mss/mss_contracts.shtml)**

It specifies additional performance standards and expectations for DPBHS Providers. These are in addition to but not in lieu of other certifications, licensures, and State or Federal requirements. DPBHS policies specifically referenced can be found on the DPBHS website and hard copies are available upon request.

1.2.4 Accreditation - DPBHS seeks to provide high quality services to children, families, and communities. To that end, DPBHS maintains accreditation by the Commission on Accreditation of Rehabilitation Facilities (CARF) under Business and Services Management Network Standards. DPBHS seeks to contract with providers who maintain their own accreditation from an approved accreditation body.

1.2.4.1 Providers with accreditation: DPBHS accepts accreditation by the following bodies:

- Joint Commission on Accreditation of Healthcare Organizations (JCAHO)
- Council on Accreditation (COA)
- Commission on Accreditation of Rehabilitation Facilities (CARF)
- Community Health Accreditation Program (CHAP).

1.2.4.2 Providers without accreditation status: At minimum, these providers must meet DPBHS clinical standards outlined in this Manual and the Commission on Accreditation of Rehabilitation Facilities (CARF) standards for unaccredited providers under the Business and Services Management Network.

- All providers who were active with DPBHS on January 31, 2007 and have an annual Contract of \$350,000 or more must have their own independent accreditation.  
Providers who have contracts ranging from \$35,000.00 to \$349,999.00: must obtain independent accreditation within three years of July 1, 2010 or within 3 years of the initiation of the contract, whichever is later, and will be



treated as unaccredited providers by DPBHS and CARF and subject to compliance with CARF survey requirements as an unaccredited provider.

- New unaccredited providers who have an annual contract of \$350,000 or more will be required in the Request for Proposals to demonstrate a plan to have their own independent accreditation within three years of start-up.

1.2.4.3 Accreditation and licensure certificates must be prominently displayed at each organizational site, and changes in accreditation status must be brought to the attention of DPBHS within 24 hours.

1.2.5 Acknowledgment of public funding – For the following providers all public relations documents (such as brochures, annual reports, other printed material or online material, etc.) must contain: ‘Member of the Division of Prevention and Behavioral Health System’:

1.2.5.1 Providers/programs that are funded by DPBHS under cost-reimbursable contracts.

1.2.5.2 Providers whose agency/program name appears on the DPBHS website

1.2.5.3 Providers whose agency/program name appears in the DPBHS brochure.

1.2.5.4 Providers/programs with unit-cost contracts whose total income from DPBHS is 60% or more of their total income for the program.

### 1.3 DPBHS Provider Network

1.3.1 DPBHS Care Assurance - DPBHS acts as a public Managed Care Organization (MCO) for children’s behavioral health treatment. It provides mental health and substance abuse treatment and case management to eligible children without limit for as long as it is clinically necessary.

1.3.1.1 DPBHS Consumer Population: Children and adolescents, who are residents of the State of Delaware, are under age 18 and are Medicaid-eligible or who are without insurance coverage. All services are voluntary in that they require consent of the parent or legal guardian. **The only exceptions that do not require consent of the parent or legal guardian are for involuntary psychiatric hospitalizations and substance abuse treatment for youth age 14 and over.**

1.3.1.2 DPBHS Role in Delaware Medicaid Managed Care: Medicaid Managed Care in Delaware is called the *Diamond State Health Plan (DSHP)*. For behavioral health care there is a public/private partnership to ensure that children with Medicaid get the care that is clinically necessary. The DSHP-contracted MCOs provide the basic health care benefit as well as the basic annual behavioral health care benefit of up to 30 hours of outpatient mental health or substance abuse services.

1.3.1.3 DPBHS provides extended services under the DSHP. This includes services beyond the 30 hours per year of outpatient behavioral healthcare that is included in the basic benefit package provided by the contracted MCOs, and more intensive treatment services. Instruction for how MCO providers can access supplementary funding for their outpatient consumers is on the DPBHS website ([http://www.kids.delaware.gov/pbhs/pbhs\\_providers.shtml](http://www.kids.delaware.gov/pbhs/pbhs_providers.shtml)).

1.3.2 Membership in the Provider Network In accordance with Delaware Code Title 29 Section 6981 DSCYF purchases professional services in excess of the established current annual expenditure threshold using a competitive bidding process. In order to join the Provider Network, one should bid to provide a service once a Request for Proposals (RFP) has been announced. To receive automatic notification of bid opportunities go to the State of Delaware’s Bid Solicitation Directory and follow the instructions to register for bid notifications.

**All licensed mental health providers must be paneled with Medicaid.** Licensed staff refers to any licensed practitioner of the healing arts who is licensed in the State of Delaware to diagnose and treat behavioral health and/or substance abuse issues acting within the scope of all applicable state laws and their professional licenses. Within the State of Delaware, those licensed by the Delaware Division of Professional Regulation are as follows:



- Licensed Psychologists
- Licensed Clinical Social Workers (LCSWs)
- Licensed Professional Counselors (LPCMHS)
- Licensed Marriage and Family Therapists (LMFTs)
- Licensed Chemical Dependency Professionals (LCDP)
- Advanced Practice Registered Nurses (must be a nurse practitioner specialist in Adult Psychiatric & Mental Health, and Family Psychiatric & Mental Health, or a Certified Nurse Specialist in Psychosocial, Gerontological Psychiatric Mental Health, Adult Psychiatric and Mental Health, or Child-Adolescent Mental Health and practice within the APRN's scope of practice)
- Physician

For any provider that submits claims to DPBHS must be appropriately licensed and/or certified to provide those services delivered. Failure to obtain and maintain proper licensure, certification or other requirements to provide services during the term of the contract and service delivery will result in penalties and/or in denial of payment by DPBHS. The contracted agency must also obtain and maintain a business license as appropriate.

1.3.2.1 Network Providers: DPBHS provides services through a contracted panel of agencies and individuals. Although DPBHS prefers to contract with providers who deliver services within the state, out-of-state contracts are negotiated for residential services not available in Delaware.

1.3.2.2 Out-of-Network Providers: DPBHS negotiates contracts/agreements for services not ordinarily available from an established DPBHS provider. These specialties include but are not necessarily limited to: eating disorders, complicated medical non-compliance, and services provided in languages other than English including American Sign Language (ASL).

### 1.3.3 Contracting and Reimbursement Methods

1.3.3.1 Cost-Reimbursable Contracts – These are services in which DPBHS fully funds a program using a line-item budget. These contracts may be used only in specific circumstances prescribed by the Department.

1.3.3.2 Unit Cost Services – These contracts are funded on a fee-for-service basis.

### 1.3.4 DPBHS Provider Contacts

1.3.4.1 Each service provider is assigned a primary DPBHS contact who is responsible for provider relations and contract management.

1.3.4.2 The names of DPBHS provider contacts can be found on the DPBHS website.

## 1.4 **General Conditions for Participation**

1.4.1 State regulations and policy define the following general standards for providers who participate as follows:

- Compliance with current licensure by the appropriate State authority for the practitioner's specialty, all applicable accrediting standards, any applicable Federal service standards, and all applicable State and Federal laws.
- Agreement to charge DPBHS no more for services to eligible consumers than is charged on the average for similar services to others.
- Agreement to accept the amounts established by DPBHS as payment-in-full and not to seek additional payment from the consumer or parent/guardian for any unpaid portion of a bill.



1.4.2 Although this is a voluntary program, a signature on a contract serves as an agreement to abide by all policies and regulations of DPBHS. This agreement also certifies that, to the best of the provider's knowledge, the information contained in the clinical record is true, accurate, and complete.



## 2 Provider Participation and Requirements

### 2.1 Provider Contract

2.1.1 Applicants who enter into a contract with DPBHS are obligated to meet certain conditions in order to remain an eligible provider and receive payment for services rendered.

2.1.2 The provider must abide by DPBHS' policies and procedures, including but not limited to:

- Submit claims only for services that were actually rendered by the billing provider
- Accept final payment disposition as payment in full for covered services
- Keep records necessary to verify the services provided and permit Federal/State representatives access to the records
- Determine the individual was eligible at the time of service
- Make restitution for any overpayment
- Notify DPBHS of any suspensions or exclusions from any program

### 2.2 Maintenance of Records and Documentation

2.2.1 All providers providing services for DPBHS are required to maintain records that will disclose services rendered and billed under the program, and upon request, to make such records available to DPBHS or its representatives in substantiation of any or all claims. These records should be retained a minimum of five (5) years in order to comply with all State and Federal regulations and laws. For more information pertaining to the expectations for records retention, please refer to section 6.10.3 Retention and Preservation of this manual.

2.2.2 In order for DPBHS to fulfill its obligation to verify services provided to consumers, providers must maintain auditable records that will substantiate the claim submitted to DPBHS.

2.2.3 At a minimum, the records must contain the following on each consumer:

- Certificate for Medical Necessity (when applicable)
- Service Admission Form (SAF)
- Admission Face Sheet
- Signed Physician's Orders (when applicable)
- Psychiatric Evaluation (when applicable)
- Medication Administration Record (MAR) (when applicable)
- 24-hour Patient Care/Monitoring (when applicable)
- Laboratory and Diagnostic tests/reports (when applicable)
- Assisted in application for insurance, if appropriate
- GAIN Short Screener (non-SA Programs for youth in services, age 12+)
- GAIN For All SA Services (for more information please see section 6.3.4)
- UCLA when clinically appropriate



- PCIT when clinically appropriate
- DPBHS Standardized Assessment
- Safety plan(s) (when applicable)
- DPBHS Standardized Admission Summary
- DPBHS Standardized Treatment plan which includes goals consistent with the SAF, goals in consumer language, risks being addressed, signatures of consumer, guardian, clinician, psychiatrist (if plan includes medication), and supervisor.
  - If Level of Care Changed, Revised Treatment Plan
- Progress notes that show collaboration with involved parties, notes are dated, specify length and type of session, list participants, and are signed by a supervisor when the clinician is not licensed, notes are linked to treatment goals as identified in DPBHS Standardized Treatment plan, and risks are addressed. Specifically, documentation needs to show collaboration with:
  - CSM team
  - School
  - DFS (if applicable)
  - YRS (if applicable)
  - Informal supports
  - Step down provider
  - Other
- Notes are co-signed
- DPBHS Standardized Discharge Summary
- DSCYF Transfer Instruction Sheet

## 2.3 Audits and Monitoring

2.3.1 All services for which charges are made to DPBHS are subject to audit. Audit proceedings should not be construed as an indication of any wrongdoing on the part of the provider. Rather, an audit should be looked upon as ongoing and necessary to ensure quality service delivery within State and Federal regulations.

