

Revision Table

Revision Date	Sections Revised	Description
7/1/2013	1.0	Added content “and in accordance to specifications included in their contracts”
7/1/2013	1.2.1.1	Mission statement revised in accordance to the change by DPBHS: Mission: To develop and support a family-driven, youth-guided, trauma-informed prevention and behavioral health system of care.
7/1/2013	1.2.4.2	Added content “or after” to read as follows: <ul style="list-style-type: none"> All providers who were active with DPBHS on or after January 1, 2007.....
7/1/2013	1.3.2.1	Added content “and other specialized treatment services” Although DPBHS prefers to contract with providers who deliver services within the state, out-of-state contracts are negotiated for residential services and other specialized treatment services not available in Delaware.
7/1/2013	4.2.2	Removed language: In collaboration with service providers,
7/1/2013	4.2.3	Replaced “consumer” with “youth”
7/1/2013	4.3 – Clinical Criteria	All DPBHS services are authorized by DPBHS CSMT’s using established criteria for each level of care, included in the Appendix of this Manual.
7/1/2013	6.2.5	Added content related to age for consent to treat for substance abuse services: “In accordance to 16 Delaware Code § 2210, Chapter 22 “Substance Abuse Treatment Act” and “for all levels of care excluding Residential Treatment Services for Substance Abuse”
7/1/2013	6.3.4 – Substance Abuse Programs	NOTE: In-state providers who are not trained on the GAIN should utilize ASAM criteria and a biopsychosocial which is approved by their licensing body (DSAMH) until they are trained on the GAIN; Out-of-state providers should continue using ASAM criteria.
7/1/2013	6.4 – DPBHS Safety Planning	NOTE: Effective July 1, 2013, initial safety plans are no longer deliverables to be submitted to DPBHS, but are to be included in the client’s clinical charts.
7/1/2013	6.4.2 –Preliminary Safety Plan	Effective July 1, 2013, DPBHS is requiring all clients entering treatment services to create an initial safety plan that would include (at a minimum) a basic procedural guide outlining how a family can respond to a mental health or substance abuse crisis.
7/1/2013	6.5 - Integrated Interpretive Assessment Summary (Admission Summary)	NOTE: Effective July 1, 2013, mental health providers no longer need to submit an admission summary as a deliverable, but it must be included in the client’s clinical chart.
7/1/2013	6.6 – Comprehensive Treatment Plan	NOTE: Effective July 1, 2013, all providers will need to submit a comprehensive safety plan in conjunction with the Comprehensive Treatment plan. If using the DPBHS standardized form, the safety

		plan is included in the content.
7/1/2013	6.9.4	Removed language “a copy will be faxed into DPBHS” as that requirement was removed this FY.
7/1/2013	6.11	Added content “or includes any information related to Protected Health Information (PHI)”
7/1/2012	SCHEDULE OF DOCUMENT DELIVERABLES	<p>The Initial Safety Plan is no longer a deliverable to be submitted to DPBHS, but is expected to be included in the clinical chart of the client</p> <p>The Safety Plan remains to be a deliverable included in the Comprehensive Treatment Plan (which is already a part of the DPBHS Standardized form). If a provider has requested to use their own Comprehensive Treatment Plan, please include a separate Safety Plan with that deliverable.</p> <p>The Transfer Instruction Sheet is no longer a deliverable to be submitted to DPBHS, but is expected to be included in the client’s clinical chart.</p>
7/1/2013	Appendices Added	Much of the content previously included in Attachment A of unit cost treatment contracts is now incorporated as Appendices of the Treatment Provider Manual. Attachment B content and Cost-Reimbursable contracts remain in the typical contract material.
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	<p>Mission: Collaborating to offer effective child and family centered prevention, early intervention and treatment services</p> <p>Vision: Resilient children and families living in supportive communities.</p>
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	<p>Added the following bullets:</p> <ul style="list-style-type: none"> • Assisted in application for insurance, if appropriate • GAIN Short Screener (non-SA Programs for youth in services, age 12+)

		<ul style="list-style-type: none"> • GAIN for All SA Services (for more information please see section specific to GAIN) • UCLA administered when clinically appropriate • PCIT used when clinically appropriate • If Level of Care Changed, Revised Treatment Plan • Notes are co-signed • DSCYF Transfer Instruction Sheet <p>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</p>
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, <u>IMPORTANT</u> 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	References Director of Clinical Services 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, the provider will communicate with CSMT in order to conduct a progress review.”
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 For behavioral intervention and crisis requirements see #6.6.1 (‘Integrated Behavioral Intervention Program Acitivity Plan) or #6.6.2 (Crisis Services Plan for Safety) within this section.
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 If the provider does not deliver services in Delaware
7/1/2012	8.1.2.2	Updated fax number for outpatient clinical reports to (302) 424-2960
7/1/2012	SCHEDULE OF DOCUMENT DELIVERABLES – ADMINISTRATIVE INFORMATION	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 infomration has been updated to the current Billing Manager’s phone number 302-633-2695
7/1/2012	9.2.3	Added content: 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
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
7/1/2011	The entire manual	The document was formatted in a similar style with DHSS Medicaid Provider Manual

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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 **and in accordance to specifications included in their contracts.**

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 – To develop and support a family-drive, youth-guided, trauma-informed prevention and behavioral health system of care.

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:

- 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

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:

- The Joint Commission (formerly referred to as 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 **or after** 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, for all services except Residential Treatment for Substance Abuse. This level of care still requires consent from the parent or legal guardian.

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).

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 (MD or DO)

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 **and other specialized treatment 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:
http://kids.delaware.gov/pbhs/pbhs_providers_mhsa.shtml

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 contracted service provider, 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) – please contact a program administrator, listed on the DPBHS website: http://kids.delaware.gov/pbhs/pbhs_providers_mhsa.shtml

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.

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 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 youth 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, included in the Appendix of this Manual.

▮ 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 a program administrator:
http://kids.delaware.gov/pbhs/pbhs_providers_mhsa.shtml

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 Delacare Requirements for Residential Child Care Facilities, § 213; Delacare 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 In accordance to 16 Delaware Code § 2210, Chapter 22 “Substance Abuse Treatment Act”, voluntary treatment for substance abuse, youth ages 14 and older *may* sign consent for treatment for alcohol or drug addiction without parental consent, for all levels of care excluding Residential Treatment Services for Substance Abuse. 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.

NOTE: In-state providers who are not trained on the GAIN should utilize ASAM criteria and a biopsychosocial which is approved by their licensing body (DSAMH) until they are trained on the GAIN; Out-of-state providers should continue using ASAM criteria.

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.

NOTE: Effective July 1, 2013, initial safety plans are no longer deliverables to be submitted to DPBHS, but are to be included in the client's clinical charts.

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 include 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.

NOTE: Effective July 1, 2013, DPBHS is requiring all clients entering treatment services to create an initial safety plan that would include (at a minimum) a basic procedural guide outlining how a family can respond to a mental health or substance abuse crisis.

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 on 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 a 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 dependent 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 can 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.

NOTE: Effective July 1, 2013, mental health providers no longer need to submit an admission summary as a deliverable, but it must be included in the client’s clinical chart.

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.

NOTE: Effective July 1, 2013, all providers will need to submit a comprehensive safety plan in conjunction with the Comprehensive Treatment plan. If using the DPBHS standardized form, the safety plan is included in the content.

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, 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. 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, or includes any information related to Protected Health Information (PHI), 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 CADC/LCDP 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 any time 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:

7.10.2 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.

7.10.3 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.

7.10.3.1 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.

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

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

7.10.3.4 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			
				RTC **	Day	IOP	BI
			Hosp				
5	Provider Certificate of Need Form	5.1.1.3	.				
N/A	Initial Safety Plan to be included in the Clinical Chart – effective July 1, 2013, please do not submit these to DPBHS	6.4	.	.	.	.	.
5	Admission Summary - with physician signature	6.5	.				
15	Admission Summary - with signature of licensed independent practitioner - NOTE: Effective July 1, 2013, Mental Health providers do not need to submit an admission summary, but it is expected to be included in the client's chart	6.5		.	.	.	
30	Comprehensive Treatment Plan, or Behavioral Intervention Program Plan, Effective 7/1/2013, Comprehensive Safety Plan to be sent in along with the Comprehensive Treatment Plan	6.6	.	.	.	.	.
N/A	Transfer Instruction Sheet – no longer required to be sent in as a Deliverable but is expected to be in the clinical chart effective July 1, 2013	6.9.4	.	.	.	.	.
7 Days after discharge	Discharge Summary	6.9	.	.	.	.	.
10 days post admission to new LOC within same agency	Updated/Revised Treatment Plan	8.1.3	.	.	.	.	.

**** 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 st 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"> · Business License, if applicable · Insurance: Proof of commercial liability and motor vehicle insurance, as applicable · Licenses as applicable · Most recent accreditation letter and certificate, survey results and PPR, ACQR, or self-studies completed for accrediting agencies. · Providers' contract manager information · Provider's contact for billing and authorization · Provider's Remittance Address · Documentation or assurance of Provider approval to provide special education from the state in which the Provider does business · Documentation or assurance that the Provider's teachers are qualified to serve students with disabilities in the State in which the Provider does business · Audited Financial Statements, if available <p>If these are checked on the DSCYF Document Checklist)</p> <ul style="list-style-type: none"> · DSCYF Rate Certification Form · DSCYF HCFA Sanctions Certification Form · Copy of Agency Operating License(s) <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"> · Business License, if applicable · Insurance: Proof of commercial liability and motor vehicle insurance, as applicable · Licenses as applicable · Documentation or assurance of Provider approval to provide special education from the state in which the Provider does business · Documentation or assurance that the Provider's teachers are qualified to serve students with disabilities in the State in which the Provider does business 		<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"> ○ Business License, if applicable ○ Insurance coverage ○ Licenses as applicable ○ Accreditation 		<p>Submit any changes or notices of investigations promptly by FAX to: the DPBHS Manager of Quality Improvement: (302) 622-4475</p>

9.0 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 Billing 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) 892-6433 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 Statement¹

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.²

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".³

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
Director, Division of Prevention and Behavioral Health Services
Delaware Children's Department

¹DPBHS 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.

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

³American Association of Children's Residential Centers.

11.0 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

12.0 Appendix – DSCYF Mental Health Criteria

12.1 Using the Criteria

The Children’s Department, comprised of three service Divisions (i.e., Prevention and Behavioral Health Services, Family Services, and Youth Rehabilitation Services), was created to address the needs of children, youth, & their families from a holistic perspective. The Divisions provide defined expertise to meet the needs of each child & family in an integrated & complementary approach.

The Division of Prevention and Behavioral Health Services is charged with the responsibility for assessment and management of treatment targeting mental health and substance abuse problems of Medicaid and uninsured children and youth. Children and youth whose mental health issues necessitate treatment more intensive than outpatient alone are assigned to a Prevention and Behavioral Health Clinical Services Management Team (CSMT). The Medicaid Managed Care Organization (MCO) covers outpatient treatment for children enrolled in Medicaid, for up to 30 units annually. If more than the allowable outpatient benefit provided by Medicaid is needed or if there is no insurance, there is a specific Prevention and Behavioral Health outpatient team that authorizes mental health care.

A mental disorder, as defined by the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders (DSM) (date),

“Is a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress ... or disability...or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom. In addition, the syndrome or pattern must not be merely an expectable and culturally sanctioned response to a particular event, for example the death of a loved one. Whatever its original cause, it must currently be considered a manifestation of a behavioral, psychological, or biological dysfunction in the individual. Neither deviant behavior nor conflicts that are primarily between the individual and society are mental disorders unless the deviance or conflict is a symptom of a dysfunction in the individual as described above.”

The diagnosis of a mental disorder must take into consideration that symptoms are not better explained by the existence of developmental, physical, cognitive, or environmental/family considerations (e.g., inadequate adult supervision; parental inability to provide for basic developmental needs; family or community sanctioned illegal activity). In addition, some behavioral or psychological syndromes or patterns identified in the DSM are more responsive to specifically designed approaches within other service systems (e.g., educational system, developmental disabilities system). Examples of these include: learning disabilities, chronic neurobehavioral syndromes, and behavior patterns which violate the rights of others and interfere with the ability to participate effectively in established mental health treatment. In light of the unique needs of the aforementioned populations and effective protocols established by alternative models of intervention, PBH works to identify and align the expertise of our sister divisions and



community resources to most effectively meet the specialized needs of these children, youth, and their families.

When a child or adolescent is referred with a mental health disorder to a CSMT, the team reviews bio-psychosocial information from numerous sources (e.g., parents, school, current counselor, court, probation officer, child welfare worker) to assist in determining an initial treatment service level of care. The goal is to provide safe and effective treatment that addresses the presenting issues by promoting maximally productive and developmentally appropriate functioning in the most normalized and least restrictive setting. The Division of Prevention and Behavioral Health Services strives to provide a treatment environment that permits children the opportunity to master the normative tasks of development. (The most normal and least restrictive setting for any child is to be living at home with his/her parents, going to a public/private school, and engaging in age appropriate play and socialization when not in school.) The potential risks of a more normative setting are continuously reviewed, and the possible safety issues are weighed against the importance of maintaining ties with family, community, culture, and supports in the child's own environment. This is an ongoing process throughout a child's involvement with the Division.

Prevention and Behavioral Health service decisions are made on an individual and case-by-case basis. While the child or adolescent is always the designated client in treatment with Prevention and Behavioral Health, it is both expected and essential that the parent or the caregiver with whom the child/youth lives, actively and regularly participates in treatment. This includes working with the therapist and even more significantly applying what is learned in therapy to the home and community setting. Treatment of young children is rarely effective without caregiver involvement and most problems presented by adolescents also cannot be effectively treated without the caregiver's participation as in any type of behavioral problem.

Prevention and Behavioral Health follows the customarily established view of mental health treatment as a dynamic process with a beginning, middle, and end. There are no predetermined durations for particular levels of care. The decision to transition from one level of care to another is based on the progress (or lack thereof) that a child or adolescent is making; and is more likely than not to be different for different children/adolescents. Complete resolution of identified issues is not expected to occur during the course of treatment in a particular service. The decision to transition to a less intensive treatment intervention is based on the clinical judgment that the presenting symptoms which necessitated that service have been reduced to a degree that they (and remaining issues) can be safely and effectively addressed in step-down services. Should symptoms not improve over time and/or risks emanating from the mental disorder become too great despite the fact that the service is being utilized as designed and there has been a good faith effort by the family, a decision may be made to consider more intensive treatment. At every juncture, treatment decisions are made in collaboration with parents/custodians and input from all stakeholders to develop and support a family-driven, youth-guided, trauma-informed prevention and behavioral health system of care for resilient children and families living in supportive communities.

Mental Health Criteria for Hospitalization

Hospitalization that provides 24 hour medically supervised care and daily treatment should be used primarily for short term acute care to address symptoms that cannot be addressed at other levels of care. When the acute crisis is resolved, the client can continue treatment in a less restrictive program.

Primary Considerations:

I. **At least one of the following:**

- A) **Self harm:** The client has made suicide attempts or credible threats of significant self injury with a plan and means. Risk factors to be considered include, but are not limited to: suicide of significant other, disturbed sense of reality, depression, hopelessness, previous suicide attempts, substance use, and recent losses.
- B) **Life threatening risk:** The client has exposed himself or herself to life threatening risk. Examples include life threatening eating disorders, repeated drug overdoses requiring medical intervention, and extreme noncompliance with medical intervention for serious medical illnesses.
- C) **Danger to others:** The client has a serious psychiatric disorder such as psychosis, or major affective disorder and displays behavior related to the disorder that may result in serious physical assault, sexual assault, or fire setting or other major harm to others.
- D) **Severe Psychiatric disorder:** The client exhibits a severe psychiatric disorder such as an acute psychotic state, or multiple disorders that require intensive or frequent psychiatric or general medical evaluation or intervention.

II. **Least restrictive:** Care cannot be provided safely or effectively in less restrictive level of care.

Mental Health Criteria for Residential Treatment Centers (RTC)

Residential Treatment Centers (RTC) offers 24 hour structure and supervision and provide safety and a context for intense individual, family, and milieu treatment services.

Primary considerations:

I. **Mental health problems (one required):** The client exhibits clearly identifiable mental health problems or symptoms such as mood disorders, significant anxiety disorders (e.g. PTSD), and/or self injurious behavior/ideation which:

- A) Result in serious impairment in the client's functioning across settings including school, family, and community; or
- B) Make it impossible for the client to self-regulate their behavior without 24 hour support and management by mental health professionals; or,
- C) Create a high level of risk of direct injury to self or others without 24 hour supervision and therapeutic intervention by mental health staff.

II. Least restrictive:

Twenty four hour inpatient hospitalization is not necessary, and the client has received outpatient treatment (including office or home based services, crisis intervention, and day treatment of partial hospitalization) and has not made progress, cannot reasonably be expected to make progress, or is regressing, or there is evidence that the client could not be safely be treated in any less restrictive level of care.

III. **Family participation:** Family members and/or significant others in the client's support network (relatives, case managers, or mentors) will commit to regular participation in the treatment process and to the client's return to the community.

However, clients affected by these conditions may have mental health concerns that should be treated at the appropriate level of care. Inter-Divisional and/or interdepartmental planning and intervention will frequently be necessary to address other conditions.

Following these guidelines, based on criteria and complicating conditions, each case is reviewed individually in order to establish the most appropriate course of intervention and treatment.

Criteria for Individualized Residential Treatment (IRT)

This level of care provides a 24 hour specialized treatment in a home environment for clients whose behavior and psychiatric status precludes their ability to function in a less structured environment after receiving treatment in a residential treatment center. The client's natural home situation is unable to provide for the child and there are no identified parents, family, or friends interested in sharing their home and/or qualified in providing the level of behavior management intervention clinically necessary to maintain client in the community, home or school setting. These children, who challenging behaviors and special needs associated with their emotional and cognitive compromise, necessitate "treatment parents" who are extensively trained to manage the issues and behaviors presented by these children and are required to be available on an as needed basis to support these children in the community. The complexity of these children's problems require a team approach whereby the "treatment parents" are clinically supported by the organization employing them, there provisions for emergency clinical support and respite is provided for the "treatment parent".

Primary Considerations: (all required)

I A. Child must be

1. Over the age of 12 and
2. Currently receiving treatment in a mental health/substance abuse residential treatment center (RTC) due to a clearly identifiable and serious mental health or substance abuse disorder and
3. Having completed treatment at the residential level

B. The child cannot function in a natural family **and** the demands presented by his/her mental health and/or substance abuse make him/her an unsuitable candidate for regular foster or group care.

C. The child is expected to attend public school within 30 days of entering the home.

II. Least restrictive:

Twenty four hour inpatient hospitalization or residential treatment is not clinically necessary, and based on child's history the child is unlikely to be successful in a home environment that offers fewer clinical services and supervision.

III. Family participation: Family members and/or significant others in the client's support network (relatives, case managers, or mentors) will commit to regular participation in the treatment process and to the client's return to a normal home environment. The "treatment parents" will participate in treatment, school, and community meetings.

Crisis Intervention Services

Crisis intervention is immediate action taken to evaluate, stabilize, and intervene in critical or emergency situations that appear to involve mental health concerns. The goals are to address issues which precipitated the crisis, provide intensive short-term intervention, and identify and provide transition to any necessary follow on services.

Primary considerations:

- I. There are mental health concerns, which require an immediate evaluation and intervention.
- II. There is no apparent condition or injury requiring immediate medical attention.



Crisis Bed Services

A crisis bed is a substitute care setting that may be utilized for a period of up to 72 hours, when such substitute care will facilitate effective implementation of crisis intervention services.

Primary Considerations:

- I. A crisis bed should not be used when other appropriate resources, e.g., extended family, are available to provide support and care.
- II. The child would be at increased risk for hospitalization or other 24 hour care if the crisis bed is not utilized.

Mental Health Criteria for Partial Hospitalization/Day Hospital

This level of care provides support and psychiatric services five days per week to clients living at home or in other residential settings. This level of care should be used for clients with severe, complex, or chronic psychiatric disorders requiring high intensity psychiatric medical services.

Primary Considerations:

I. At least one of the following:

- A) **Self harm:** The client has made suicide attempts or credible threats with a plan and means. Risk factors to be considered include, but are not limited to: suicide of significant other, disturbed sense of reality, depression, hopelessness, previous suicide attempts, substance use, and recent losses.
- B) **Medical risk:** The client has exposed himself or herself to medical risk, for example, eating disorders, repeated drug overdoses requiring medical intervention, and noncompliance with medical intervention for serious medical illnesses.
- C) **Danger to others:** The client has a serious psychiatric disorder such as psychosis, or major affective disorder and displays behavior related to the disorder that may result in serious physical assault, sexual assault, or fire setting or other major harm to others.
- D) **Severe, Complex, or Chronic Psychiatric disorder:** The client exhibits a severe, complex, or chronic psychiatric disorder that has led to compromised functioning in multiple areas which require frequent or intensive psychiatric or general medical evaluation or intervention which cannot safely or effectively be provided in alternative programs.
- E) **Psychiatric oversight:** Is a necessary part of the client's treatment.

II. Least restrictive :

Twenty four hour inpatient hospitalization or RTC care is not necessary, and the client has received outpatient treatment (including office or home based services, crisis intervention, and day program) and has not made progress, cannot reasonably be expected to make progress, or is regressing in outpatient treatment, or there is evidence that the client could not be safely be treated in any less restrictive level of care.

III. Family participation: Family members and/or significant others, in the client's support network (relatives, case managers, or mentors) will commit to regular participation in the treatment process and to the client's return to the community.

Mental Health Criteria for Day Treatment

Day treatment provides intensive psychiatric services and a milieu facilitating a more successful adaptation to community and regular educational environments when 24 hour care and intensive psychiatric/medical monitoring are not necessary. Services are provided five (5) days a week.

Primary consideration:

I. At least one of the following:

- A) **Self harm:** The client within the last two years has made a significant suicide attempt or gesture and currently threatens self -harm or self -mutilation, especially in combination with a history of substance abuse, significant depression, borderline personality disorder, or other significant psychiatric conditions.
- B) **Danger to others:** The client has a serious psychiatric disorder such as psychosis, or major affective disorder and displays behavior related to the psychiatric condition that may result in serious physical assault, sexual assault, or fire setting, or other major harm to others.
- C) **Severe or Chronic Psychiatric disorder:** The client exhibits a psychiatric disorder such as major depression or chronic conditions that compromises functioning in multiple areas, and requires intensive psychotherapeutic intervention and/or a milieu that facilitates social skill development and reintegration into a regular community school environment.

II. Least restrictive:

Twenty four hour inpatient hospitalization or RTC or partial hospital care is not necessary and outpatient treatment (including office or home based services, or crisis intervention) has been attempted or considered and the youth has not made progress, or cannot reasonably be expected to make progress.

III. **Family participation:** Family members and/or significant others, in the client's support network (relatives, case managers, mentors) will commit to regular participation in the treatment process and to the client's return to the community.

Intensive Outpatient (IOP) Services

Intensive Outpatient Treatment is focused, professionally directed evaluation and treatment of at least 3 hours per week. It is designed for the client who needs intensive treatment including services at school, in the client's home, and in the community in addition to the therapist's office, but can live at home and attend school or work during the day.

Payment Considerations

I. Mental health problems that significantly compromise functioning.

II. Least restrictive (one of the following required):

A. Twenty four hour inpatient hospitalization, RTC or Day Treatment is no longer necessary and more intensive services than traditional outpatient are required, or

B. The client has received lower intensity outpatient treatment and has not made progress, cannot reasonably be expected to make progress, is regressing in outpatient treatment, or is not likely to benefit from outpatient treatment.

III. **Family participation:** Family members or, in exceptional cases significant others, in the client's support network (relatives, case managers, mentors) will commit to regular participation in the treatment process and to maintaining the client in the community.

Mental Health Outpatient

Mental health outpatient treatment is the least restrictive level of mental health intervention. It is designed for children/youth who have been identified as exhibiting mental health symptoms requiring evaluation and/or treatment, most typically on a scheduled basis. Although the frequency of appointments might range from once a month to several times a week, the typical client would be seen once or twice a week for a period of three to six months. Family participation and utilization of community resources are emphasized.

Primary considerations:

- I. The child has at least one mental health symptom requiring evaluation or treatment.
- II. The child or youth can be maintained in the family and school setting within this level of care.
- III. The child's or youth's family or support system should be willing to participate in treatment.

Criteria for Behavioral Intervention Services
(Formerly known as Wrap-Around Aide Services)

Aide services are designed to augment mental health services provided directly by mental health providers through the use of a paraprofessional working directly with the client and family to carry out elements of the mental health treatment plan. Generally the aide would be available to help generalize treatment efforts to other settings. The service should generally be time limited, focused on specific goals, and used to aid in transition between levels of care or to facilitate adjustment to developmental tasks.