2.3.2 During a review audit, the provider shall furnish to the Department or its representative, pertinent information regarding claims for payment. Should an audit reveal incorrect payments were made, or that the provider's records do not support the payments that were made, the provider shall make appropriate restitution.

2.3.3 In addition to performing audits, the Department may routinely monitor a provider's performance with respect to compliance with certification and/or enrollment requirements. Both fiscal and clinical compliance shall be monitored. Should a provider be found to be non-compliant, Medicaid enrollment may be suspended or revoked, until at which time the provider can prove compliance with necessary requirements.

## 2.4 Administrative Sanctions



2.4.1 Payments made by DPBHS are subject to review to ensure the quality, quantity, and medical need for services. Administrative sanctions may be imposed against any provider who does not meet the State and Federal guidelines, regulations and laws.

2.4.2 Administrative sanction refers to any administrative action applied by DPBHS, and is designed to remedy inefficient and/or illegal practices that are in noncompliance with the DPBHS policies and procedures, statutes, and regulations.

2.4.3 DPBHS may impose various levels of administrative sanctions against a provider, including the following:

- Give warning through written notice or consultation
- Require education in program policies and billing procedures
- Require prior authorization of services
- Place claims on Manual review before payment is made
- Suspend or withhold payments
- Recover money improperly or erroneously paid either by crediting against future billings or by requiring direct payment
- Refer to the State licensing authority for review
- Refer for review by appropriate professional organizations
- Refer to Attorney General's Fraud Control Unit for fraud investigation
- Suspend certification and participation in the Provider Network
- Refuse to allow participation in the Provider Network.

2.4.4 DPBHS may impose sanctions against a provider of services if the agency finds that the provider:

- Is not complying with policy or rules and regulations, or with the terms and conditions prescribed in the provider contract
- Has submitted a false or fraudulent application for provider enrollment status
- Is not properly licensed or qualified, or that the provider's professional license, certificate or other authorization has not been renewed or has been revoked, suspended or terminated
- Has failed to correct any deficiencies in its delivery of service or billing practices after having received written notice of these deficiencies from DPBHS
- Has presented any false or fraudulent claim for services
- Has failed to repay or make arrangements for the repayment of any identified overpayment or erroneous payment
- Has failed to keep or make available for review, audit, or copying any information or records to substantiate payment of claims for service provision



### 3 Consumer Eligibility

#### 3.1 Eligibility

3.1.1 DPBHS Consumer Eligibility - DPBHS provides mental health and substance abuse services to children under age 18, who are Medicaid-eligible, or who are without insurance coverage; who are residents of the State of Delaware and who meet the DPBHS criteria for treatment at specific levels of care (NOTE: For further information see the DPBHS Eligibility Policy [CS 001] and “clinical criteria” available on the DPBHS website).

3.1.2 DPBHS Eligibility for Non-Residents of the State of Delaware - Crisis services and short-term emergency hospitalization may be provided to non-resident youth under the age of 18 who are in Delaware and whose behaviors present imminent danger to self or others due to behavioral health disorders. DPBHS reserves the right to seek reimbursement for services provided to non-Delaware residents.

3.1.3 Access - There are three access points through which a consumer may be admitted to DPBHS treatment services:

-*Outpatient Services* - Parents/caretakers may call any of the DPBHS mental health or substance abuse outpatient providers listed in the DPBHS information brochure and on the DPBHS Website. These providers will assess clinical and financial eligibility and assist consumers and their families to obtain appropriate care. Brochures are available on the DPBHS Website.

-*Central Intake* - For information and referrals in non-emergency situations an application may be made to DPBHS’s central intake, information and referral office.

▷ DPBHS Central Intake, Information and Referral:

(302) 633-2571

▷ or Toll-Free 1-800-722-7710

-*Crisis Services* - DPBHS offers 24-hour, 7 day a week crisis response for children or adolescents who are exhibiting behaviors that pose a serious and immediate danger to himself/herself or others due to emotional disturbance, substance abuse or mental illness (e.g., suicidal attempts or threats, command hallucinations, aggressive behavior, etc). This program also responds to children in crisis who may have experienced recent and severe trauma (e.g. witness to a suicide, murder, etc).

**IMPORTANT:** If the child is physically injured, seek medical attention first before calling the crisis number. If the behavior poses serious threats to self or others because of weapons or the inability to contain the situation without assistance, call the police by dialing 911 before calling the crisis number. 1-800-969-HELP (1-800-969-4357)

**If the child has been or is suspected to have been physically abused or neglected call the Division of Family Services Hotline: 1-800-292-9582**

3.1.4 MCO Referral - If you are a MCO Provider seeking DPBHS services for your consumer:

3.1.4.1 for extended outpatient benefits (beyond the 30-unit MCO limit) – call Vanessa Bennifield (302) 633-2597

3.1.4.2 For a more intensive level of care call the DPBHS Intake number: (302) 633-2571

3.1.5 Delaware Medical Assistance Program (Medicaid) – Please refer to the following website for information on how to apply to the respective panels for the Medicaid Managed Care organizations, or to obtain information about applying for Medicaid: <http://www.dmap.state.de.us/home/index.html>.



3.1.6 Medicaid Transportation - LogistiCare is the transportation provider for Delaware Medicaid. Delaware Medicaid recipients can reach LogistiCare by calling 1-866-412-3778. Case Managers at facilities wishing to schedule medical transportation appointments for their consumers may call 1-866-469-2824. If you have problems with your transportation services, please contact LogistiCare at 1-866-896-7211 and complete the **MEDICAID TRANSPORTATION SERVICE IMPROVEMENT FORM** available through the DPBHS Provider Website (<http://www.kids.delaware.gov/pbhs/pbhs.shtml>). A copy of this form needs to be provided to your program administrator.

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## 4 Clinical Services Management

**4.1 CLINICAL SERVICES MANAGEMENT - With the exception of routine outpatient services discussed within this document, each child and family receiving DPBHS treatment services is assigned to a Clinical Services Management Team (CSMT), with a specific Clinical Service Coordinator (CSC) who will work with them until the child is discharged from the system. Provider services are coordinated through the CSMT.**

### 4.2 Clinical Services Management Team Responsibilities:

4.2.1 In collaboration with consumer, family and providers, the CSMT plans services, determines the most appropriate level of service and works with the family to design an individual service plan for the child.

4.2.2 In collaboration with service providers, the CSMT authorizes initial admission and continued stay. This process includes the forwarding of a Service Admission Form (SAF) to the provider that gives information regarding goals of the service, issues to be addressed in the treatment plan and risk and safety issues that should be noted.

4.2.3 The CSMT monitors and evaluates individual consumer progress in treatment based on the provider's comprehensive treatment plan, and re-authorizes continued treatment as clinically indicated. The provider is expected to conduct clinical reviews with the CSMT member on each consumer. When appropriate, the CSMT may request revision in a treatment plan.

4.2.4 The CSMT authorizes and facilitates transition in level of care (i.e. from outpatient to intensive outpatient) and among network providers by coordinating with the discharging and admitting service providers to assure continuity of care.

4.2.5 The CSMT provides clinical consultation as appropriate to providers on complex cases and/or cases where treatment progress is slow or minimal.

4.3 **Clinical Criteria** - All DPBHS services are authorized by DPBHS CSMT's using established criteria for each level of care.

▮ Clinical criteria are available on the DPBHS web site or upon request from the Director, Clinical Services Management (302) 633-2599



## 5 Authorization Process

### 5.1 Authorization Process for Services Other Than Routine Outpatient Services

#### 5.1.1 Initial Authorization by DPBHS

##### 5.1.1.1 Process

- DPBHS will notify the named agency's business contact to verify that service for a child has been authorized by DPBHS and will provide an authorization number for use in the billing process. Written notice of this authorization will be provided.
- The Provider must call the identified CSMT within 24 hours (or the next working day) to notify DPBHS of the consumer's admission. (If admissions are not entered into the DSCYF data system, payment cannot be made.)
- If the provider operates a fully-funded program via a cost-reimbursable contract, the provider will work with the Department's referral sources to admit referred individuals to the program in a prompt and efficient manner in order to maximize utilization of the program. Both parties to the contract appreciate the need to maximize effective use of the resources committed by the Department to this program, and commit to a minimum utilization target of 85% of capacity. Both parties agree to monitor program utilization against this target, and to work to identify and remove any procedural impediments to the efficient admission of consumers to the program

5.1.1.2 Retroactivity - Retroactive authorization and/or payment will not be made. Providers are responsible to submit appropriate documentation within sufficient time-frames for the authorization process to be completed. DPBHS has no obligation to reimburse unauthorized services.

5.1.1.3 Accredited Hospitals - The initial authorization of a consumer for accredited hospitals is contingent on the provider's timely submission of a provider Certificate of Need on the approved DPBHS form. Please refer to the Schedule of Deliverables in this Manual.

5.1.2 Authorization of Continued Treatment - If treatment is to continue beyond the authorization period, a Progress Review must be conducted between the provider and the CSMT.

5.1.2.1 Progress Review - Prior to the end of the authorization period, **the provider will communicate with CSMT in order to conduct a progress review.** The review (usually by telephone) will be based on the DPBHS Progress Review form. **NOTE:** Active provider participation is essential to assure all data necessary to evaluate consumer progress and enable timely reauthorization or for service discharge planning.

**IMPORTANT** - If the pertinent provider representative is not available when the CSM team member calls, it is the provider's responsibility to return the progress review call in a timely fashion.

5.1.2.2 Re-authorization - The CSMT member will give verbal or faxed re-authorization within two business days and re-authorization will be confirmed by DPBHS. DPBHS has no obligation to reimburse unauthorized services.

5.1.2.3 Consumer Discharge - All discharges of youth, funded by DPBHS must be authorized by DPBHS in advance of the actual discharge, and coordinated with DPBHS in order to allow for a therapeutic transition of each youth to another level of care.

5.1.2.3.1 When discharge of a youth from a DPBHS service is anticipated, all parties, including the provider, the CSMT member and the parents must try to reach mutual agreement about the discharge, the after-care plan and activities.



Confirmation of a discharge date should be done together. Services after this date are not authorized and the provider will not be reimbursed for them.

5.1.2.3.2 If the consumer is on medication at the time of discharge, the provider shall ensure that a record of all current medications is given, including dosage and administration. The documents shall be made available at the time of discharge to the parent or legal guardian, DPBHS and appropriate receiving agencies and personnel.