Primary consideration:

- I. The client must be engaged in mental health treatment at least at the outpatient level. (Aide services are not a stand-alone treatment.)
- II. The goals for the aide must be integrated into the mental health treatment plan.
- III. There should be an attainable goal with a time limited period of intervention for each goal. Goals should be stated in concrete behavioral or skills terms.
- IV. The client has mental health symptoms that are severe, chronic, and/or pervasive, and are not responding or cannot reasonably be expected to respond to traditional outpatient treatment alone.
- V. Without the aide service, the client would require a higher level of service provision.

Substance Abuse Criteria

For Substance Abuse Disorders, DPBHS uses the criteria developed by the American Society of Addiction Medicine, Inc. Since these are copyrighted they cannot be reprinted. The reference is:

American Society of Addiction Medicine. (2001). *ASAM PPC-2R: ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders. Second Edition –Revised.* Chevy Chase, MD: American Society of Addiction Medicine, Inc.

Web Address for American Society of Addiction Medicine: <http://www.asam.org/>

I. SERVICE OVERVIEW

A. Definition

DPBHS	Division of Prevention and Behavioral Health Services
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B. Description/Purpose/Goals

Behavioral Intervention Services are designed to augment mental health or substance abuse treatment through the use of a paraprofessional working directly with the client and family to carry out elements of the treatment plan developed by the therapist. The behavioral interventionist is available to help generalize treatment to other settings. The service is time-limited, focused on specific goals, and used to aid in transition between levels of care or to facilitate acquisition of specific developmental tasks. Objectives for behavioral intervention services include:

1. To provide home/community-based services as an adjunct to mental health or substance abuse treatment to children and their families who require more than routine, office-based outpatient services.
2. To provide additional therapeutic services as an alternative to a higher level of service provision or to aide in the transition between levels of care.
3. To provide transition for the client to natural, community based support systems

C. Program Dimensions

1. Community-Based Non-Residential – Low Restrictiveness - Child supervision is the responsibility of the primary caretaker while program staff may provide supervision during a specific service episode. Provider comes to the home or a community-based site other than their own to provide services.
2. Medium/Low Client Supervision - Clients and families are seen from 4 - 12 hours per week over a series of weeks with a variety of service modalities included on a treatment/service plan which may include but not be limited to: individual therapy, family therapy, group therapy, home and school visits, and intensive case management.
3. Low-Clinical - Services provided by one or two trained supervised persons with clinical staff available for consultation and some intervention. This may be in collaboration with other contracted service providers.

II. SERVICE COMPONENTS

Services will be tailored to the individual needs of the client and family and will be developed in collaboration with the therapist, the family and the client. Goals will be time

limited, measurable, and stated in behavioral terms. Services will be provided before and after school, in the evenings, and on weekends when clinically appropriate. The family and community support system will be actively involved in the treatment process. Activities will occur in the client's environment (i.e. home, community center, etc.) and will include but not be limited to:

- A. Psychosocial activities, community events, skill building activities and other related therapeutic services according to the prescribed treatment plan.
- B. Transportation to and from provided activities.
- C. Treatment team planning meetings, school meetings, and other related activities that facilitate the treatment plan.
- D. Skill building groups such as parenting and parent support, social skills groups, etc.

III. STAFF CREDENTIALS

- A. The program will be headed by someone with a minimum of a graduate degree in a mental health discipline and supervised by a licensed mental health professional.
- B. Training and orientation will include aspects of safety unique to community-based services



I. SERVICE OVERVIEW

A. Definition

CADC	Certified Alcohol & Drug Counselor
CSMT	Clinical Services Management Team
DPBHS	Division of Prevention and Behavioral Health Services
DSAMH	Division of Substance Abuse and Mental Health
EPSDT	Early and Periodic Screening, Diagnosis, Treatment
IOP	Intensive Outpatient Service
LCDP	Licensed Chemical Dependency Professional
MCO	Managed Care Organization
RN	Registered Nurse

B. Description

An outpatient community substance abuse treatment provider acts as an intake point for the DPBHS. In that capacity, the CONTRACTOR may take referrals for services, assess eligibility for DPBHS services and submit applications to DPBHS. Providers in this category are identified as a DPBHS agency on documents produced by the DPBHS. Outpatient substance abuse services include individual and family assessment, psychiatric and psychological services, individual, group, and family counseling, consultation to other child-serving agencies and case management.

C. Program Dimensions

1. Provider Site Non-Residential – Child supervision is the responsibility of the primary caretaker while program staff may provide supervision during a specific intervention or service episode. Client(s) go to the provider’s location to obtain services.
2. Level of Supervision/Monitoring - Clients are seen mostly during day and evening hours on average one hour per week.
3. Professional Level of Staff - Services provided with a team approach. The team must be headed by a clinician with a graduate degree in a behavioral science and includes, at minimum:
 - One or more trained clinical staff, e.g. minimum of master’s level in some human service discipline, RN, etc., and
 - Trained, supervised staff specializing in some aspect of behavioral change, e.g. residential childcare workers or non-residential community interventionists, and
 - Clinical staff available for consultation, and some intervention, e.g. physicians including psychiatrists and psychologists.

II. TARGET POPULATION

A. Age

Children and adolescents under the age of eighteen are the identified clients. Family participation which addresses the identified client's presenting problems as specified on the treatment plan is encouraged.

B. Client Criteria

1. Clinical Eligibility - EPSDT
2. Financial Eligibility
 - a. Uninsured clients without Medicaid or other insurance benefits whose maximum sliding scale fee when calculated using family size and family income is less than 80% of the agency maximum fee, or
 - b. Medicaid clients who have exceeded the annual maximum MCO benefit of 30 units if authorized by DPBHS, or
 - c. Otherwise financially ineligible clients who are referred and/or authorized by DPBHS.

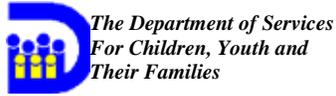
C. Source of Referrals

1. All referrals to the CONTRACTOR may be accepted under the Contract if they meet financial and clinical eligibility requirements.
2. Exclusions:
 - a. Clients who are eligible for Medicaid or Chips must be assisted to make appropriate applications;
 - b. All clients who have private insurance;
 - c. Youth who are in institutional care, e.g., Ferris School, detention centers, Stockley Center and youth who are in other levels of treatment, e.g., ACT, IOP, day treatment, emergency services, psychiatric hospital, unless specifically requested and authorized by the DPBHS Managed Care Team.

III. SERVICE COMPONENTS

A broad menu of service components will be available and provided for each identified client/family as needed for the duration of each outpatient service episode.

- ### A. Direct Treatment Services - Direct services are those in which the therapist meets with the child who is the identified client, siblings and/or the parents or legal guardians of the identified client to plan for treatment or work toward achievement of the goals stipulated in the client's treatment plan. These services may be provided on-site (at the agency) or off-site (at home, school or other setting).



1. Direct Services - Allowable/billable direct services are face-to-face meetings with the client and/or family for the purpose of moving toward the goals listed on the treatment plan. All direct, services will be documented by a progress note that contains, at minimum, date and length of the contact, and summary of the intervention provided by the therapist and its relationship to the treatment plan goal and signature and title of the therapist.
 2. Time Limits - Individual, group and family sessions should be within the following parameters unless a clinical emergency or other special circumstance is documented.

Intake Session	up to 1.5 hours
Individual Session	1.0 hour
Family Session	1.5 hours
Group (3-7 clients)	1.5 hours
Medication Monitoring	0.5 hour
 3. Session Limits - The number of sessions per individual client will be authorized by DPBHS based on documentation submitted by the therapist listing the nature/severity of the problem, treatment goals and objectives and progress toward achieving those goals.
 4. Not Reimbursable
 - a. Psychiatric and psychological assessments are not reimbursable. The exception is for psychiatric sessions for the purpose of evaluating the need for medication, and the required initial integrated assessment at the beginning of each treatment episode.
 - b. No-Shows - If a client fails to keep an appointment, the hour reserved for that client should be used by the therapist to contact parents, other case workers, etc., to encourage the family to reschedule. This activity will be recorded under indirect service listed below.
 - c. Extra payment for additional therapists in a session will not be made. Therapists who participate for supervision and/or consultation purposes do so under contract requirements for peer review, quality assurance and supervision. No additional payment will be approved.
- B. Indirect Services - Are case related activities and are documented in the client record as a progress note. This note will include the date, the time spent on the activity, the kind of activity provided, and a summary of the activity and the signature of the therapist who completed the activity. Indirect services include but are not limited to:
1. Therapist telephone contacts with clients or family.
 2. Interagency and/or school service planning meetings about client issues without the client present.
 3. Therapist telephone contacts with other agencies about client issues.

4. Supervision and case review - The supervision will be included in the case record and will include, at minimum, the names of the reviewer(s), content of the review, supervisory suggestions.
- C. Multi-System Intervention - Case coordination/consultation with systems involved with the family resources represent an integral part of the service to be provided. These may include but not be limited to DEPARTMENT workers, school system, Court, church, mosque or synagogue. The CONTRACTOR will regularly anticipate these interactions by obtaining signed releases for these contacts from parent or guardian on intake. All contacts including telephone communications will be documented in progress notes.
1. The CONTRACTOR will furnish written case review and discharge summary information as appropriate to professional staff in other agencies when presented with an appropriate signed release.
 2. Communication with DEPARTMENT case managers involved in outpatient cases:
 - a. The CONTRACTOR will notify the referring DSCYF case manager of the date and time of the first scheduled appointment as soon as it is arranged with the family.
 - b. The CONTRACTOR will notify the referring case manager verbally within 5 working days if the client/family fails to keep the first scheduled appointment and will keep in regular contact with the case manager if clients demonstrate a pattern of failed/canceled appointments.
 - c. The CONTRACTOR will provide ongoing verbal communication as needed with all DSCYF case managers involved with the case.

IV. CLINICAL PROGRAM

- A. Staffing - All staff providing direct treatment services will practice within the scope of their qualifications, licensure or certification.
1. Clinical Director – The CONTRACTOR will identify a Delaware licensed mental health professional (psychiatrist, psychologist, licensed clinical social worker, licensed mental health counselor, licensed marriage and family therapist or licensed chemical dependency professional) who is responsible for the overall operation of the clinical program. If the licensed practitioner is not an LCDP and does not have a CADC, a second clinical supervisor in addictions with a CADC must be available to supervise all staff that are uncertified in this area.
 2. Staffing - Staff must have at least one of the minimum requirements:
 - a. Master's degree with an emphasis on clinical practice from an accredited program of social work education.
 - b. Master's or Doctoral degree in Clinical or Counseling Psychology.

- c. Master's degree in Counseling.
 - d. RN with a specialty in psychiatric nursing or a Master's degree from an accredited program in psychiatric nursing.
 - e. Certification as psychiatric nurse practitioner with specialty in treatment of children/adolescents.
 - f. Medical degree and board eligibility in psychiatry.
 - g. Baccalaureate degree with a Delaware certification in addictions, CADC and or is actively working toward this certification as required by DSAMH licensure.
3. Unlicensed/uncertified staff will receive a minimum of one hour of documented individual supervision per week. Practicing with Less than Minimum Qualifications - Clinicians may, under special circumstances, provide outpatient treatment under the Contract if a written waiver is obtained in advance from the DPBHS. Graduate student interns and individuals with specific and unique combinations of training and experience who have less than the qualifications listed above may apply for a waiver. Documentation sent to DSCYF shall include:
- a. In the case of full time employees, justification for why this staff member is necessary to provide the service.
 - b. Staff member's resume with sections of the training and experience category highlighted which provide documentation that the staff member is uniquely qualified to provide the service.
 - c. Identification of the agency employee who will take clinical responsibility for cases being seen by this staff member.
 - d. Presence of Supervisor - The supervisor will be on-site and available to the student/staff member at any time when he/she is providing direct treatment service. In the event of the absence of the supervisor, another appropriate substitute shall be identified. The supervisor shall accept clinical responsibility for all cases carried by the student/staff member during his/her internship/employment.
 - e. Minimum Supervision Time - Students and staff under waiver must receive a minimum of one (1) hour documented individual supervision for every ten (10) hours of direct service time they provide.
 - f. Documentation of Supervision - The CONTRACTOR shall maintain an individual student file on each supervisee. These may be written by the supervisee. At minimum the file shall contain log sheets for each individual and group supervision sessions covering DPBHS clients, which contain the date, time, and the DPBHS client-related content of the session with



signatures of both supervisor and supervisee. A note of this session will also appear in the client record.

4. Psychiatric Treatment - The CONTRACTOR will provide medication evaluation and monitoring by a psychiatrist or psychiatric nurse practitioner for any client requiring this service on an as needed basis. The CONTRACTOR will assure that all treatment plans which include medication as part of the treatment to be provided will be reviewed and signed by the treating physician/psychiatrist/nurse practitioner.



I. SERVICE OVERVIEW

A. Definitions

CADC	Certified Alcohol & Drug Counselor
CSMT	Clinical Services Management Team
DPBHS	Division of Prevention and Behavioral Health Services
DSAMH	Division of Substance Abuse and Mental Health
EPSDT	Early and Periodic Screening, Diagnosis, Treatment
IOP	Intensive Outpatient Service
LCDP	Licensed Chemical Dependency Professional
MCO	Managed Care Organization
RN	Registered Nurse

B. Description

An outpatient community mental health provider acts as an intake point for the DPBHS. In that capacity, the CONTRACTOR may take referrals for services, assess eligibility for DPBHS services and submit applications to DPBHS. Providers in this category are identified as a DPBHS agency on documents produced by the Division. Outpatient mental health services include individual and family assessment, psychiatric and psychological services, individual, group, and family counseling, consultation to other child-serving agencies and case management.

C. Program Dimensions

1. Provider Site Non-Residential – Low Restrictiveness - Child supervision is the responsibility of the primary caretaker. Program staff may provide supervision during a specific service episode.
2. Client Supervision - Outpatient providers do not provide client supervision except during treatment sessions if no caretaker is present. These occur on average one hour per week.
3. High Professional Level of Staff - Treatment individuals and treatment teams must meet the criteria below. The program must be overseen by a licensed mental health professional, and therapists must have minimum qualification listed below.

II. TARGET POPULATION

A. Age

Children and adolescents under the age of eighteen are the identified clients. Family participation which addresses the identified client’s presenting problems as specified on the treatment plan is encouraged.

B. Client Criteria

1. Clinical Eligibility - EPSDT

2. Financial Eligibility
 - a. Uninsured clients without Medicaid or other insurance benefits whose maximum sliding scale fee when calculated using family size and family income is less than 80% of the agency maximum fee, or
 - b. Medicaid clients who have exceeded the annual maximum MCO benefit of 30 units if authorized by DPBHS, or
 - c. Otherwise financially ineligible clients who are referred and/or authorized by DPBHS.

C. Source of Referrals

1. All referrals to the CONTRACTOR may be accepted under the Contract if they meet financial and clinical eligibility requirements.
2. Exclusions
 - a. Clients who are eligible for Medicaid or Chips must be assisted to make appropriate applications.
 - b. All clients who have private insurance
 - c. Youth who are in institutional care, e.g., Ferris School, detention centers, Stockley Center and youth who are in other levels of treatment, e.g., ACT, IOP, day treatment, emergency services, psychiatric hospital, unless specifically requested and authorized by the DPBHS Managed Care Team

III. SERVICE COMPONENTS

A broad menu of service components will be available and provided for each identified client/family as needed for the duration of each outpatient service episode.

A. Direct Treatment Services

Direct services are those in which the therapist meets with the child who is the identified client, siblings and/or the parents or legal guardians of the identified client to plan for treatment or work toward achievement of the goals stipulated in the client's treatment plan. These services may be provided on-site (at the agency) or off-site (at home, school or other setting).

1. Direct Services - Allowable/billable direct services are face-to-face meetings with the client and/or family for the purpose of moving toward the goals listed on the treatment plan. All direct, services will be documented by a progress note that contains, at minimum, date and length of the contact, and summary of the intervention provided by the therapist and its relationship to the treatment plan goal and signature and title of the therapist.
2. Time Limits - Individual, group and family sessions should be within the following parameters unless a clinical emergency or other special circumstance is documented.



Intake Session	up to 1.5 hours
Individual Session	1.0 hour
Family Session	1.5 hours
Group (3-7 clients)	1.5 hours
Medication Monitoring	0.5 hour

3. Session Limits - The number of sessions per individual client will be authorized by DPBHS based on documentation submitted by the therapist listing the nature/severity of the problem, treatment goals and objectives and progress toward achieving those goals.
4. Not Reimbursable
 - a. Psychiatric and psychological assessments are not reimbursable. The exception is for psychiatric sessions for the purpose of evaluating the need for medication, and the required initial integrated assessment at the beginning of each treatment episode.
 - b. No-Shows - If a client fails to keep an appointment, the hour reserved for that client should be used by the therapist to contact parents, other case workers, etc., to encourage the family to reschedule. This activity will be recorded under indirect service listed below.
 - c. Extra payment for additional therapists in a session will not be made. Therapists who participate for supervision and/or consultation purposes do so under contract requirements for peer review, quality assurance and supervision. No additional payment will be approved.

B. Indirect Services

Are case related activities and are documented in the client record as a progress note. This note will include the date, the time spent on the activity, the kind of activity provided, and a summary of the activity and the signature of the therapist who completed the activity. Indirect services include but are not limited to:

1. Therapist telephone contacts with clients or family.
2. Interagency and/or school service planning meetings about client issues without the client present.
3. Therapist telephone contacts with other agencies about client issues.
4. Supervision and case review - The supervision will be included in the case record and will include, at minimum, the names of the reviewer(s), content of the review, supervisory suggestions.

C. Multi-System Intervention

Case coordination/consultation with systems involved with the family resources represent an integral part of the service to be provided. These may include but not be limited to DEPARTMENT workers, school system, Court, church, mosque or synagogue. The CONTRACTOR will regularly anticipate these interactions by obtaining signed releases for

these contacts from parent or guardian on intake. All contacts including telephone communications will be documented in progress notes.

1. The CONTRACTOR will furnish written case review and discharge summary information as appropriate to professional staff in other agencies when presented with an appropriate signed release.
2. Communication with DEPARTMENT case managers involved in outpatient cases:
 - a. The CONTRACTOR will notify the referring DSCYF case manager of the date and time of the first scheduled appointment as soon as it is arranged with the family.
 - b. The CONTRACTOR will notify the referring case manager verbally within 5 working days if the client/family fails to keep the first scheduled appointment and will keep in regular contact with the case manager if clients demonstrate a pattern of failed/canceled appointments.
 - c. The CONTRACTOR will provide ongoing verbal communication as needed with all DSCYF case managers involved with the case.

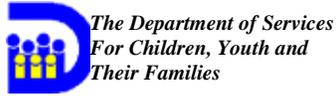
IV. CLINICAL PROGRAM

A. Staffing

All staff providing direct treatment services will practice within the scope of their qualifications, licensure or certification.

1. Clinical Director - The contractor will identify a Delaware licensed mental health professional (psychiatrist, psychologist, licensed clinical social worker, licensed mental health counselor or licensed marriage and family therapist) who is responsible for the overall supervision of the clinical program.
2. Staffing - Staff must have at least one of the minimum requirements:
 - a. Master's degree with an emphasis on clinical practice from an accredited program of social work education
 - b. Master's or Doctoral degree in Clinical or Counseling Psychology
 - c. Master's degree in Counseling
 - d. RN with a specialty in psychiatric nursing or a Master's degree from an accredited program in psychiatric nursing
 - e. Certification as a psychiatric nurse practitioner with specialty in treatment of children and adolescents.
 - f. Medical degree and board eligibility in psychiatry.

3. Unlicensed staff will receive a minimum of one hour of documented individual supervision per week.
4. Practicing with Less than Minimum Qualifications - Clinicians may, under special circumstances, provide outpatient treatment under the Contract if a written waiver is obtained in advance from the DPBHS. Graduate student interns and individuals with specific and unique combinations of training and experience who have less than the qualifications listed above may apply for a waiver. Documentation sent to DSCYF shall include:
 - a. In the case of full time employees, justification for why this staff member is necessary to provide the service.
 - b. Staff member's resume with sections of the training and experience category highlighted which provide documentation that the staff member is uniquely qualified to provide the service.
 - c. Identification of the agency employee who will take clinical responsibility for cases being seen by this staff member.
 - d. Presence of Supervisor - The supervisor will be on-site and available to the student/staff member at any time when he/she is providing direct treatment service. In the event of the absence of the supervisor, another appropriate substitute shall be identified. The supervisor shall accept clinical responsibility for all cases carried by the student/staff member during his/her internship/employment.
 - e. Minimum Supervision Time - Students and staff under waiver must receive a minimum of one (1) hour documented individual supervision for every ten (10) hours of direct service time they provide.
 - f. Documentation of Supervision - The CONTRACTOR shall maintain an individual student file on each supervisee. These may be written by the supervisee. At minimum the file shall contain log sheets for each individual and group supervision sessions covering DPBHS clients, which contain the date, time, and the DPBHS client-related content of the session with signatures of both supervisor and supervisee. A note of this session will also appear in the client record.
5. Psychiatric Treatment - The CONTRACTOR will provide medication evaluation and monitoring by a psychiatrist or psychiatric nurse practitioner for any client requiring this service on an as needed basis. The CONTRACTOR will assure that all treatment plans which include medication as part of the treatment to be provided will be reviewed and signed by the treating physician/psychiatrist/nurse practitioner.



I. SERVICE OVERVIEW

A. Definitions

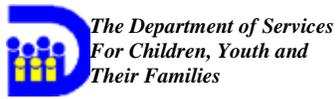
CADC	Certified Alcohol and Drug Counselor
CSMT	Clinical Services Management Team
DPBHS	Division of Prevention and Behavioral Health Services
EBP	Evidence-Based Practices
IOP	Intensive Outpatient Service
LCDP	Licensed Clinical Drug Practitioner
RN	Registered Nurse

B. Description/Purpose and Goals/Objectives

Intensive Outpatient Services provide community-based mental health and/or substance abuse intervention to assist the youth and the family/caretakers, the school, and other members of the natural helping network to learn skills to deal with existing problems. Objectives are to:

- Reduce frequency of inpatient psychiatric hospitalization episodes.
- Reduce the need for residential treatment placements.
- Reduce frequency and duration of behaviors leading to residential treatment or psychiatric hospitalization.
- Increase the number of days between hospital, residential and crisis episodes.
- Increase the frequency of appropriate social contacts made by the youth and family in his/her community, and/or within the psychosocial group.
- Increase the number of consecutive days the youth engages in academic, vocational, or other training programs.
- Reduce the behaviors or symptoms which led to the referral. Associated with the reduction in symptomatology can be an increase in functioning across the domains of work, school and community.

Service Hours: Hours should be based upon youth and family needs and should include nights and weekends.



C. Program Dimensions

1. Restrictiveness of Living/Service Setting- Community-Based Non-Residential

Child supervision is the responsibility of the primary caretaker while program staff may provide supervision during a specific service episode. Provider comes to the home or a community-based site other than their own to provide services.

2. Level of Supervision/Monitoring- Medium/Low

Clients and families are seen from 4 - 12 hours per week over a series of weeks with a variety of service modalities included on a treatment/service plan which may include but is not limited to:

- individual therapy
- family therapy
- group therapy
- home and school visits
- intensive case management

3. Professional Level of Staff- High Team

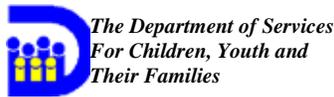
Services provided with a team approach. The team must be headed by a licensed mental health professional and includes, at minimum

- One or more trained clinical staff, e.g. minimum of master's level in some human service discipline, RN, etc.
- Clinical staff available for consultation and some intervention, e.g. physicians including psychiatrists and psychologists
- Trained, supervised staff may be added to the team. These individuals specialize in some aspect of behavior change, e.g. residential childcare workers or non-residential community interventionists

II. TARGET POPULATION

A. Age, Gender, and Service Capacity

1. Age - Children and adolescents through age 17
2. Gender – No gender will be excluded from this contract
3. Capacity – Subject to CSMT authorization(s)
4. Location – as specified in the RFP response



B. Client Criteria and Eligibility

For more specifics around this component of the contract, please refer to [DPBHS Service Eligibility Policy CS001].

C. Exclusion Criteria

DPBHS managed care teams make referrals to IOP providers and they are expected to accept most youth unless there are immediate safety issues. Few referrals should be excluded. The youth served by IOP are among the most complex, and in the absence of safe alternatives, the youth would probably be in more restrictive settings.

III. ADMISSIONS, DISCHARGES AND FUNDING AUTHORIZATION(S)

A. Referrals

For more specifics around this component of the contract, please refer to the DPBHS Treatment Provider Manual.