5.2 **Authorization Process for Routine Outpatient Services** – The process outlined within this section pertains *only* to outpatient providers. DPBHS intends that services at the outpatient level be as accessible as possible to provide the least restrictive mental health and substance abuse treatment to children, adolescents and families in a community setting. These cases open with DPBHS when there is no insurance to assist the family in paying for these services, when the number of allowed insurance sessions is exhausted, or in other special circumstances as outlined in this section.

Unlike insurance companies, prospective DPBHS outpatient consumers are not already registered as consumers. That means outpatient providers must gather registration information such as financial eligibility in addition to clinical information.

· **If providers receive the referral and authorization directly from a DPBHS clinical management team member, it is not necessary to complete the initial documents outlined below**

· For *ALL* other cases, authorization and subsequent payment will not be made unless following process is followed:

### 5.3 Initial Authorization for Routine Outpatient Services

5.3.1 Eligibility Determination – When Providers receive a request for DPBHS services, they will complete 3 assessments to determine eligibility

5.3.1.1 Clinical Eligibility – DPBHS EPSDT Screen ([available on the DPBHS website](#)) to determine the presence of at least one mental health or substance abuse disorder requiring outpatient therapy.

5.3.1.2 Demographic Eligibility including age and residence

5.3.1.3 Insurance Status:

**5.3.1.3.1 Medicaid or SCHIP Eligibility Determination, including assistance to parents/guardians in submitting appropriate application for enrollment at the first session.**

**5.3.1.3.2 When a family does not have insurance, DPBHS will only pay for sessions subsequent to intake if the provider has assisted the family in completing the application for Medicaid at the first session.**

5.3.1.3.3 Financial Eligibility Determination – Consumers, who are uninsured, do not have Medicaid, or whose insurance co-payment can be documented as being beyond their means to pay. In the latter case, DPBHS will authorize only the difference between the co-payment plus a reasonable sliding scale fee and the hourly rate contracted with the provider by the insurance company. This must, of course, be consistent with individual provider agreements with the insurance providers.

5.3.2 Form Submission – After completing the eligibility determination, submit a completed Admission to Outpatient Mental Health Services *or* Admission to Outpatient Substance Abuse Services Form. These forms and directions can be found on the [DPBHS website under the section, “Forms for Providers”](#).



5.3.3 Agency notification of the initial authorization – If clinical and financial eligibility is confirmed by DPBHS, the initial authorization will be faxed back to the agency.

- *Initial authorization will be valid for 3 months and up to 20 sessions (from the date of admission)*

**NOTE:**

- *Complete* means that the form is legible and that every line has a response.
- In certain sections under Financial Eligibility, “NA” (Not Applicable) may be entered. Otherwise, all information must be completed.
- There must be a Primary Diagnosis other than “deferred.”
- The parent/legal guardian must sign the form.

▮ DPBHS Outpatient FAX Number: (302) 424-2960

5.4 **Request for Re-Authorization** - If the youth is to continue to receive services beyond the initial authorization, the Provider will submit the following:

5.4.1 Revised Treatment Plan that includes (at minimum) the problems that will be addressed and measurable objectives. If progress has not been made within the last authorization period, a plan must be included for how treatment will be changed in order to move toward the treatment goal. The treatment plan will be signed by the therapist (and the supervisor if the therapist is not licensed), the parent or guardian of the child, and the child (if the child is 12 or older).

**NOTE:** All treatment plans that include medication as part of the treatment to be provided must be reviewed and signed by the treating psychiatrist.

5.4.2 Request for Re-Authorization Form – Can be found on the DPBHS Website.

- If the treatment plan and form are fully completed, legible, and clinically appropriate, DPBHS will fax authorization of up to an additional 20 hours of service which may be provided within the same 12-month period from the date of initial admission.

DPBHS Outpatient FAX Number: (302) 424-2960

5.4.3 If the agency does not send a *Request for Reauthorization of Treatment or Discharge Summary*, the DPBHS outpatient case will be closed 3 months after the authorization has expired.

5.5 **Discharge Form** – This form will be sent immediately after a planned discharge and in no more than 18 days of the last face-to-face contact with the youth after documented assertive follow-up in the case of an unplanned discharge. The Discharge Form and directions can be found on the DPBHS website at under the section “Forms for Providers”.

▮ Questions regarding consumer authorization: (302) 424-6102.

▮ Questions regarding contractual matters will be handled by Vanessa Bennifield at (302) 633-2597.



## 6 Treatment Protocol

6.1 Consumer Information/Education: Written Information Provided to Youth and Families – Upon admission, providers will meet with youth and families to discuss rights, responsibilities, procedures and expectations. Providers will have a system for documenting youth and family receipt of such information (e.g. progress note, signatures, etc). This information will include, but not necessarily be limited to, the following:

6.1.1 General service orientation, including the names and numbers of primary contacts

6.1.2 Complaint/grievance procedures

6.1.3 Consumer rights and responsibilities

6.1.4 Prevention resource information

6.1.5 Emergency procedures

- Residential and hospital providers will include any applicable seclusion/restraint procedures.
- Non-residential providers will inform caretakers as to how to reach the therapist in an emergency and will assure that caretakers are informed of the DPBHS Crisis Service numbers.
- Non-residential substance abuse treatment providers will inform primary caretakers about the potential dangers and signs of alcohol and/or drug overdose and how to obtain medical treatment.
- For crisis and routine outpatient services, providers will review with youth and families, and provide a copy of the DPBHS Child/Family Entering Care Handbook for that level of service. The signed form indicating the youth has received this document must be contained in the record. **These documents are on the DPBHS website.** The CSMT provides copies to youth and families in other levels of care.
- If a youth is open for more than one year in any outpatient service treatment episode, documentation that he/she has been re-informed of her/his rights and responsibilities, the complaint procedure and emergency procedures must appear in the record.

6.2 Consent to Treat - The provider will have written policies and procedures to assure that no minor will be treated without documentation of informed written consent to treat, signed by at least one parent or a person having legal authority to consent to treatment and witnessed by a representative of the provider. This consent must be renewed after one year. In certain cases, consent to treat may be signed by someone other than the parent or legal guardian.

6.2.1 If a youth is prescribed psychotropic medication, the provider shall ensure that written informed consent is obtained from the parent, legal guardian or other individual with legal authority to make such decisions, prior to the implementation of the medication treatment. At a minimum, such informed consent shall indicate the drug and dosage, likely benefits, potential risks and side effects of the prescribed medication. Such informed consent shall also inform, to the extent permitted by law, the youth, their parents, legal guardians and other individuals with legal authority to give such consent, of their right to refuse specific medication or treatment procedures (see applicable Delaware Requirements for Residential Child Care Facilities, § 213; Delaware Requirements for Day Treatment Programs 215(e); 16 Del. C. 5161(b) (3), (5)); DFS policies # 3045, 3046, 3047).

6.2.2 *Delaware's Relative Caregiver statute* allows relative caregivers to consent to lawful medical treatment for minors if the relative caregiver is in possession of a valid affidavit of establishment of power to consent to medical treatment. For further information please see: <http://www.dhss.delaware.gov/dhss/dsaapd/intergen.html>.

6.2.3 In mental health emergencies when a minor is exhibiting behaviors of such severity that failure to provide an immediate mental status examination and follow-up would result in imminent harm to the child, evaluations may be



performed by the DPBHS Crisis Services without initial written parental consent, if reasonable efforts have been documented to contact parents, legal guardians or other legally authorized caregivers. All follow-up treatment provided by crisis services must be with the appropriate signed consent-to-treat.

6.2.4 A representative of the Division of Family Services (DFS) may sign consent to treat in all levels of DPBHS services with the exception of psychiatric hospital and/or the provision of psychotropic medication, if the youth is in the custody of DFS, the parent cannot be contacted or reached and reasonable effort has been documented to notify the parent, legal guardian or legally authorized caregiver that the child has been admitted to those services.

6.2.5 Youth ages 14 and older *may* sign consent for treatment for alcohol or drug addiction without parental consent. DPBHS highly recommends that every effort be made to work with such a youth to involve parents, legal guardian or legally authorized caregiver as soon as possible in the treatment process. If parents sign consent to treat, it is not required that the youth do so, although involving them in the consent process would be desirable.

6.2.6 Consent-to-treat in behavioral intervention program services must include a statement describing the clinical purpose of behavioral intervention program services and document that the parent/caretaker understands that this service will continue only if the youth and family continue to participate in mental health or substance abuse treatment.

6.3 Initial Diagnostic Evaluation – Mental health providers will use the DPBHS Assessment form. (See DPBHS Provider Page website for the most updated form)

Providers with Electronic Medical Records Systems may request exception to the use of standardized forms by contacting their program administrator and ensuring that their records contain the required content.

6.3.1 When assessments indicate exposure to abuse or trauma, the provider will complete a UCLA and, if indicated, make a DFS abuse report as warranted and/or mandated by law

6.3.1.1 Upon completion of the UCLA, if a client has multiple (more than 1) symptom in two domains, the CSM team should be advised. If appropriate, the therapist shall provide TF-CBT or discuss with the CSM team how to best manage the youth's needs.

6.3.1.1.1 Therapists providing TF-CBT, are responsible to provide to the CSM team the pre & post UCLA score with the Discharge Summary.

6.3.2 In addition to completing the assessment, all mental health providers (with the exception of Crisis or Inpatient Services) shall utilize the GAIN Screener or another empirically validated screener on children ages 12 or older.

6.3.3 Behavioral Intervention Program(s) should be considered an expansion of the clinical assessment performed at the treatment agency and the clinical work done by the DPBHS CSMTs. Information obtained from the behavioral intervention assessment must be communicated back to the outpatient therapist and clinical team. Elements of the behavioral intervention assessment will include but not be limited to:

6.3.3.1 *Key points from reviewing the DPBHS Service Admission Form (SAF)* – Diagnostic information, treatment history, child risk factors (self, others, peers, property), medications, physical health, family background, school functioning, and current therapist.

6.3.3.2 *Key points from interviewing the outpatient therapist* – Current contact information, current household/family composition, frequency and compliance with treatment and medication, and primary reason for referral and behaviors being targeted.

6.3.3.3 *Presenting Problem* – Describe the clinical diagnosis in concrete, behavioral terms, asking questions like:

- What does the family define as the problem or behavior they want changed? What does the problem or behavior look like in the home? In the classroom? In the community?
- What is the child doing or not doing?



- Is the presenting problem as described by the family similar to the reason for referral?
- How do family members respond to the problem or behavior? Does the family identify any of these behaviors as contributing to stress in the family?
- What ideas do family members have for solutions?

6.3.3.4 *Household Management and Structure* – Describe the family composition, dynamics, and activities asking questions such as:

- Who currently resides in the home? Who does the family identify as its members? Who is visiting in the home and for how long?
- How do people interact with each other?
- What kind of schedules are kept and by whom? What is the “traffic pattern” in and out of the house? Are there any restrictions on days/times for providing wrap-around services or for family visits?
- What are the daily activities in the home? Who is responsible for:
  - Ø Waking the child, making breakfast and packing lunch?
  - Ø Ensuring arrival at school/day care?
  - Ø Helping with homework?
  - Ø Administering medication?
  - Ø Wrap aide transitions – may “hand-off/receive” child
- Are there family defined stressors? What do these look like for family members? For the child?
- What are the family’s strengths, talents, and experiences that can be used in working with the child and that encourage family participation?
- What are the child’s strengths, talents, likes and dislikes that can be used in developing appropriate psycho-social/skill-building activities?

6.3.3.5 *Physical Surroundings and Child Safety* – Describe the child’s environment and the various settings in which the aide may see the child, assessing for safety, and identifying areas of caution for the child and wrap aide. These should include, but are not limited to, the home environment, neighborhood, behavior management in a vehicle, and other surroundings that might impact the consumer’s safety.

6.3.3.6 *Values held by the family* – Describe the unique belief system and customs which may be “invisible” but to an observant assessor may become more apparent. Ask questions like:

- How do family members define their cultural identity?
- What are the customs, manners of interacting with the child/ family?
- What are the implications of family values and belief systems: in working with the child and family? In developing culturally competent wrap activities? In planning home visits?
- What things are important to the family and how can wrap-around services respond to those things?

6.3.3.7 *Maintenance of new behavior/skills* – Address how the improved behavior/treatment gains will be maintained by the parent/family when the wrap aide is no longer in the home

6.3.4 *Substance abuse programs* will use the Global Appraisal Need Initial Version (GAIN-I), including the Collateral Supplemental Information. At minimum the GAIN-I Core will be used, although the optional GAIN-I Full may be substituted.

-When completed, the GAIN covers all domains listed in section 6.5 below (‘all other admission assessments’), with the exception of *developmental history*. This domain must be assessed in addition to the GAIN, and discussed with the parent/caretaker while completing the Collateral Supplemental Information.

-If completed online, notation in the clinical record must reference the date the GAIN was completed and add the notations on assessment of developmental history. This must be available to DPBHS representatives.

-If the provider receives a completed GAIN from another part of the DPBHS service system, e.g. Drug Court, YRS secure care facility, or another DPBHS substance abuse provider:



\*If the GAIN is dated 90 days or less from the date of the current admission, the therapist will document a re-assessment focusing on the changes in the consumer's condition within those 90 days. This re-assessment will use all the elements listed in #5 below ('all other admission assessments').

\*If the GAIN is dated within 91 to 119 days of the current admission, the youth will be re-assessed using the GAIN 90-Day Monitor.

\*The GAIN will be re-administered if the prior evaluation is dated 120 days or more from the date of the current admission.

**6.4 DPBHS Safety planning** Time frames for completion of this document for all levels of care are listed in the 'Deliverables Section' of this Manual.

Safeguarding the welfare of DPBHS youth and families is a primary organizational responsibility. In order to ensure safety, we carefully monitor services for each youth to identify behaviors that may jeopardize their welfare or the welfare of those around them. Working with our service partners and our families, we develop plans that will reduce the likelihood that these behaviors will occur, and to intervene quickly and safely if they do.

Many youth enter our system specifically to reduce or eliminate these risk-producing behaviors. Others may have these behaviors identified or emerge while under our care. In either case, ongoing assessment, management, and monitoring of any unsafe behavior is necessary throughout a consumer and family's participation in our services.

#### **6.4.1 Identifying Safety Concerns**

Identification of safety concerns usually occurs in one of three ways: through the initial referral to DPBHS, through a provider assessment conducted as part of treatment planning, or as a new issue that emerges in the course of treatment. Regardless of how the concern is identified, it should generate a safety plan as a portion of the overall treatment plan. In fact, DPBHS encourages provider partners to routinely include safety planning as part of their treatment planning for any and all cases, even when no immediate safety concern has been identified. Safety planning then becomes a habit for providers and families, and heightened awareness of even potential safety issues will work in all our favor.

Referrals to our provider partners for services for our youth and families usually includes transmission of a service admission form (SAF) early in the process. The SAF lists risks that have been identified by others and communicated to DPBHS in the referral for services. DPBHS identifies a list of commonly-seen risks routinely: threats to injure others; destruction of property; fire-setting/fire-play; noncompliance with necessary medical treatment; inappropriate sexual behavior; injuring others; injuring self; noncompliance with mental health treatment (including medication); running away; substance use; and suicidal ideas/threats. DPBHS requires safety planning around any such safety concerns identified in the referral.

DPBHS provider partners conduct their own assessments as part of treatment planning with the family. Families and youth regularly identify safety concerns as part of their agency intake assessment that were not communicated in referral materials. Any safety concerns identified through the assessment should also precipitate safety planning (as well as any new that emerge in the course of treatment).

#### **6.4.2 Preliminary Safety Planning**

Initial, preliminary safety planning should be conducted at the time of initial contact and diagnostic evaluation with the youth and family. This preliminary plan usually deals with risk behavior that had been identified in the original referral, as the more detailed evaluation of the youth and family functioning and analysis of risk will not have been completed. This preliminary plan should, at a minimum, mobilize the family: to modify the home environment by eliminating access to items that may aggravate safety concerns; sensitize them to precipitants of risk behavior; make them aware of helpful and unhelpful actions by others around the youth; and increase their level of supervision and monitoring to ensure safety while the intake assessment and treatment plan is completed. At this time, the provider will also provide written directions for contacting their program during an emergency as well as contacting DPBHS child priority response and/or local law enforcement. Substance abuse programs will also provide information about the symptoms of overdoses and a plan for obtaining emergency medical evaluation/treatment.

This initial, preliminary safety plan should be updated as soon as the diagnostic evaluation is completed, and information from that evaluation should be incorporated into the risk analysis and safety plan. Broadly speaking, the risk analysis from



the diagnostic evaluation should identify both risk and protective factors to be included in the safety plan. Factors identified in the diagnostic evaluation that tend to elevate risk include: significant mental illness and/or substance use; impulsiveness/aggressiveness; past trauma; domestic conflicts and/or violence; major life events/losses (including relocation, divorce, major illness, death of loved one); past personal or family history of suicidal behavior and/or mental illness; sense of pessimism/hopelessness; lack of supportive social relationships. Protective factors that mitigate against risk include: engaged and supportive caregivers; access to medical and mental health care; large social support system; problem-solving and conflict resolution skills in the household; strong ties and connection to friends, community, and church; and a belief system that discourages harming self or others.

Multiple systems exist for analyzing risk factors and protective factors, and for assigning a level of risk to the overall presentation. Our provider partners may find it helpful to access such systems and incorporate them into their diagnostic evaluations. This would no doubt help their conceptualization of risk with their clientele and help in the continuous improvement in services we strive to achieve. Constructing such a risk profile may also help determine whether a youth is in the right level of service.

Generally speaking, the assessment of risk and safety planning *does not* extend to suicidality. The presence of suicidal ideas and impulses should prompt an assessment by a psychiatrist or an emergency room evaluation in conjunction with DPBHS child priority response.

Part of risk analysis in safety planning includes developing youth-specific information about events, feelings, and ideas that have precipitated high-risk behavior in the past (“triggers”), subjective/objective signs that the consumer is going to exhibit high-risk behaviors; actions by others that tend to reduce the likelihood of high-risk behaviors; actions by others that tend to aggravate high-risk behaviors; and strategies/activities that the consumer has or can use to calm themselves (‘coping skills”).

### **6.4.3 Final Safety Plan**

The safety plan, as it is expanded after the completion of the diagnostic evaluation, should be based a risk analysis as well as an assessment of specific child and family factors that will be employed to manage risk. While the preliminary plan draws heavily from modifications in the child’s environment and close supervision by family, the final plan will be much better differentiated and attempt to intervene at multiple points to interrupt the cycle of high-risk behavior.

Ideally, the safety plan should be considered an essential, core component of the treatment plan and should be developed in detail when the presenting problems and goals of treatment are discussed with the family. Reduction or elimination of identified safety concerns should *always* be included as a problem on the treatment plan.

Formulation of the plan should begin with an survey of the risk behaviors that need to be reduced or eliminated. At the same time, there needs to be a clear understanding of **who** the plan is trying to protect; **what** the plan is protecting them from; **where** those safety concerns are likely to arise, and **when** we are likely to see them.

While the details of formulating the plan are somewhat dependant on the service and professionals involved, there are common components to the process. There needs to be a review of the specific behaviors that are creating risk. There needs to be a review of who is at risk due to these behaviors, and what harm could potentially arise. There should be a detailed review of the natural context of these behaviors, including: identification likely settings; identification of precursors and precipitants; actions of others that make the risk behaviors worsen; actions of others that have made them somewhat better; and activities by the consumer that can be deployed to lessen the likelihood or severity of the behaviors. The core of this approach to safety planning involves multiple components: (1) successful modification of the environment to eliminate aspects that could contribute to high-risk behaviors (firearms, combustibles, medications, potential victims); (2) developing a supervision strategy that maximizes caregiver awareness of the consumer’s location, companions, and activities; (3) understanding precipitating events (“triggers”) and identifying their occurrences; (4) monitoring the consumer’s subjective/objective responses to “triggers” to be aware that a safety concern is becoming more likely; (5) having others in the environment avoid actions that tend to make safety concerns worse; (6) having others in the environment engage in actions that tend to make safety concerns improve; (7) encouraging the youth to engage in activities that have helped them calm themselves in the past (deploying “coping skills”).

Generally speaking, the emphasis in the plan should be on its *preventative* and *proactive* aspects, rather than on actions to be taken if the plan fails. There is little question that the easiest crisis to manage is one that has been prevented by good caregiver supervision or short-circuited by a proactive response to precipitating events.



The interplay between the safety plan and the remainder of the treatment plan is also very important, particularly in a strengths-based approach. There should be an overall emphasis in treatment that attempts to enhance and augment protective factors and use them to mitigate against identified risk factors.

#### 6.4.4 Writing Up the Safety Plan

✓ **What unsafe behaviors are included?**

§ Any/all safety concerns should be identified in terms of their underlying ‘unsafe behaviors’ and included in the safety plan. Very frequently the interventions and precipitants will overlap considerably.

✓ **Who is the plan protecting?**

§ There needs to be real clarity about the potential for harm created in the unsafe behaviors and who is likely to experience that harm.

✓ **Where/When/What/How the behavior occurs.**

∅ Each unsafe behavior needs to be reviewed in terms of:

§ What leads up to the behaviors?