B. Initial Service Authorization and Expected Length of Stay/Service

1. Initial Service Authorization – For more specifics around this component of the contract, please refer to the DPBHS Treatment Provider Manual. This is subject to CSMT authorization(s).
2. Expected Length of Stay/Service - Length of stay is targeted at 4-6 months. This is a collaborative effort between the provider and the DPBHS Clinical Management Team involved with the case.

C. Admissions

For more specifics around this component of the contract, please refer to the DPBHS Treatment Provider Manual.

D. Medical Services Not Covered By Contract

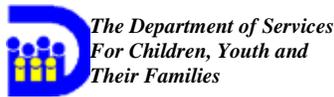
No medical services are covered by this contract.

E. Process for Re-Authorization Request

For more specifics around this component of the contract, please refer to the DPBHS Treatment Provider Manual, under section 5. This is subject to CSMT authorization(s).

F. Discharges and Funding Termination

For more specifics around this component of the contract, please refer to the DPBHS Treatment Provider Manual, under section 5. This is subject to CSMT authorization(s).



IV. PROGRAM AND SERVICE COMPONENTS

A. Program Description

1. Services include, but are not limited to professional therapeutic services, such as individual, group and family treatment, medication evaluation/monitoring and case management. Activities include individual and group therapeutic recreation, parent and school consultation, behavior management, psychosocial activities, crisis availability and transportation. Collaborative planning activities with other agencies active with the child and his/her support system are also required.
2. A minimum of 70% of all direct services must occur in sites other than agency offices.
3. Services are available to the family 24-hours per day and are tailored to the individual needs of the youth and family. Since many IOP youth have no supportive family available to them, part of the IOP service helps them identify a support system.

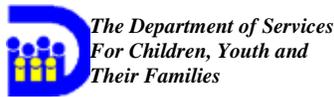
B. Service Components - No less than 70% of all direct-service activities will occur in sites other than the program office, and will include but not be limited to:

1. Psychiatric Services - medication evaluation/monitoring
2. Therapeutic Services - such as those provided in outpatient services, e.g., individual, group and family treatment, and case management.
3. Community Interventionist Activities – activities such as individual and group therapeutic recreation, parent and school consultation, behavior management, and other psycho-social activities.

C. Evidence-Based Practices - Based on proposals in response to the Community-Based RFP, the CONTRACTOR shall use the specified EBPs as outlined in Attachment A of their contract

D. Crisis Availability for Active Clients which includes:

1. The client and/or family will be able to reach a member of the IOP team in an emergency.
2. If the client's behavior appears to signal that he/she may be approaching a crisis, the IOP team member will alert the PBH crisis unit, including instructions for how to contact the IOP team member if there is an emergency.
3. If the PBH mobile crisis team is contacted at any time, a member of the IOP team will be available to make telephone recommendations about disposition.



Division Of Prevention And Behavioral Health Services
Treatment Provider Manual
Description of Services
Intensive Outpatient Substance Abuse Community Provider
(IOP SA)

4. During the regular working day, if an emergency occurs, the IOP team will notify the PBH CSMT and respond in-person to the crisis if possible, with the PBH crisis team if they are dispatched.

E. Transportation – This includes transportation to and from provided activities.

V. STRUCTURE AND OPERATIONS

A. Staffing and Credentials - Direct treatment services must be provided by no less than someone with a master's level in a mental health or related field. Where appropriate, community interventionists may work in collaboration with treatment professionals, e.g., IOP and behavioral intervention services. All unlicensed staff must be actively supervised by a licensed mental health professional.

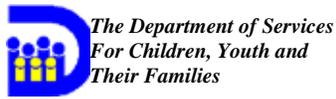
B. Clinical Program Matrix - All staff providing direct treatment services will practice within the scope of their qualifications, licensure or certification.

1. Clinical Director – The CONTRACTOR will identify a Delaware licensed mental health professional (psychiatrist, psychologist, licensed clinical social worker, licensed mental health counselor, licensed marriage and family therapist or licensed chemical dependency professional) who is responsible for the overall operation of the clinical program. If the licensed practitioner is not an LCDP and does not have a CADC, a second clinical supervisor in addictions with a CADC must be available to supervise all staff that are uncertified in this area.

2. Staffing - Staff must have at least one of the minimum requirements:

- a. Master's degree with an emphasis on clinical practice from an accredited program of social work education.
- b. Master's or Doctoral degree in Clinical or Counseling Psychology.
- c. Master's degree in Counseling.
- d. RN with a specialty in psychiatric nursing or a Master's degree from an accredited program in psychiatric nursing.
- e. Certification as psychiatric nurse practitioner with specialty in treatment of children/adolescents.
- f. Medical degree and board eligibility in psychiatry.
- g. Baccalaureate degree with a Delaware certification in addictions, CADC and or is actively working toward this certification as required by DSAMH licensure.

3. Unlicensed/uncertified staff will receive a minimum of one hour of documented individual supervision per week. Practicing with Less than Minimum Qualifications - Clinicians may, under special circumstances, provide outpatient treatment under the Contract if a written waiver is obtained in advance from the DPBHS. Graduate student interns and individuals with specific and unique combinations of training and experience who have less than the qualifications listed above may apply for a waiver. Documentation sent to DSCYF shall include:
 - a. In the case of full time employees, justification for why this staff member is necessary to provide the service.
 - b. Staff member's resume with sections of the training and experience category highlighted which provide documentation that the staff member is uniquely qualified to provide the service.
 - c. Identification of the agency employee who will take clinical responsibility for cases being seen by this staff member.
 - d. Presence of Supervisor - The supervisor will be on-site and available to the student/staff member at any time when he/she is providing direct treatment service. In the event of the absence of the supervisor, another appropriate substitute shall be identified. The supervisor shall accept clinical responsibility for all cases carried by the student/staff member during his/her internship/employment.
 - e. Minimum Supervision Time - Students and staff under waiver must receive a minimum of one (1) hour documented individual supervision for every ten (10) hours of direct service time they provide.
 - f. Documentation of Supervision - The CONTRACTOR shall maintain an individual student file on each supervisee. These may be written by the supervisee. At minimum the file shall contain log sheets for each individual and group supervision sessions covering DPBHS clients, which contain the date, time, and the DPBHS client-related content of the session with signatures of both supervisor and supervisee. A note of this session will also appear in the client record.
 4. Psychiatric Treatment - The CONTRACTOR will provide medication evaluation and monitoring by a psychiatrist or psychiatric nurse practitioner for any client requiring this service on an as needed basis. The CONTRACTOR will assure that all treatment plans which include medication as part of the treatment to be provided will be reviewed and signed by the treating physician/psychiatrist/nurse practitioner.
- C. IOP team members are expected to be on call for their clients. A member of the IOP team will be on-call for IOP crisis events and will call the crisis service only after having



assessed the situation and determining that the crisis bed or hospital is necessary for safety.

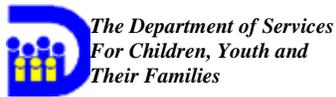
- D. Staff comprising IOP team(s) may be used in other therapeutic services offered by the CONTRACTOR if and when the minimum capacity is not met and in collaboration with PBH.

VI. CLIENT SERVICE DOCUMENTATION

- A. Direct Services - These are face-to-face meetings with the client and/or family for the purpose of moving toward the goals listed on the treatment plan. All direct services will be documented by a progress note which contains, at minimum, date and length of the contact, summary of the contact which reflects progress on the treatment objectives including the intervention used by the therapist, and signature and title of the therapist.
 - 1. For all contract deliverables, please see the DPBHS Treatment Provider Manual.
- B. Indirect Services - These services are non-billable case related activities and are documented in the client record as a progress note. This note will include the date, the time spent on the activity, the kind of activity provided, and a summary. These will be signed by the person who completed the activity. Indirect services can include but are not limited to:
 - 1. Therapist telephone contacts with clients or family.
 - 2. Interagency and/or school service planning meetings about client issues without the client present.
 - 3. Therapist telephone contacts with other agencies about client issues.
 - 4. Supervision and case review - The supervision will be recorded and will include, at minimum, the names of the reviewer(s), content of the review, supervisory suggestions. All unlicensed staff must be actively supervised by a licensed mental health professional.

VII. PERFORMANCE EXPECTATIONS

- A. Client Outcome Expectations
It is expected that 70% of clients discharged from IOP will be maintained in less intensive and restrictive services for 6 months or more post-discharge.
- B. Process Expectations
It is expected that 70% of direct services occur in the community.



I. Service Overview

a. Definitions

CSMT	Clinical Services Management Team, Division of Prevention and Behavioral Health Services
IOP	Intensive Outpatient Services: IOP is an alternative to psychiatric hospitalization, residential treatment or day treatment. It provides community-based interventions designed to assist the client, and the family (especially those who are unable to benefit from insight oriented treatment), the school, and other members of the natural helping network to learn skills to deal with existing problems.
PBH	Division of Prevention and Behavioral Health Services (DPBHS)

b. Description/Purpose and Goals/Objectives

Intensive Outpatient Services provides community-based mental health and/or substance abuse intervention to assist the youth and the family/caretakers, the school, and other members of the natural helping network to learn skills to deal with existing problems.

Objectives are to:

- Reduce frequency of inpatient psychiatric hospitalization episodes.
- Reduce the need for residential treatment placements.
- Reduce frequency and duration of behaviors leading to residential treatment or psychiatric hospitalization.
- Increase the number of days between hospital, residential and crisis episodes.
- Increase the frequency of appropriate social contacts made by the youth and family in his/her community, and/or within the psychosocial group.
- Increase the number of consecutive days the youth engages in academic, vocational, or other training programs.
- Reduce the behaviors or symptoms which led to the referral. Associated with the reduction in symptomatology can be an increase in functioning across the domains of work, school and community.

Service Hours: Hours should be based upon youth and family needs and should include nights and weekends.

c. Program Dimensions

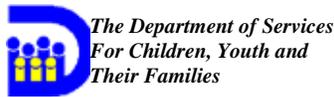
1. Restrictiveness of Living/Service Setting- Community-Based Non-Residential

1. Child supervision is the responsibility of the primary caretaker while program staff may provide supervision during a specific service episode. Provider comes to the home or a community-based site other than their own to provide services.

2. Level of Supervision/Monitoring- Medium/Low

2. Clients and families are seen from 4 - 12 hours per week over a series of weeks with a variety of service modalities included on a treatment/service plan which may include but is not limited to:

- individual therapy
- family therapy
- group therapy
- home and school visits



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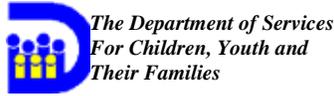
- intensive case management
- 4. Professional Level of Staff- High Team
Services provided with a team approach. The team must be headed by a licensed mental health professional and includes, at minimum
 - one or more trained clinical staff, e.g. minimum of master's level in some human service discipline, RN, etc.
 - clinical staff available for consultation and some intervention, e.g. physicians including psychiatrists and psychologists
 - trained, supervised staff may be added to the team. These individuals specialize in some aspect of behavior change, e.g. residential childcare workers or non-residential community interventionists

II. Target Population

- a. Age, Gender, and Service Capacity
 - i. Age - Children and adolescents through age 17
 - ii. Gender – No gender will be excluded from this contract
 - iii. Capacity – Subject to CSMT authorization(s)
 - iv. Location – as specified in the RFP response
- b. Client Criteria and Eligibility
 - i. For more specifics around this component of the contract, please refer to [DPBHS Service Eligibility Policy CS001]
- c. Exclusion Criteria
 - i. DPBHS managed care teams make referrals to IOP providers and they are expected to accept most youth unless there are immediate safety issues. Few referrals should be excluded. The youth served by IOP are among the most complex, and in the absence of safe alternatives, the youth would probably be in more restrictive settings.

III. Admissions, Discharges, and Funding Authorization(s)

- a. Referrals
 - i. For more specifics around this component of the contract, please refer to the Division of Prevention and Behavioral Health Services Treatment Provider Manual
- b. Initial Service Authorization and Expected Length of Stay/Service
 - i. Initial Service Authorization – For more specifics around this component of the contract, please refer to the Division of Prevention and Behavioral Health Services Treatment Provider Manual. This is subject to CSMT authorization(s).
 - ii. Expected Length of Stay/Service - Length of stay is targeted at 4-6 months. This is a collaborative effort between the provider and the DPBHS Clinical Management Team involved with the case.
- c. Admissions

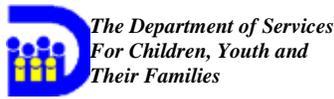


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- i. For more specifics around this component of the contract, please refer to the Division of Prevention and Behavioral Health Services Treatment Provider Manual
- d. Medical Services Not Covered By Contract
 - i. No medical services are covered by this contract
- e. Process for Re-Authorization Request
 - i. For more specifics around this component of the contract, please refer to the Division of Prevention and Behavioral Health Services Treatment Provider Manual, under section 5. This is subject to CSMT authorization(s).
- f. Discharges and Funding Termination
 - i. For more specifics around this component of the contract, please refer to the Division of Prevention and Behavioral Health Services Treatment Provider Manual, under section 5. This is subject to CSMT authorization(s).