- Being touched
- Being alone
- Being forced to talk
- Not having control
- Feeling misunderstood
- Not being left alone
- Being told what to do
- Not being listened to
- Feeling embarrassed
- Anniversaries/holidays
- Being tired
- Being hungry/thirsty
- Losing a game
- Feeling lonely
- Tests
- School
- Meeting new people
- Trying new things

§ Signs of emerging risk behaviors

- Sweating
- Clenching teeth
- Crying
- Not taking care of self
- Breathing hard
- Running
- Yelling
- Clenching fists
- Hurting others:
- Swearing
- Throwing Objects
- Not eating
- Pacing
- Being rude



- Injuring self:

§ What makes them worse?

- Being touched
- Called names or made fun of
- Being forced to do something
- Yelling
- Physical force
- Loud Noise
- Contact with person who is upsetting
- Some else lying about my behavior
- Being threatened

§ What makes them better?

- Listen to music
- Exercise
- Read a book
- Have a hug with my consent
- Write in a journal
- Drink a beverage
- Watch TV
- Talk with peers
- Read religious/spiritual readings
- Call a friend or family member
- Write a letter
- Hug a stuffed animal
- Take a shower
- Do artwork (painting, drawing)
- Go for a walk

✓ **Who implements the plan?**

- Ø Either caregiver or the youth can begin to implement the safety plan, and it should include a basic set of instructions about what every involved household member's specific role is. For instance, it may require one caregiver to supervise siblings while the other engages or supervises the youth. It may call for siblings to move to a certain location and for household members to engage in certain activities while avoiding certain activities. Regardless, it should be specific enough to be clear about who does what.

✓ **What if the safety plan fails?**

- Ø If your preventative measures don't work, have a list of crisis numbers to call. Consider a therapist, case manager, or close friends/family to be on this list. Be prepared to report the incident to the proper crisis service, case workers or other authorities if the behavior is severe enough. If the child's behavior is a crime against another person or property, you may have to call the police.

✓ Specific family safety strategies:

- Ø Direct line-of-site supervision
- Ø No shut doors while with friends or siblings
- Ø No 1-on-1 time with friends or siblings
- Ø No unsupervised time with friends/siblings
- Ø Opposite sex parent never left alone with child
- Ø No overnight stay with friends
- Ø Secret location of matches and lighters



- Ø No firearms in home.
- Ø Lockboxes for medication
- Ø Portable door alarms
- Ø House alarm systems

**6.5 Integrated Interpretive Assessment Summary (Admission Summary)** – Mental health providers will complete the **DPBHS Assessment Summary form**. Time frames for completion of this document for all levels of care are listed in the ‘Deliverables Section’ of this Manual. *All levels of care with the exception of adjunctive and behavioral intervention program services* must have this document completed for every admission.

For routine outpatient services, this document must be included in the clinical record within five working days after the third session.

**For crisis services, because of the short length of stay, one summary for admission and discharge may be completed.**

For substance abuse providers the GAIN instrument provides an integrated assessment that may be edited by the clinician. Once the clinician has reviewed, edited and dated the summary appropriately, the print-out of this assessment will constitute the integrated interpretive summary. No matter what level of GAIN assessment/re-assessment is used, an integrated summary must be completed and dated for every admission.

An integrated interpretive summary is a narrative synthesis of the data gathered from the Initial Assessment (section VI.C above), and from collateral information obtained from schools and other sources such as the DPBHS Service Admission Form (SAF). It covers physical, psychological, psychiatric, social and spiritual domains. It is used to facilitate the identification of individual treatment requirements, strengths, and risks currently presented by the consumer. The integrated assessment is used to develop appropriate treatment interventions. This summary will be contained in the consumer record.

**6.6 Comprehensive Treatment Plan** - Mental health providers will complete the **DPBHS Master Treatment Plan**. Time frames for completion of this document for all levels of care are listed in the ‘Deliverables Section’ of this Manual. This document will be consistent with the level of care and will be based on the integrated assessment. All levels of care with the exception of adjunctive, behavioral intervention program and crisis services must have a comprehensive treatment plan. ***For behavioral intervention and crisis requirements see #6.6.1 (‘Integrated Behavioral Intervention Program Activity Plan’) or #6.6.2 (Crisis Services Plan for Safety) within this section.*** Where applicable, it will be consistent with the service plan contained on the DPBHS Service Admission Form. It is done in conjunction with the consumer and family (as documented by their signatures), and where applicable, include input from the CSMT.

**6.6.1 Integrated Behavioral Intervention Program Activity Plan** – Where treatment is being supplemented by a behavioral interventionist, whether or not the provider is employing the behavioral interventionist, the behavioral intervention program activity plan must reference the treatment plan. In agencies that provide only the behavioral intervention program service, a copy of the current treatment plan from the treating agency must be included in the record. Behavioral Intervention Program Activity Plan will include but not necessarily be limited to:

6.6.1.1 Specific behaviors targeted for change.

6.6.1.2 The community activities in which the youth will be engaged to change these behaviors. (There must be a relationship between the target behaviors and the activities. For example, a youth whose problems involve relationship problems with peers should be engaged in social activities in which he/she can practice positive peer interaction.)

6.6.1.3 Frequency of community activities to be provided.

6.6.1.4 Documentation that the parent/caretaker understands the therapeutic purpose of the wrap activities, that they are provided specifically to support the treatment that is being provided, and that continuation of the service is contingent on the youth’s and family’s ongoing participation in treatment.

6.6.1.5 Signature of behavioral interventionist, the supervisor, the parent and the child



6.6.2 *Crisis Services Plan for Safety*- the purpose of crisis services treatment plan is to mobilize the family's helping network, both informal and professional, in order to minimize risk while decisions are made about next steps for treatment. This is to be completed before the end of the first crisis session. At minimum a crisis treatment plan (Plan for Safety) will include:

6.6.2.1 Risk factors as determined from the initial assessment, how they will be monitored and by whom.

6.6.2.2 Realistic and detailed plan for the safety of the consumer and/or the community if applicable.

6.6.2.3 Specification of the persons responsible for implementing each part of the plan.

6.6.2.4 Specification of the number of treatment sessions to be provided within the crisis period

6.6.2.5 Criteria for discharge from crisis service.

6.6.2.6 DSM IV 5-Axis Diagnosis.

6.6.2.7 Signature of primary therapist, licensed supervisor, parent and child.

6.7 Treatment Plan Review and Revision - As appropriate for the level of care, the treatment plan will be reviewed and revised whenever new goals and objectives are added; or when identified goals or objectives are accomplished; or no less often than every 90 days. If goals are added to the treatment plan or other significant changes are made, it is necessary for the provider to add pages to the plan or to write a new plan, depending on the agency format for this purpose. Significant treatment plan changes will be communicated with the DPBHS CSMT as a part of the progress review.

6.8 Progress Notes - Progress notes are documentation of the services that have been provided. They will document all direct (face-to-face) services and indirect services. Failure to document services consistent with billing and activity reporting to DPBHS may result in an audit exception and resultant financial penalties.

6.8.1 Progress notes should be completed and filed within 24 hours of the service provided.

6.8.2 Progress notes for direct service will document progress toward treatment goals and objectives, and will be appropriate to the level of care.

6.8.3 For services in which billing/activity is reported in units of hours, every specific billing code reported to DPBHS will have a separate progress note. The content of this note will be appropriate to the amount of time spent on the activity and will always relate to the treatment plan.

6.8.4 For service in which billing activity is reported in units of days, every specific day reported to DPBHS must have at least one progress note. Where individual, family and psychiatric sessions are provided in the course of a specific day, these will be separately documented.

6.8.5 Progress notes will be dated, signed by the therapist and specify the location of the service provided and all those participating.

6.8.6 Clinical progress notes by unlicensed mental health staff will be reviewed and co- signed by a licensed mental health professional. Notes should be reviewed within 1 week of the service provided in the note.

6.9 Discharge

6.9.1 At a reasonable point in advance of discharge from any level of care, the provider will document that they have discussed follow-up treatment recommendations with the youth and family and in collaboration with DPBHS CSMT. The provider will offer assistance in and/or provide information for the referral process to the next level of treatment, if applicable.

6.9.1.1 The provider determines in collaboration with the CSMT, when the youth no longer meets clinical necessity for the current level of care.

6.9.1.2 Where applicable, the CSMT, in conjunction with the provider, will plan for transition to adult services and the CSMT will document efforts to implement this plan.



6.9.2 Within 7-days of discharge, the provider will complete the DPBHS Discharge Summary, a copy of which will be retained in the clinical record. The Discharge Summary will be submitted to DPBHS as indicated in the “deliverables” section of this Manual, and will be made available to subsequent treatment providers upon request and appropriate signed release.

6.9.3 Providers of routine outpatient services will send a Discharge Form to DPBHS within 18 days of the last direct face-to-face contact. If a youth stops attending sessions and the therapist wishes to follow up to try to re-engage the youth and family, this must be done within the 18-day timeframe. DPBHS consumers may not simply be administratively discharged without follow-up attempts being documented. Notification of this discharge is done through the Outpatient Discharge Form available on the [DPBHS website](#).

6.9.4 Transfer Instruction Sheet will be completed upon discharge and a copy will be kept for the provider record, a copy will be given to the family, a copy will be faxed into DPBHS, and with appropriate consent, a copy will be provided to the new provider.

6.10 Clinical Record Maintenance - The provider will maintain clinical records on all consumers in accordance with accepted professional standards and practices. These will be completely and accurately documented, readily accessible, and systematically organized to facilitate prompt retrieval.

6.10.1 Completion of records – All clinical information pertaining to a consumer will be centralized in the clinical record. This will include but not necessarily be limited to correspondence, consents and releases, copies of collateral reports.

6.10.1.1 The provider will have policies and procedures in place to assure that all clinical records, including those of discharged consumers are completed promptly.

6.10.2 Storage and Security - The provider will assure that written, electronic and other records containing confidential consumer information will be accessible only to those individuals who have a right to the information.

6.10.3 Retention and Preservation - DPBHS providers are required to retain, in an easily accessible format, the entire clinical record of any DPBHS consumer for a minimum of five years and at least three years past the eighteenth birthday of the minor. Following the required period of retention, the provider will retain for an indefinite period, the discharge summary for each specific treatment episode.

6.11 Email Communication- When the Provider and a DPBHS representative are using e-mail to discuss a consumer, it will be sent via a secure e-mail system. See the Operating Guidelines for more information regarding the use of IronPort.



## 7 Consumer Safety and Outcome

### 7.1 Clinical Program

7.1.1 Staffing - All staff providing direct clinical services will practice within the scope of their qualifications, licensure or certification.