IV. Program and Service Components

- a. Program Description
 - i. Services include, but are not limited to professional therapeutic services, such as individual, group and family treatment, medication evaluation/monitoring and case management. Activities include individual and group therapeutic recreation, parent and school consultation, behavior management, psychosocial activities, crisis availability and transportation. Collaborative planning activities with other agencies active with the child and his/her support system are also required.
 - ii. A minimum of 70% of all direct services must occur in sites other than agency offices
 - iii. Services are available to the family 24-hours per day and are tailored to the individual needs of the youth and family. Since many IOP youth have no supportive family available to them, part of the IOP service helps them identify a support system.
- b. Service Components - No less than 70% of all direct-service activities will occur in sites other than the program office, and will include but not be limited to:
 - i. Psychiatric Services - medication evaluation/monitoring
 - ii. Therapeutic Services - such as those provided in outpatient services, e.g., individual, group and family treatment, and case management.
 - iii. Community Interventionist Activities – activities such as individual and group therapeutic recreation, parent and school consultation, behavior management, and other psycho-social activities.
- c. Evidence-Based Practices - Based on proposals in response to the Community-Based RFP, the CONTRACTOR shall use the specified EBPs as outlined in Attachment A of their contract



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- d. Crisis Availability for Active Clients which includes:
 - 3. The client and/or family will be able to reach a member of the IOP team in an emergency.
 - 4. If the client's behavior appears to signal that he/she may be approaching a crisis, the IOP team member will alert the PBH crisis unit, including instructions for how to contact the IOP team member if there is an emergency.
 - 5. If the PBH mobile crisis team is contacted at any time, a member of the IOP team will be available to make telephone recommendations about disposition.
 - 6. During the regular working day, if an emergency occurs, the IOP team will notify the PBH CSMT and respond in-person to the crisis if possible, with the PBH crisis team if they are dispatched.
- e. Transportation – which includes transportation to and from provided activities

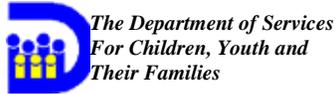
V. Structure and Operations

- a. Staffing and Credentials - Direct treatment services must be provided by no less than someone with a master's level in a mental health or related field. Where appropriate, community interventionists may work in collaboration with treatment professionals, e.g., IOP and behavioral intervention services. All unlicensed staff must be actively supervised by a licensed mental health professional.
- b. Clinical Program Matrix - All staff providing direct treatment services will practice within the scope of their qualifications, licensure or certification.
 - 3. Clinical Director - The contractor will identify a Delaware licensed mental health professional (psychiatrist, psychologist, licensed clinical social worker, licensed mental health counselor or licensed marriage and family therapist) who is responsible for the overall supervision of the clinical program.
 - 4. Staffing - Staff must have at least one of the minimum requirements:
 - g. Master's degree with an emphasis on clinical practice from an accredited program of social work education
 - h. Master's or Doctoral degree in Clinical or Counseling Psychology
 - i. Master's degree in Counseling
 - j. RN with a specialty in psychiatric nursing or a Master's degree from an accredited program in psychiatric nursing
 - k. Certification as a psychiatric nurse practitioner with specialty in treatment of children and adolescents.
 - l. Medical degree and board eligibility in psychiatry.
 - 3. Unlicensed staff will receive a minimum of one hour of documented individual supervision per week.
 - 5. Practicing with Less than Minimum Qualifications - Clinicians may, under special circumstances, provide outpatient treatment under the Contract if a written waiver is obtained in advance from the DPBHS. Graduate student interns and individuals with specific and unique combinations of training and experience who have less than the qualifications listed above may apply for a waiver. Documentation sent to DSCYF shall include:

- g. In the case of full time employees, justification for why this staff member is necessary to provide the service.
 - h. Staff member's resume with sections of the training and experience category highlighted which provide documentation that the staff member is uniquely qualified to provide the service.
 - i. Identification of the agency employee who will take clinical responsibility for cases being seen by this staff member.
 - j. Presence of Supervisor - The supervisor will be on-site and available to the student/staff member at any time when he/she is providing direct treatment service. In the event of the absence of the supervisor, another appropriate substitute shall be identified. The supervisor shall accept clinical responsibility for all cases carried by the student/staff member during his/her internship/employment.
 - k. Minimum Supervision Time - Students and staff under waiver must receive a minimum of one (1) hour documented individual supervision for every ten (10) hours of direct service time they provide.
 - l. Documentation of Supervision - The CONTRACTOR shall maintain an individual student file on each supervisee. These may be written by the supervisee. At minimum the file shall contain log sheets for each individual and group supervision sessions covering DPBHS clients, which contain the date, time, and the DPBHS client-related content of the session with signatures of both supervisor and supervisee. A note of this session will also appear in the client record.
6. Psychiatric Treatment - The CONTRACTOR will provide medication evaluation and monitoring by a psychiatrist or psychiatric nurse practitioner for any client requiring this service on an as needed basis. The CONTRACTOR will assure that all treatment plans which include medication as part of the treatment to be provided will be reviewed and signed by the treating physician/psychiatrist/nurse practitioner.
- C. IOP team members are expected to be on call for their clients. A member of the IOP team will be on-call for IOP crisis events and will call the crisis service only after having assessed the situation and determining that the crisis bed or hospital is necessary for safety.
- D. Staff comprising IOP team(s) may be used in other therapeutic services offered by the CONTRACTOR if and when the minimum capacity is not met and in collaboration with PBH.

VI. Client Service Documentation

- a. Direct Services - These are face-to-face meetings with the client and/or family for the purpose of moving toward the goals listed on the treatment plan. All direct services will be documented by a progress note which contains, at minimum, date and length of the contact, summary of the contact which reflects progress on the treatment objectives including the intervention used by the therapist, and signature and title of the therapist.
 - i. For all contract deliverables, please see the DPBHS Treatment Provider Manual.
- b. Indirect Services - These services are non-billable case related activities and are documented in the client record as a progress note. This note will include the date, the time spent on the activity, the kind of activity provided, and a summary. These will be



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signed by the person who completed the activity. Indirect services can include but are not limited to:

- i. Therapist telephone contacts with clients or family.
- ii. Interagency and/or school service planning meetings about client issues without the client present.
- iii. Therapist telephone contacts with other agencies about client issues.
- iv. Supervision and case review - The supervision will be recorded and will include, at minimum, the names of the reviewer(s), content of the review, supervisory suggestions. All unlicensed staff must be actively supervised by a licensed mental health professional.

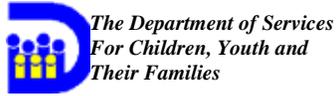
VII. Performance Expectations

a. Client Outcome Expectations

- i. It is expected that 70% of clients discharged from IOP will be maintained in less intensive and restrictive services for 6 months or more post-discharge.

b. Process Expectations

- i. It is expected that 70% of direct services occur in the community.



I. SERVICE OVERVIEW

A. Definitions

CSMT	Clinical Services Management Team, Division of Prevention and Behavioral Health Services
IOP	Intensive Outpatient Services: IOP is an alternative to psychiatric hospitalization, residential treatment or day treatment. It provides community-based interventions designed to assist the client, and the family (especially those who are unable to benefit from insight oriented treatment), the school, and other members of the natural helping network to learn skills to deal with existing problems.
DPBHS	Division of Prevention and Behavioral Health Services

B. Description/Purpose and Goals/Objectives

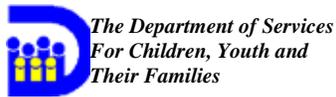
Intensive Outpatient Services provides community-based mental health and/or substance abuse intervention to assist the youth and the family/caretakers, the school, and other members of the natural helping network to learn skills to deal with existing problems. Objectives are to:

- Reduce frequency of inpatient psychiatric hospitalization episodes.
- Reduce the need for residential treatment placements.
- Reduce frequency and duration of behaviors leading to residential treatment or psychiatric hospitalization.
- Increase the number of days between hospital, residential and crisis episodes.
- Increase the frequency of appropriate social contacts made by the youth and family in his/her community, and/or within the psychosocial group.
- Increase the number of consecutive days the youth engages in academic, vocational, or other training programs.
- Reduce the behaviors or symptoms which led to the referral. Associated with the reduction in symptomatology can be an increase in functioning across the domains of work, school and community.

Service Hours: Hours should be based upon youth and family needs and should include nights and weekends.

C. Program Dimensions

1. Restrictiveness of Living/Service Setting- Community-Based Non-Residential Child supervision is the responsibility of the primary caretaker while program staff may provide supervision during a specific service episode. Provider comes to the home or a community-based site other than their own to provide services.



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SPECIALIZED POPULATION

2. Level of Supervision/Monitoring- Medium/Low

Clients and families are seen from 4 - 12 hours per week over a series of weeks with a variety of service modalities included on a treatment/service plan which may include but is not limited to:

- individual therapy
- family therapy
- group therapy
- home and school visits
- intensive case management

3. Professional Level of Staff- High Team

Services provided with a team approach. The team must be headed by a licensed mental health professional and includes, at minimum

- One or more trained clinical staff, e.g. minimum of master's level in some human service discipline, RN, etc.
- Clinical staff available for consultation and some intervention, e.g. physicians including psychiatrists and psychologists
- Trained, supervised staff may be added to the team. These individuals specialize in some aspect of behavior change, e.g. residential childcare workers or non-residential community interventionists

II. TARGET POPULATION

Specialized IOP

A. Age and Location

Specialized Intensive Outpatient Mental Health Service is targeted for DPBHS clients, primarily children and adolescents aged 6 – 17 years, who are having difficulty functioning in home/school/community settings, have behavioral health problems with behaviors that are externalized, and who have a range of cognitive, neurological impairments and/or developmental disabilities including mild-moderate mental retardation, pervasive developmental disorder spectrum and/or language disabilities. It is anticipated that this service will be available statewide.

B. Number

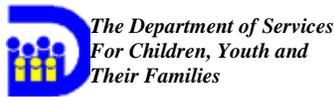
The minimum number of available slots will be 8 at any given time when the program is fully staffed for New Castle County.

Kent and Sussex Counties in total will have a capacity of 8 for this specialized population.

C. Client Criteria and Eligibility

For more specifics around this component of the contract, please refer to [DPBHS Service Eligibility Policy CS001] and the DPBHS Treatment Provider Manual.

D. Exclusion Criteria



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DPBHS managed care teams make referrals to IOP providers and they are expected to accept most youth unless there are immediate safety issues. Few referrals should be excluded. The youth served by IOP are among the most complex, and in the absence of safe alternatives, the youth would probably be in more restrictive settings.

III. ADMISSIONS, DISCHARGES AND FUNDING AUTHORIZATION(S)

A. Referrals

For more specifics around this component of the contract, please refer to the DPBHS Treatment Provider Manual.

B. Initial Service Authorization and Expected Length of Stay/Service

1. Initial Service Authorization – For more specifics around this component of the contract, please refer to the DPBHS Treatment Provider Manual. This is subject to CSMT authorization(s).
 - a. For each IOP program, the CSMT must authorize as clinically necessary for either the IOP MH program or the Specialized IOP MH program
2. Expected Length of Stay/Service - Length of stay is targeted at 4-6 months. This is a collaborative effort between the provider and the DPBHS Clinical Management Team involved with the case.

C. Admissions

For more specifics around this component of the contract, please refer to the DPBHS Treatment Provider Manual.

D. Medical Services Not Covered By Contract

No medical services are covered by this contract.

E. Process for Re-Authorization Request

For more specifics around this component of the contract, please refer to the DPBHS Treatment Provider Manual, under section 5. This is subject to CSMT authorization(s).

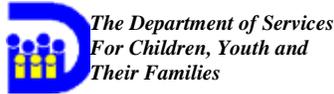
F. Discharges and Funding Termination

For more specifics around this component of the contract, please refer to the DPBHS Treatment Provider Manual, under section 5. This is subject to CSMT authorization(s).