7.1.1.1 Clinical Director - The provider will identify one of the following Delaware licensed behavioral health professionals to be responsible for the clinical program. This will include clinical supervision, where applicable.

-Psychiatrist

-Licensed Psychologist

-Licensed Clinical Social Worker (LCSW)

-Licensed Professional Counselor of Mental Health (LPCMH)

-Licensed Marriage and Family Therapist (LMFT)

-Substance abuse programs (only) may be clinically directed by a Licensed Chemical Dependency Professional (LCDP)

7.1.1.2 Psychiatric Services – The provider will have the capacity to provide medication evaluation and medication monitoring for clients on an as-needed basis in a volume consistent with average program utilization and clinical need, unless specifically exempted from this requirement by the contract.

7.1.1.2.1 Child Psychiatrist

7.1.1.2.2 General Psychiatrist - may treat adolescents age fourteen and older

7.1.1.2.3 Psychiatric/Mental Health Nurse Practitioner with national certification in child/adolescent mental health and with prescriptive authority

7.1.1.2.4 Psychiatric/Mental Health Clinical Nurse Specialist with national certification in child and adolescent mental health and with prescriptive authority.

7.1.2 Supervision – As appropriate to the level of care and the type of services (MH or SA), the provider will document consistent oversight/supervision for all employees who are providing direct treatment services. Documentation will include but not necessarily be limited to:

7.1.2.1 Signature of a licensed practitioner on all initial assessments if performed by an unlicensed clinician. This signature indicates that the form and content is clinically appropriate, consistent with agency and DPBHS standards and assumes clinical responsibility for the treatment being provided. For crisis services, this signature must be within 24-hours of the assessment.

7.1.2.2 Signature of a CADC/LCDP on initial assessments in substance abuse programs. This signature indicates that the form and content is clinically appropriate, consistent with agency and DPBHS standards and assumes clinical responsibility for the treatment being provided.

7.1.2.3 Signature of a licensed practitioner on all treatment plans if developed by an unlicensed clinician. This signature indicates that the form and content is clinically appropriate, consistent with agency and DPBHS standards and assumes clinical responsibility for the treatment being provided. For crisis services, this signature must be within 24-hours of the safety plan.



7.1.2.4 Signature of a CADDC/LCDDP on all treatment plans in substance abuse programs. This signature indicates that the form and content is clinically appropriate, consistent with agency and DPBHS standards and assumes clinical responsibility for the treatment being provided.

7.1.2.5 Case specific supervision notes indicating that the supervisor and the supervisee have discussed the case periodically and decided on a course of action to be taken. Where supervisory recommendations have been made, there should be documentation that the recommended actions have been taken. (This follow-up documentation may be in the form of a modified treatment plan, progress note or supervisory note.)

7.1.2.6 Unlicensed clinical staff providing direct treatment services must document, at minimum, one hour per week of supervision.

7.1.2.7 A log of the dates and times of supervision provided to each staff.

7.1.2.8 The provider will document that the work of licensed treatment staff and/or licensed supervisory staff is reviewed. This may be in the form of Peer Review or Quality Improvement Review. The purpose of this review is to assure that every clinician is held accountable to comply with agency and DPBHS standards.

7.2 Performance Improvement - DPBHS is committed to the provision of safe appropriate services that facilitate positive behavioral change and positive outcomes for consumers and their families. Providers will use a continuous performance improvement process that will achieve these outcomes.

7.2.1 The provider will have and implement a written performance and quality improvement plan which establishes a process for ongoing monitoring and evaluation of the quality and effectiveness of treatment and consumer safety.

7.2.1.1 The plan and resulting process will assure that there is clinical oversight of services provided by all staff.

7.2.1.2 Where licensed staff are otherwise operating without clinical supervision, there will be a process by which the quality of their work is reviewed. This may be through peer-review, QI Committee review, etc.

7.2.1.3 In agencies/programs that have non-licensed staff providing services, the process and frequency of the supervision of these staff by a licensed professional will be included in the plan.

7.2.2 This plan and related procedures will start with data/information. Design and implementation of improvements will be tracked and data will be gathered to assess whether the improvements achieved the desired outcomes.

7.2.3 Where appropriate, the provider will collaborate with DPBHS in their performance planning and evaluation process.

7.3 Outcome Measurement - DPBHS conducts empirical measurement of consumer outcomes both at the individual consumer level and at the systems level.

7.3.1 Consumer Progress Reviews - The CSMT's initiate consumer Progress Reviews to evaluate consumer progress periodically throughout treatment and at discharge. Providers will insure that staff is reasonably available for these reviews and that accurate and complete information as to progress in treatment is provided.

7.3.2 Pre- and Post-Measurement and Data Submission - The provider will cooperate with DPBHS in administering reasonable pre- and post-treatment outcome measurement instruments, and report on requests for data on approved DPBHS forms or systems.

#### 7.4 Consumer Rights and Responsibilities

7.4.1 The Provider will have policies and procedures addressing consumers' rights and responsibilities. These policies will conform to the DPBHS policy on rights and responsibilities. Documentation that consumers have been informed of these rights in a language they can understand will be contained in the clinical record.



7.4.2 DPBHS will make available to providers copies of the DPBHS Handbook for Child/Family Entering Care. The provider will maintain copies at sites where individuals are served so that they are accessible upon request.

#### 7.5 Confidentiality

7.5.1 *General Requirements* - The provider will have written policies and procedures to assure that staff comply with state and federal laws and with appropriate professional practice regarding the handling of confidential consumer information, including release of information. These policies and procedures will specify the condition under which consumer information will be disclosed and the procedures for releasing such information. All DPBHS providers will follow **DSCYF (No. 205) and DPBHS (CS002)** and will be in compliance with HIPAA 45 CFR. Policies on Confidentiality are available on the Department and Division web sites. Releases will be time-limited for periods not to exceed one year and have specific beginning and ending dates.

7.5.2 *Substance Abuse* - Written policies and procedures shall specify how confidentiality relates to the individuals receiving substance abuse treatment. All statements of confidentiality, releases and consumer rights must include reference to the Federal confidentiality standards cited in 42 CFR Part 2, Confidentiality of Alcohol and Drug Abuse Patient Records and will also be in compliance with HIPAA 45 CFR.

7.6 Complaints - Consumers and providers have the right to address grievances and complaints to DPBHS. Please note that at anytime individuals covered by Medicaid may lodge a complaint with the Medicaid Office, the Health Benefits Manager or request a Fair Hearing process (see **DPBHS Handbook for Consumer/Family Entering Care**).

7.6.1 *Complaints about DPBHS* - The DPBHS complaint policy ensures an accessible and fair process for resolving the concerns of providers and youth, their parents, relative caregivers, guardians, custodians, or their authorized representatives. It is the intent of DPBHS to resolve concerns without the use of formal processes where possible. However, if a concern cannot be resolved to the satisfaction of the aggrieved individual or entity, they may file a complaint with the appropriate DPBHS Manager of Quality Improvement.

7.6.2 *Complaints about DPBHS Providers* - Family or youth complaints about DPBHS service providers should always be addressed first to the service provider. If a DPBHS staff member is notified of a complaint about a provider, the DPBHS staff will direct the aggrieved individual to the appropriate person at the provider organization. In addition, a DPBHS Program Administrator may also address the complaint with the provider, depending on the circumstances. If the complainant is not satisfied with the provider's response, the complainant may contact the DPBHS contact assigned to the program.

7.6.3 The Manager of Quality Improvement, (302) 633-2738, is available to assist in the complaint process.

#### 7.7 Risk Management

7.7.1 *Risk Management System* - The provider will have an overall risk management system as well as procedures for developing individual consumer risk management plans which includes procedures for assuring consumer safety.

7.7.2 *After-Hours Clinical Emergencies* - The provider will have 24-hour, 7 day/week on-call coverage for active consumers. Services performed by on-call coverage are subject to the same clinical standards as those of the contracted provider.

7.7.2.1 The provider will give active consumers and families clear written directions for how to reach the provider in an after-hours emergency. In substance abuse programs, this will also include information for caretakers that they have been informed about the signs of overdose as it applies to each youth's pattern of substance abuse and instructions for obtaining medical help in this emergency. The provider will document that youth have been given this information with a signed form that will be filed in the clinical record.

7.7.2.2 For all nonresidential programs, recorded telephone messages will include the DPBHS crisis number(s).

7.7.2.3 If the provider has an active youth who may be in danger of going into crisis during periods when the consumer is not receiving direct services, the provider will:

7.7.2.3.1 Remind the youth and family about the provider's crisis procedures.



7.7.2.3.2 Provide reasonable and sufficient hours of operation, including 24-hour availability of information, referral and treatment for emergency conditions

7.7.2.3.3 Provide the appropriate DPBHS Crisis Services number to the youth and primary caretaker.

7.7.2.3.4 With parental consent, provide for the notification of the appropriate DPBHS Crisis Services team about the youth, current clinical status, and instructions for how to reach the provider if a crisis occurs.

7.7.2.3.5 If a youth is active with DPBHS Crisis Services, work with them to reach disposition of youth in crisis.

## 7.8 Critical Incidents

7.8.1 *General Requirements* - All DSCYF providers are required to follow the procedures as listed in the DSCYF Operating Guidelines. These procedures are further articulated in the DPBHS Incident Reporting Policy and Procedure that is found at the following Internet site. Written reports are to be faxed to the DPBHS Quality Improvement Unit at E-Fax 1-302-661-7270. **The form for this report is located on the DPBHS Provider Website.**

7.8.2 *Alleged Child Abuse* - For any allegation of child abuse:

7.8.2.1 *If the DPBHS provider delivers services in Delaware* - The Provider recognizes that its employees and therapists are mandated reporters as specified in Title 16, Delaware Code, Chapter 9, Paragraphs 901-909. The provider shall assure that its entire staff who provide services under this Contract are trained in DFS reporting procedures. When a provider's employee or agent knows or reasonably suspects child abuse or neglect, including any such incident within the agency, or receives a complaint of same from a consumer receiving services by the provider, then he/she shall make an oral report to the Delaware Child Abuse Report Line by calling 1-800-292-9582. Within 72 hours of the oral report, a completed Child Abuse Reporting Form shall be sent to the appropriate regional office of the Division of Family Services. At the same time, a copy of this report must be forwarded to DPBHS Quality Improvement Unit.

Ø For further information about professional responsibility with regard to abuse and neglect, consult <http://kids.delaware.gov/information/cai.shtml> to read "**The Professional's Guide to Reporting Abuse and Neglect.**" The Division of Professional Regulation, <http://dpr.delaware.gov/> also contains relevant information.

7.8.2.2 *If the provider does not deliver services in Delaware* - The provider shall adhere to the guidelines for critical incident reporting set forth in the DPBHS policy. Additionally, the provider shall follow the legal requirements for reporting child abuse and neglect in the State in which services are provided. A copy of this report must be forwarded to the DPBHS Quality Improvement Unit. **(See DPBHS website)**

▷ DPBHS Quality Improvement Unit Fax 1-302-661-7270

## 7.9 Environment and Milieu

7.9.1 *Emergency Preparedness* - The provider will have and implement a written plan for natural and man-made emergencies, including but not limited to fire, weather emergencies, criminal and/or terroristic acts. Fire safety plan will comply with the National Fire Protection Association Life Safety Code. It will also comply with the DSCYF Operating Guidelines regarding consumer safety. At minimum, these procedures will list evacuation and shelter-in-place/lockdown procedures as appropriate to the level of care.

7.9.1.1 Drills for evacuation procedures will be documented as having occurred, at minimum, once per year on every shift at every location, as applicable to the level of care.

7.9.1.2 Drills for lock-down/shelter-in-place will be documented as having occurred, at minimum, once per year on every shift, at every location, as applicable to the level of care.

7.9.1.3 Table-top exercises involving all pertinent staff may replace *in vivo* drills if they are appropriate to the level of care.

7.9.1.4 Documentation for drills will include at minimum, date, time, purpose, participants, outcome summary, and lessons learned, if applicable.



7.9.2 Smoking - Smoking is not permitted by any minor in any state operated or funded facility or program. Smoking by adults will be permitted only in designated areas which are away from space used in common for therapeutic and living activities and recreation as well as being out of sight of the children. Under no circumstances will the purchase of tobacco products by minors be directly or indirectly supported by program personnel.

7.9.3 Hazardous Materials - If applicable to the treatment setting, the provider will establish and maintain a program to safely control and dispose of hazardous or potentially infectious materials and waste.

7.9.4 Medication - The provider will have policies and procedures for prescribing, transporting, dispensing, administering and/or ordering medications, as applicable. These policies and procedures will address, at minimum, procurement, storage, control and documentation thereof of all medication in accordance with rules and regulations of the State Board of Pharmacy, the State Board of Nursing, Delacare and other authorizing agencies as applicable.

7.9.5 Other Medical Expenses - DPBHS is not responsible for medical/dental costs for youth in authorized residential treatment. Providers of 24-hour facilities are responsible for ensuring that youth receive necessary medical and dental care. DPBHS will supply Medicaid numbers for all youth in programming for 30 days or longer. It is the responsibility of all providers to encourage their local healthcare providers to enroll in the Delaware Medicaid program if they wish to avoid assuming the costs of routine medical care that is provided by external health care entities and not covered by private health insurance.

7.9.6 Behavior Management/Seclusion/Restraint (Only for hospital, residential and related day treatment programs which are licensed and/or accredited.) These providers will have policies and procedures in place for the safe and appropriate use of restrictive behavior management techniques such as seclusion and restraint.

7.9.6.1 Staff in community-based programs, e.g. crisis, outpatient, wraparound, intensive outpatient, may not restrain youth. This should be reflected in policy and procedure for providers of these levels of care, and all staff must know about this limitation.

#### 7.10 Personnel Practices and Staff Credentialing

7.10.1 The provider will have and implement written policies and procedures for personnel management which will include but not necessarily be limited to:

7.10.1.1 Job descriptions for each position outlining the minimum education, training and experience required to perform each function. These job descriptions must specify education and experience in child-related programs/activities.

7.10.1.2 Documentation that primary verification of education, training, past employment history, professional license and/or certification, etc. is completed prior to the hire. Primary verification means that receipt of transcripts, letters of recommendation, etc. are directly from the source with no intermediary. Primary source verification of licenses may be done on-line with the various licensing boards. The date this verification was made and the person completing this search will be on file.

7.10.1.3 Specification of the scope of the criminal background check being performed at the agency and justification that this is sufficient to minimize risk within the level of care being provided.

7.10.1.4 Annual performance plans and reviews. For licensed practitioners, this will include submission of a copy of the current license.

7.10.1.5 Processes for disciplinary actions and termination and documentation that staff are informed of these processes.

7.10.1.6 Processes for tracking participation of staff in training and other professional development opportunities.



7.11 Program Review - DPBHS performs program reviews, which may include but not be limited to: desk audits of available data on utilization and outcome, accreditation and licensure status, complaints, incident reporting and deliverable submissions, etc. Periodically, DPBHS also conducts on-site monitoring surveys to evaluate consumer safety, appropriateness of services and compliance with DSCYF and DPBHS standards in accordance with the Contract, Statement of Agreement, Article V.



## **8 Document Deliverables**

See the schedules of deliverables for specific requirements

### **8.1 Clinical Reports**

8.1.1 Requirements - Each provider will send copies of youth-specific clinical reports to DPBHS. These include, but are not limited to safety plans, admission summaries, treatment plans, transfer instruction sheet, and discharge summaries. See the schedule of clinical documentation deliverables that follow for specific requirements.

8.1.2 Document Submission - The required clinical reports will be sent or faxed to the DPBHS office indicated on the service admission form (new consumers) DPBHS Records Technician 302-622-4470.

8.1.2.1 Please fax all required clinical reports **except** for outpatient services to 302-622-4470.

8.1.2.2 Please fax all required outpatient clinical reports to **302-424-2960**.

8.1.3 When a client moves through levels of care within one agency, the agency will need to submit a revised treatment plan for the new level of care within 10 days. Agencies are not expected to complete an updated assessment or admission summary for the new level of care nor are they expected to complete a discharge summary for the previous level of care.

### **8.2 Consumer Safety Documents**

8.2.1 Incident Reports - Copies of critical incident reports to DPBHS as directed by and on forms specified in the DSCYF Operating Guidelines. This is pursuant to DPBHS Incident Reporting Policy (PI002).

▮ Fax copy of incident reports to the E-fax at 1-302-661-7270 within 72-hours of the incident.

▮ Abuse/Neglect Reports – by out of state providers to their state regulatory authority.

8.3 Credentialing - DPBHS is committed to meeting the highest standards in quality consumer care. It is therefore expected that all DPBHS employees and network providers will possess appropriate education, skills, and training to fulfill their job responsibilities in a competent manner.

8.3.1 Human Resources Forms (HR Forms and Directions available on the DPBHS Website) will be submitted via fax (302-622-4475) to the respective DPBHS administrative contact for all staff who are providing treatment services or who are supervising staff who are providing services under contract or agreement with DPBHS. HR forms will be re-submitted as needed to update information previously submitted.

8.3.2 Providers who submit HR forms on staff are required to notify DPBHS when employment in one or more program is terminated. This can be done by adding the termination date to the original HR Form and re-submitting to DPBHS.

8.3.3 Providers will notify the appropriate DPBHS contact within 48 hours if there has been a serious change in status of any staff seeing DPBHS consumers. These changes include but are not necessarily limited to:

8.3.3.1 Termination of employment for cause involving performance in program for use of drugs or alcohol, or whose records and/or conduct may negatively affect fiscal and/or program audits.

8.3.3.2 Arrest for any reason

8.3.3.3 Loss of driver's license if staff are required to transport consumers

8.3.3.4 Accusation of abuse or neglect of staff's own children or those in the care of the program.



8.3.3.5 Loss of professional license or certification.

8.4 Provider Accreditation and Licensing

8.4.1 Providers will notify the appropriate DPBHS contact within 48 hours if there has been a material change in status including but not limited to.

8.4.1.1 Accreditation

8.4.1.2 Licensing

8.4.1.3 Insurance

8.4.1.4 Financial condition



**8.5 SCHEDULE OF DOCUMENT DELIVERABLES - CLINICAL INFORMATION FOR MENTAL HEALTH OR SUBSTANCE ABUSE SERVICES**

# Days Post Admission Rec'd by DPBHS	CLINICAL DOCUMENTATION TO BE SENT TO DPBHS	Reference from Provider Manual	ACUTE CARE PROGRAMS		NON-ACUTE CARE PROGRAMS			
			Crisis	Hosp	RTC **	Day	IOP	BI
5	Provider Certificate of Need Form	5.1.1.3		.				
5	Safety Plan	6.4	.	.	.	.	.	.
5	Admission Summary - with physician signature	6.5		.				
15	Admission Summary - with signature of licensed independent practitioner (RTC's must have physician signature)	6.5			.	.	.	.
30	Comprehensive Treatment Plan, or Behavioral Intervention Program Plan.	6.6		.	.	.	.	.
10 days post admission to new LOC within same agency	Updated/Revised Treatment Plan	8.1.3		.	.	.	.	.
24 hours after discharge	Transfer Instruction Sheet	6.9.4	.	.	.	.	.	.
7 Days after discharge	Discharge Summary	6.9	.	.	.	.	.	.

**\*\* Note:** RTC includes all residential treatment, including individualized residential treatment (IRT) and therapeutic group care.

**ROUTINE OUTPATIENT SERVICES ONLY**

DOCUMENT	OUTPATIENT DOCUMENTATION TO BE SENT TO DPBHS	Reference from Provider Manual	Received at DPBHS
Initial Request for Service Authorization	Admission to Mental Health or Substance Abuse Outpatient Services	5.3	Immediately after 1 <sup>st</sup> Session
Request for Continued Service Authorization	Revised/current Treatment Plan Request for Re-authorization	5.4	By Expiration Date or by use of last units authorized
Discharge	Discharge Form	5.5	Within 18 days after discharge



**SCHEDULE OF DOCUMENT DELIVERABLES - ADMINISTRATIVE INFORMATION**

ADMINISTRATIVE DOCUMENTATION	Reference from Provider Manual Reference	SUBMISSION TO
Incident Reports	DSCYF Operating Guidelines	Quality Services Administrator at E-Fax 1-302-661-7270 within 72-hours of the incident.
<p>Provider Documentation</p> <ul style="list-style-type: none"> <li>• Business License, if applicable</li> <li>• Insurance: Proof of commercial liability and motor vehicle insurance, as applicable</li> <li>• Licenses as applicable</li> <li>• Most recent accreditation letter and certificate, survey results and PPR, ACQR, or self-studies completed for accrediting agencies.</li> <li>• Providers’ contract manager information</li> <li>• Provider’s contact for billing and authorization</li> <li>• Provider’s Remittance Address</li> <li>• Documentation or assurance of Provider approval to provide special education from the state in which the Provider does business</li> <li>• Documentation or assurance that the Provider’s teachers are qualified to serve students with disabilities in the State in which the Provider does business</li> <li>• Audited Financial Statements, if available</li> </ul> <p>If these are checked on the DSCYF Document Checklist)</p> <ul style="list-style-type: none"> <li>• DSCYF Rate Certification Form</li> <li>• DSCYF HCFA Sanctions Certification Form</li> <li>• Copy of Agency Operating License(s)</li> </ul> <p>Criteria for Provision of Inpatient Psych Services for Individuals under Age 21.</p>	<p>DSCYF Document Checklist</p> <p><i>Enclosed Annually with Contract</i></p>	<p>Submit with the signed contract to: DSCYF Contracts Unit 1825 Faulkland Road Wilmington, Delaware 19805</p>