IV. PROGRAM AND SERVICE COMPONENTS

A. Program Description

1. Services are available to treat children with developmental delays and autism. The treatment needs of this population require specialized expertise and effort. In addition to direct clinical services, this program will provide psycho-education, family support, and case management services in order to prevent the disruption of the family and the placement of the child in a residential program or some other out of home service.
2. Services include, but are not limited to professional therapeutic services, such as individual, group and family treatment, medication evaluation/monitoring and case



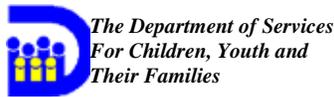
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management. Activities include individual and group therapeutic recreation, parent and school consultation, behavior management, psychosocial activities, crisis availability and transportation. Collaborative planning activities with other agencies active with the child and his/her support system are also required.

3. A minimum of 70% of all direct services must occur in sites other than agency offices
 4. Services are available to the family 24-hours per day and are tailored to the individual needs of the youth and family. Since many IOP youth have no supportive family available to them, part of the IOP service helps them identify a support system.
- B. Service Components - No less than 70% of all direct-service activities will occur in sites other than the program office, and will include but not be limited to:
1. Psychiatric Services - medication evaluation/monitoring
 2. Therapeutic Services - such as those provided in outpatient services, e.g., individual, group and family treatment, and case management.
 3. Community Interventionist Activities – activities such as individual and group therapeutic recreation, parent and school consultation, behavior management, and other psycho-social activities.
- C. Evidence-Based Practices – Based on proposals in response to the Community-Based RFP, the CONTRACTOR shall use the specified EBPs as outlined in Attachment A of their contract
- D. Crisis Availability for Active Clients which includes:
1. The client and/or family will be able to reach a member of the IOP team in an emergency.
 2. If the client's behavior appears to signal that he/she may be approaching a crisis, the IOP team member will alert the PBH crisis unit, including instructions for how to contact the IOP team member if there is an emergency.
 3. If the PBH mobile crisis team is contacted at any time, a member of the IOP team will be available to make telephone recommendations about disposition.
 4. During the regular working day, if an emergency occurs, the IOP team will notify the PBH CSMT and respond in-person to the crisis if possible, with the PBH crisis team if they are dispatched.
- E. Transportation – This includes transportation to and from provided activities.

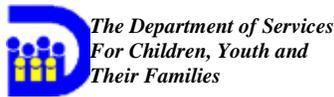
V. STRUCTURE AND OPERATIONS

Specialized IOP



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- A. The IOP team will be comprised, at minimum, of one FTE Master's level therapist and one FTE Community Behavioral Health Aides/Interventionists under the supervision of a licensed mental health professional with experience/expertise in treating children and adolescents with intellectual/developmental disabilities. All staff providing service must have the ability, as demonstrated by a combination of knowledge/skills/experience, to effectively serve the target population, specifically child and adolescents dually diagnosed with mild to moderate mental retardation, cognitive and/or neurological impairment.
- B. Staffing and Credentials - Direct treatment services must be provided by no less than someone with a master's level in a mental health or related field. Where appropriate, community interventionists may work in collaboration with treatment professionals, e.g., IOP and behavioral intervention services. All unlicensed staff must be actively supervised by a licensed mental health professional.
- C. Clinical Program Matrix - All staff providing direct treatment services will practice within the scope of their qualifications, licensure or certification.
 1. Clinical Director - The contractor will identify a Delaware licensed mental health professional (psychiatrist, psychologist, licensed clinical social worker, licensed mental health counselor or licensed marriage and family therapist) who is responsible for the overall supervision of the clinical program.
 2. Staffing - Staff must have at least one of the minimum requirements:
 - a. Master's degree with an emphasis on clinical practice from an accredited program of social work education
 - b. Master's or Doctoral degree in Clinical or Counseling Psychology
 - c. Master's degree in Counseling
 - d. RN with a specialty in psychiatric nursing or a Master's degree from an accredited program in psychiatric nursing
 - e. Certification as a psychiatric nurse practitioner with specialty in treatment of children and adolescents.
 - f. Medical degree and board eligibility in psychiatry.
 3. Unlicensed staff will receive a minimum of one hour of documented individual supervision per week.
 4. Practicing with Less than Minimum Qualifications - Clinicians may, under special circumstances, provide outpatient treatment under the Contract if a written waiver is obtained in advance from the DPBHS. Graduate student interns and individuals with specific and unique combinations of training and experience who have less than the qualifications listed above may apply for a waiver. Documentation sent to DSCYF shall include:
 - a. In the case of full time employees, justification for why this staff member is necessary to provide the service.
 - b. Staff member's resume with sections of the training and experience category highlighted which provide documentation that the staff member is uniquely qualified to provide the service.
 - c. Identification of the agency employee who will take clinical responsibility for cases being seen by this staff member.

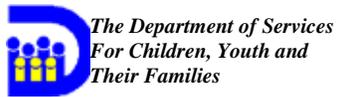


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- d. Presence of Supervisor - The supervisor will be on-site and available to the student/staff member at any time when he/she is providing direct treatment service. In the event of the absence of the supervisor, another appropriate substitute shall be identified. The supervisor shall accept clinical responsibility for all cases carried by the student/staff member during his/her internship/employment.
 - e. Minimum Supervision Time - Students and staff under waiver must receive a minimum of one (1) hour documented individual supervision for every ten (10) hours of direct service time they provide.
 - f. Documentation of Supervision - The CONTRACTOR shall maintain an individual student file on each supervisee. These may be written by the supervisee. At minimum the file shall contain log sheets for each individual and group supervision sessions covering DPBHS clients, which contain the date, time, and the DPBHS client-related content of the session with signatures of both supervisor and supervisee. A note of this session will also appear in the client record.
5. Psychiatric Treatment - The CONTRACTOR will provide medication evaluation and monitoring by a psychiatrist or psychiatric nurse practitioner for any client requiring this service on an as needed basis. The CONTRACTOR will assure that all treatment plans which include medication as part of the treatment to be provided will be reviewed and signed by the treating physician/psychiatrist/nurse practitioner.
- D. IOP team members are expected to be on call for their clients. A member of the IOP team will be on-call for IOP crisis events and will call the crisis service only after having assessed the situation and determining that the crisis bed or hospital is necessary for safety.
- E. Staff comprising IOP team(s) may be used in other therapeutic services offered by the CONTRACTOR if and when the minimum capacity is not met and in collaboration with PBH.

VI. CLIENT SERVICE DOCUMENTATION

- A. Direct Services - These are face-to-face meetings with the client and/or family for the purpose of moving toward the goals listed on the treatment plan. All direct services will be documented by a progress note which contains, at minimum, date and length of the contact, summary of the contact which reflects progress on the treatment objectives including the intervention used by the therapist, and signature and title of the therapist.
- 1. For all contract deliverables, please see the DPBHS Treatment Provider Manual.
- B. Indirect Services - These services are non-billable case related activities and are documented in the client record as a progress note. This note will include the date, the time spent on the activity, the kind of activity provided, and a summary. These will be signed by the person who completed the activity. Indirect services can include but are not limited to:
- 1. Therapist telephone contacts with clients or family.
 - 2. Interagency and/or school service planning meetings about client issues without the client present.



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3. Therapist telephone contacts with other agencies about client issues.
4. Supervision and case review - The supervision will be recorded and will include, at minimum, the names of the reviewer(s), content of the review, supervisory suggestions. All unlicensed staff must be actively supervised by a licensed mental health professional.

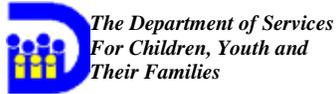
VII. PERFORMANCE EXPECTATIONS

A. Client Outcome Expectations

It is expected that 70% of clients discharged from IOP will be maintained in less intensive and restrictive services for 6 months or more post-discharge.

B. Process Expectations

It is expected that 70% of direct services occur in the community.



I. SERVICE OVERVIEW

A. Definitions

CSMT	Clinical Services Management Team
DPBHS	Division of Prevention and Behavioral Health Services
DSAMH	Division of Substance Abuse and Mental Health
DSCYF	Department of Services for Children, Youth and Their Families

B. Description

Day Treatment is a minimum of 3 days per week intensive program of three (3) hours per day that provides a developmentally appropriate after-school intervention for substance abusing children and adolescents who are unable to fulfill the functional requirements of this developmental stage without this level of intensive service.

The program is available to youth for whom it is clinically necessary. Youth receive the same clinical services as are provided in full day treatment except for the academic component. Substance abuse programs also focus on client and family education regarding a variety of topics related to substance abuse, e.g., AIDS prevention, 12-Step activities and relapse prevention.

C. Program Dimensions

1. Provider Site Non-Residential – Low Restrictiveness Child supervision is the responsibility of the primary caretaker. Program staff may provide supervision during a specific service episode.
2. Client Supervision - Client attends for a full (6-8 hours) or half (3-4 hours) day between 3 and 5 days per week. The program is available to meet with families after-hours and in emergencies. The client receives multiple services each day which are included on a treatment plan. These may include but not be limited to education, individual and family counseling, supervised recreational activities and medical/psychiatric services.
3. High Professional Level of Staff - The treatment individuals and treatment teams must meet the criteria below. The program must be overseen by a licensed mental health professional, and therapists must have minimum qualification listed below.

II. TARGET POPULATION

- A. Age - Twelve (12) through seventeen (17).
- B. Number To Be Served - As referred and approved by the DPBHS Clinical Services Management Team.



III. PROGRAM AND SERVICE COMPONENTS

The program will be available to clients for 12 months of the year and must be open a minimum of 250 days per year will provide no less than 2.5 hours of direct service to each client. Additional activities will also be provided in afternoons and/or evenings to assure that working parents are able to participate in treatment. Activities will occur both on-site at the program and in the client's natural environment. They will include but not be limited to:

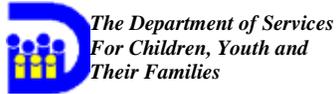
- A. Professional diagnostic and therapeutic services, e.g., substance abuse evaluations, drug screens, psychological and psychiatric services, individual and family and family assessment, individual, group and family treatment, medication evaluation/monitoring and case management.
- B. All clinical interventions will be provided by a master's level clinician.
- C. Unlicensed staff will be supervised by a licensed mental health professional. This supervision will be documented.
- D. Activities provided within a therapeutic milieu, e.g., individual and group therapeutic recreation, field trips, parent and school consultation, behavior management, and other psycho-social education activities.
- E. Evidence-Based Practices - Based on proposals in response to the Community-Based RFP, the CONTRACTOR shall use the specified EBPs as outlined in Attachment A of their contract
- F. Crisis Response For Active Clients
 - 1. The client and/or family will be able to reach a member of the part-day program team in an emergency.
 - 2. If the client's behavior appears to signal that he/she may be approaching a crisis, the part-day program team member will alert the DPBHS crisis unit, including instructions for how to contact the part-day program team member if there is an emergency.
 - 3. If the DPBHS mobile crisis team is contacted at any time, a member of the part-day program team will be available to make telephone recommendations about disposition.
 - 4. During the regular working day, if an emergency occurs, the part-day program team will notify the DPBHS CSMT, respond in-person to the crisis if possible, with the DPBHS crisis team if they are dispatched.
- G. Transportation to and from program activities.

IV. PERFORMANCE EXPECTATIONS



- A. Length of stay is targeted at 1-3 months. This is a collaborative effort between the provider and the DPBHS Clinical Management Team involved with the case.

- B. Interface with DPBHS Team Working with Drug Court Clients - In addition to the regular progress reviews, the Drug Court team requires status reviews every three weeks that address clinical, case management and compliance with conditions of the court. Appearance in Court may be required if there is a specific purpose for the therapist's report.



I. SERVICE OVERVIEW

A. Definitions

CADC	Certified Alcohol and Drug Counselor
CSMT	Clinical Services Management Team
DPBHS	Division of Prevention and Behavioral Health Services
LCDP	Licensed Clinical Drug Practitioner

B. Description

Day Treatment is a 5-full-day intensive program that provides developmentally appropriate treatment for children or adolescents with moderate to severe behavioral health disorders who are unable to fulfill the functional requirements without this level of intensive service.

The program is available as clinically appropriate and is open approximately 250 days per year and provides no less than 5 hours of direct service per day. Activities are also provided in afternoons and/or evenings to assure that working parents are able to participate in treatment. Activities occur both on-site at the program and in the youth’s natural environment.