<p>Annual Provider Documentation</p> <ul style="list-style-type: none"> <li>· Business License, if applicable</li> <li>· Insurance: Proof of commercial liability and motor vehicle insurance, as applicable</li> <li>· Licenses as applicable</li> <li>· Documentation or assurance of Provider approval to provide special education from the state in which the Provider does business</li> <li>· Documentation or assurance that the Provider's teachers are qualified to serve students with disabilities in the State in which the Provider does business</li> </ul>		<p>Submit annually to: DSCYF Contract Administrator 1825 Faulkland Road Wilmington, Delaware 19805</p>
<p>Change in Documentation status including:</p> <ul style="list-style-type: none"> <li>○ Business License, if applicable</li> <li>○ Insurance coverage</li> <li>○ Licenses as applicable</li> <li>○ Accreditation</li> </ul>		<p>Submit any changes or notices of investigations promptly by FAX to: the DPBHS Manager of Quality Improvement: (302) 622-4475</p>



## 9 Reimbursement

REIMBURSEMENT - DPBHS makes every effort to process bills and authorize reimbursement so that payment may be obtained in less than the thirty days stipulated in the contracts. If, however, the Provider submits bills which are inaccurate, illegible, are for unauthorized services, have calculation errors or are otherwise problematic, DPBHS will not accept responsibility for delayed and/or reduced payments.

Providers must submit bills in a timely fashion. Timely fashion as defined by DPBHS is within 6 months of the date of service. Any claim or bill submitted outside of that timeframe will not be paid unless the provider can demonstrate proof of timely submission.

In the case of electronic billing, providers will be unable to enter any claim which is not authorized.  
*Reimbursement is contingent upon receipt of all contract deliverables due at the time invoices are submitted.*

▷ **Mail all bills and activity logs to Data Unit, Division of Prevention and Behavioral Health Services, 1825 Faulkland Road, Wilmington, Delaware 19805**

### 9.1 Submission of Hardcopy Billing

9.1.1 Cost-reimbursable Contracts and State Operated Programs - RTC's, day treatment, intensive outpatient, crisis intervention, crisis bed, urgent response

9.1.1.1 Activity logs and/or calendar logs must be submitted monthly directly to the DPBHS Data Unit no later than the 15th of the next month.

9.1.1.2 Line item bills from cost-reimbursable programs will be submitted monthly and contain at minimum:

- Column # 1 - Annual contracted budget by line-item with total.
- Column # 2 - Current-month expenditures by line-item with total.
- Column # 3 - Total billed to date by line item with total.

9.1.2 Unit Cost Contracts (Per hour, per diem)

9.1.2.1 Non-residential programs (Intensive outpatient, outpatient and wrap-around services) - Bills will be submitted on Standard Individual DPBHS Non-Residential Billing Forms with a standard Billing Summary Sheet at the face of each package of consumer billing forms. All information must be completed (e.g., dates of authorization, diagnosis).

9.1.2.2 All Other Unit-Cost Contracts - At minimum, bills must contain:

- Consumer name
- Consumer date of birth
- Admission date
- Each date billed in that month on which units of service were provided and for which the unit cost is being charged, along with a subtotal for each consumer.
- Provider of the service (primary therapist)
- Dates of authorization and the authorization number
- DSM-IV diagnosis
- Cover sheet with total being billed for the program/service level

9.1.2.3 Bills for each level of service must be submitted separately

9.2 Submission of Electronic Billing - Please refer to the DPBHS Electronic Billing Procedure for detailed instructions on how to use electronic billing. Providers must be trained prior to participation in electronic billing. Contact DPBHS at (302) 633-2695 to inquire about the training.

9.2.1 All providers must also complete any billing/activity data entry by entering their data into FACTS no later than 4:30 PM on the tenth working day of the month following the close of the month being billed. Bills not entered by 4:30 PM on the tenth working day of the month will be submitted in the next month's bill.

9.2.2 Providers do not have to submit a hardcopy bill if participating in electronic billing.



**9.2.3 For a more comprehensive review of the DPBHS acceptable billing practices and instructions on how to bill, please refer to the DPBHS Treatment Provider Billing Manual**

9.3 Direct Deposit - DSCYF offers direct deposit for vendor checks. To find out more about the direct deposit option or to enroll call Karen Connell at 302-892-4533. Participating vendor feedback has been positive and the system has been operating smoothly since October 2002. Electronic payment benefits cited include quicker receipt of payment, elimination of lost checks in the US mail service and time saved on payment questions.



## 10. Division Seclusion and Restraint Philosophy Statement<sup>1</sup>

The Division of Prevention and Behavioral Health Services (DPBHS) is committed to the effective implementation of trauma-informed care across its continuum of services for children and youth. Trauma-informed care requires that we first acknowledge the overwhelming stress and trauma so common in the lives of children and families we treat. Trauma-informed care is an approach to organizing treatment that integrates an understanding of the impact and consequences of trauma into all clinical interventions as well as all aspects of organizational function.<sup>2</sup>

Safety—physical, emotional, and psychological—are critically important in supporting recovery from trauma. Treatment programs seek to provide safe, comfortable, and nurturing environments where children and youth can work through issues and develop new skills. Yet, some interventions such as restraint and seclusion may have the unintended consequence of triggering traumatic memories or re-traumatizing the child or youth.

Some individuals enter the behavioral health system for help in coping with the aftermath of traumatic experiences. Others enter the system in hope of learning how to control symptoms that have left them feeling helpless, hopeless and fearful. Many enter the system involuntarily. Any intervention that recreates aspects of previous traumatic experiences or that uses power to punish is harmful to the individuals involved. In addition, using power to control an individual's behavior or to resolve arguments can lead to escalation of conflict and can ultimately result in serious injury or even death. "A trauma-informed mindset assumes that: 'bad behavior' is a result of unmet needs; in fact there is 'no such thing as a bad child'; children and youth are doing the best they can; and if they are not doing well, there is a reason related to how well they are able to think about and process their immediate circumstances".<sup>3</sup>

DPBHS is committed to the continued prohibition against seclusion and reduction in the use of restraint in its facilities and programs. This goal is consistent with a mental health system that treats people with dignity, respect and mutuality, protects their rights, provides the best care possible, and supports them in their recovery. DPBHS understands that achieving this goal may require changes in the culture of the clinical environment and the ways in which the physical milieu environment is managed.

**DPBHS** recognizes that many individuals who have been recipients of mental health services consider restraint and seclusion abusive, violent and unnecessary. For more than 35 years, the consumer/survivor movement has continuously voiced its opposition to restraint and seclusion in documents, forums and protests. This movement has consistently championed the development of gentle, voluntary, empowering and holistic alternatives.

To accomplish the goal of eliminating the use of restraint and seclusion in its facilities and programs, DPBHS endorses and promotes a public health model that values input from patients, families, staff and advocates, and that emphasizes:

- § *Primary Prevention: preventing* the need for restraint or seclusion;
- § *Secondary Prevention: early intervention* which focuses on the use of creative, least restrictive alternatives, tailored to the individual, thereby *reducing* the need for restraint or seclusion; and
- § *Tertiary Prevention: reversing or preventing* negative consequences when, in an emergency, restraint or seclusion cannot be avoided.

Furthermore, the public health model uses feedback from each stage to inform and improve subsequent actions. This is a strength-based, patient-driven approach that focuses on enhancing self-esteem, thereby promoting each individual's goals toward recovery. DPBHS strongly believes this approach is essential in establishing a culture that is proactive, responsive and collaborative, rather than reactive. Comprehensive training, education, modeling, mentoring, supervision and ample support mechanisms foster a therapeutic and healing environment for patients and a supportive environment for staff.

Such a therapeutic and healing environment must take into account the experiences of the clients, families and staff. Staff must be given opportunities to increase their empathy for and awareness of the client's and family's subjective and objective experience, including that of mental illness and the physical and emotional impact of restraint and seclusion.



DPBHS recognizes that in an emergency situation where less restrictive alternatives have failed, the judicious and humane use of restraint may be necessary to prevent the imminent risk of harm. In these instances, staff must use these interventions for the least amount of time and in the least restrictive way, taking into consideration the patient's history, preferences and cultural perspective. Intensive de-briefing is expected to promote greater understanding of the potential causes of the child's/youth's behavior, as well as to identify alternative supportive responses in the future.

DPBHS is committed to the continuous evaluation of restraint and seclusion data, and to the ongoing use of targeted performance improvement initiatives. These actions will reinforce the prevention model, improve practice, lead to better outcomes and support the goal of eliminating the use of restraint except for rare circumstances of imminent serious harm in DPBHS facilities and programs.

March 29, 2011

Susan A. Cycyk, M.Ed., CRC  
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Delaware Children's Department

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<sup>1</sup>DPBHS gratefully acknowledges that most of this Philosophy Statement was taken from the Seclusion and Restraint Philosophy Statement of the Commonwealth of Massachusetts/Department of Mental Health, September 18, 2007.

<sup>2</sup>Redefining Residential: Trauma-informed Care in Residential Treatment (Adopted December, 2010). American Association of Children's Residential Centers. Milwaukee, WI.

<sup>3</sup>American Association of Children's Residential Centers.

## 11. FEEDBACK AND SUGGESTIONS

This Manual is updated regularly as requirements are added or changed. DPBHS welcomes feedback and suggestions for improvement from providers and the public at large. Please direct any questions or comments to:

Mental Health Program Administrator II  
1825 Faulkland Road  
Wilmington, DE 19805  
(302) 633-2600

### NOTE:

Any references to DSCYF and DPBHS policies and procedures, and/or forms for various purposes can be found on the DSCYF Website. <http://kids.delaware.gov/>

Necessary Forms, e.g. Billing, Outpatient Forms, Standardized Forms, Human Resources Forms can be found on the DPBHS website in the special section for providers. [http://www.kids.delaware.gov/pbhs/pbhs\\_providers.shtml](http://www.kids.delaware.gov/pbhs/pbhs_providers.shtml)