C. Program Dimensions

1. Provider Site Non-Residential – Low Restrictiveness - Child supervision is the responsibility of the primary caretaker. Program staff may provide supervision during a specific service episode.
2. Client Supervision - Client attends for a full (6-8 hours) or half (3-4 hours) day between 3 and 5 days per week. The program is available to meet with families after-hours and in emergencies. The client receives multiple services each day which are included on a treatment plan. These may include but not be limited to education, individual and family counseling, supervised recreational activities and medical/psychiatric services.
3. High Professional Level of Staff - The treatment individuals and treatment teams must meet the criteria below. The program must be overseen by a licensed mental health professional, and therapists must have minimum qualification listed below.

II. TARGET POPULATION

A. Age - Twelve (12) through seventeen (17).

B. Number to be served - As referred and approved by the DPBHS Clinical Services Management Team.



- C. Service – Treatment modalities to serve clients with identified substance abuse issues.

III. PROGRAM AND SERVICE COMPONENTS

The program will be available to clients for 12 months of the year and must be open a minimum of 250 days per year will provide no less than five full hours of direct service to each client. Additional activities will also be provided in afternoons and/or evenings to assure that working parents are able to participate in treatment. Activities will occur both on-site at the program and in the client's natural environment. They will include but not be limited to:

- A. All clinical interventions will be provided by a clinician at a minimum of master's level.
- B. Unlicensed staff will be supervised by a licensed mental health professional. The CONTRACTOR will identify a Delaware licensed mental health professional (psychiatrist, psychologist, licensed clinical social worker, licensed mental health counselor or licensed chemical dependency professional) who is responsible for the overall operation of the clinical program. If the licensed practitioner is not an LCDP and does not have a CADC, a second clinical supervisor in addictions with a CADC must be available to supervise all staff that are uncertified in this area.
- C. Every client will have a psychiatric evaluation and there will be availability of psychiatric consultation on every active client at this level. In addition, there will always be 24 hour psychiatric back up for these clients.
- D. Nursing services will be available to all clients at this level as consultation and evaluation is needed.
- E. Professional diagnostic and therapeutic services, e.g., substance abuse evaluations, drug screens, psychological and psychiatric services, individual and family and family assessment, individual, group and family treatment, medication evaluation/monitoring and case management.
- F. Activities provided within a therapeutic milieu, e.g., individual and group therapeutic recreation, field trips, parent and school consultation, behavior management, and other psycho-social education activities.
- G. Evidence Based Practices
 - 1. Multi-Dimensional Family Therapy
 - 2. Brief Strategic Family Therapy
 - 3. Dialectic Behavioral Therapy
 - 4. Trauma Focused-Cognitive Behavioral Therapy
- H. Crisis response for active clients
 - 1. The client and/or family will be able to reach a member of the day program team in an emergency.
 - 2. If the client's behavior appears to signal that he/she may be approaching a crisis, the day program team member will alert the DPBHS crisis unit, including instructions for how to contact the IOP team member if there is an emergency.
 - 3. If the DPBHS mobile crisis team is contacted at any time, a member of the day program team will be available to make telephone recommendations about disposition.

4. During the regular working day, if an emergency occurs, the day program team will notify the DPBHS CSMT, respond in-person to the crisis if possible, with the DPBHS crisis team if they are dispatched.
- I. Transportation to and from program activities.
 - J. Day Treatment Contractors
 1. Some youth are placed (out of medical necessity or for legal reasons) in programs which inhibit or interfere with participation and attendance at the local sending school. In such cases the CONTRACTOR is responsible for ensuring that the youth continue to be educated at the appropriate level. To meet this need, CONTRACTORS must ensure compliance with the following processes:
 - a. Prior to enrollment CONTRACTOR will obtain written consent from parent or legal guardian to obtain records and maintain communication with the sending district.
 - b. Within three business days of admission to the day treatment program, CONTRACTOR will contact home school to determine current standing with the school (e.g. enrolled attending; enrolled not attending; officially withdrawn.). Written confirmation of status will be obtained. If youth is attending school, CONTRACTOR will obtain course schedule, level of credits and current grades.
 - c. Within five business days CONTRACTOR will establish a written agreement with the sending school for ‘Homebound’ instruction to be provided by the school district or the CONTRACTOR.
 - d. At the close of each week and at the conclusion of each month, written documentation will be provided by the CONTRACTOR to the school district regarding student’s participation and assignment completion during “homebound” instruction. This will include documented length of services per day/week and monthly. Course grades and/ or actual assignments will be provided to the sending school at the close of each week and month.
 - e. The services provided are in accordance with the student’s
 - i. Grade Level
 - ii. Educational services are provided in accordance with student’s educational status as either a General or Special Education Student
 - iii. Parent/Guardian Permission(s)
 - f. Students not participating in “homebound” instruction or pursuing a GED must be 16 years or older, have written consent by parent or legal guardian, AND be officially withdrawn from school. CONTRACTORS may receive written notification from the sending district that the youth has legally withdrawn from school. Parents and youth who are identified as needing special education services should receive the special education procedural safeguards prior to making this decision. Such decisions must be evidenced by written notification and parental signatures. (Contractors will receive training from DSCYF to ensure appropriate understanding of this requirement)
 2. Student Records File Folder

CONTRACTOR will maintain educational files in a separate, secure (locked) location Educational files shall include the following documents:

Section I-

- 1.) Signed release of information for educational records and on- going communication
- 2.) Student Records Request form
- 3.) Record Review/Inspection Form
- 4.) Written “Homebound” instruction agreement
- 5.) Telephone/Mail Contact Log Form
 - a. Weekly/Monthly contact between Agency Teacher and School district
 - b. Assignment log with due dates
- 6.) Medical Alerts
- 7.) Official withdrawal from school notification

Section II- Special Education Students only

- 1.) Evaluation Report/Eligibility
- 2.) IEP/Section 504 Accommodation Form
- 3.) Teacher IEP Review Form

Section III-

- 1.) Student Progress reports
 - a. Attendance
 - b. Grades
 - c. Assignments Progress
 - d. Effort
- 2.) Home School District Transcripts/Report Cards

K. DSCYF Education Unit Support- DSCYF acknowledges the arduous task of educating youth needing such services. The student population is transient and most youth participating in these programs have scattered school histories. As such the DEPARTMENT’S education unit will provide the following supports:

- 1.) Annual training and update of the most current regulations and guidelines found in Individual with Disabilities Education Act (IDEA) for CONTRACTOR education employees.
- 2.) Model forms and processes
- 3.) Focus review of each agency school site two times per year
- 4.) Additional support(s) upon request in the areas of :
 - a. Academic Instruction
 - b. IDEA – State and Federal regulations
 - c. Technical Assistance

IV. PERFORMANCE EXPECTATIONS

- A. Length of stay is targeted at 1-3 months. This is a collaborative effort between the provider and the DPBHS Clinical Management Team involved with the case.
- B. Interface with DPBHS Team Working with Drug Court Clients
In addition to the regular progress reviews, the Drug Court team requires status reviews every three weeks that address clinical, case management and compliance with conditions of the court. Appearance in Court may be required if there is a specific purpose for the therapist’s report.

I. SERVICE OVERVIEW

A. Definition

Day Treatment is a 5-full-day intensive program that provides developmentally appropriate treatment for children or adolescents with moderate to severe behavioral health disorders who are unable to fulfill the functional requirements without this level of intensive service.

The program is available as clinically appropriate and is open approximately 250 days per year and provides no less than 5 hours of direct service per day. Activities are also provided in afternoons and/or evenings to assure that working parents are able to participate in treatment. Activities occur both on-site at the program and in the youth's natural environment.

B. Program Dimensions

1. Provider Site Non-Residential – Low Restrictiveness Child supervision is the responsibility of the primary caretaker. Program staff may provide supervision during a specific service episode.
2. Client Supervision Client attends for a full (6-8 hours) or half (3-4 hours) day between 3 and 5 days per week. The program is available to meet with families after-hours and in emergencies. The client receives multiple services each day which are included on a treatment plan. These may include but not be limited to education, individual and family counseling, supervised recreational activities and medical/psychiatric services.
3. High Professional Level of Staff The treatment individuals and treatment teams must meet the criteria below. The program must be overseen by a licensed mental health professional, and therapists must have minimum qualification listed below.

III. TARGET POPULATION

- A. Age – Six (6) through fourteen (14).
- B. Number to be served - As referred and approved by the DPBHS Clinical Services Management Team.
- C. Service – Treatment modalities to serve clients with identified behavioral and mental health issues.

V. PROGRAM AND SERVICE COMPONENTS

The program will be available to clients for 12 months of the year and must be open a minimum of 250 days per year, and will provide no less than five full hours of direct service to each client. Additional activities will also be provided in afternoons and/or evenings to assure that working parents are able to participate in treatment. Activities will occur both on-site at the program and in the client's natural environment. They will include but not be limited to:

- A. All clinical interventions will be provided by a clinician at a minimum of master's level.



- B. Unlicensed staff will be supervised by a licensed mental health professional. The CONTRACTOR will identify a Delaware licensed mental health professional (psychiatrist, psychologist, licensed clinical social worker, or licensed mental health counselor) who is responsible for the overall operation of the clinical program.
- C. Every client will have a psychiatric evaluation and there will be availability of psychiatric consultation on every active client at this level. In addition, there will always be 24 hour psychiatric support for these clients.
- D. Nursing services will be available to all clients at this level as consultation and evaluation is needed.
- E. Professional diagnostic and therapeutic services, e.g., psychological and psychiatric services, individual and family and family assessment, individual, group and family treatment, medication evaluation/monitoring and case management.
- F. Activities provided within a therapeutic milieu, e.g., individual and group therapeutic recreation, field trips, parent and school consultation, behavior management, and other psycho-social education activities.
- G. Evidence-Based Practices - Based on proposals in response to the Community-Based RFP, the CONTRACTOR shall use the specified EBPs as outlined in Attachment A of their contract
- H. Crisis response for active clients
 - 1. The client and/or family will be able to reach a member of the day program team in an emergency.
 - 2. If the client's behavior appears to signal that he/she may be approaching a crisis, the day program team member will alert the DPBHS crisis unit, including instructions for how to contact the IOP team member if there is an emergency.
 - 3. If the DPBHS mobile crisis team is contacted at any time, a member of the day program team will be available to make telephone recommendations about disposition.
 - 4. During the regular working day, if an emergency occurs, the day program team will notify the DPBHS CSMT, respond in-person to the crisis if possible, with the DPBHS crisis team if they are dispatched.
- I. Transportation to and from program activities.
- J. Education
 - 1. Some youth are placed (out of medical necessity or for legal reasons) in programs which inhibit or interfere with participation and attendance at the local sending school. In such cases the CONTRACTOR is responsible for ensuring that the youth continue to be educated at the appropriate level. To meet this need, CONTRACTORS must ensure compliance with the following processes:

- a. Prior to enrollment CONTRACTOR will obtain written consent from parent or legal guardian to obtain records and maintain communication with the sending district.
 - b. Within three business days of admission to the day treatment program, CONTRACTOR will contact home school to determine current standing with the school (e.g. enrolled attending; enrolled not attending; officially withdrawn.). Written confirmation of status will be obtained. If youth is attending school, CONTRACTOR will obtain course schedule, level of credits and current grades.
 - c. Within five business days CONTRACTOR will establish a written agreement with the sending school for ‘Homebound’ instruction to be provided by the school district or the CONTRACTOR.
 - d. At the close of each week and at the conclusion of each month, written documentation will be provided by the CONTRACTOR to the school district regarding student’s participation and assignment completion during “homebound” instruction. This will include documented length of services per day/week and monthly. Course grades and/ or actual assignments will be provided to the sending school at the close of each week and month.
 - e. The services provided are in accordance with the student’s
 - i. Grade Level
 - ii. Educational services are provided in accordance with student’s educational status as either a General or Special Education Student
 - iii. Parent/Guardian Permission(s)
 - f. Students not participating in “homebound” instruction or pursuing a GED must be 16 years or older, have written consent by parent or legal guardian, AND be officially withdrawn from school. CONTRACTORS may receive written notification from the sending district that the youth has legally withdrawn from school. Parents and youth who are identified as needing special education services should receive the special education procedural safeguards prior to making this decision. Such decisions must be evidenced by written notification and parental signatures. (Contractors will receive training from DSCYF to ensure appropriate understanding of this requirement)
2. **Student Records File Folder**
CONTRACTOR will maintain educational files in a separate, secure (locked) location Educational files shall include the following documents:
- Section I:**
- 8.) Signed release of information for educational records and on- going communication
 - 9.) Student Records Request form
 - 10.) Record Review/Inspection Form
 - 11.) Written “Homebound” instruction agreement
 - 12.) Telephone/Mail Contact Log Form
 - a. Weekly/Monthly contact between Agency Teacher and School district
 - b. Assignment log with due dates
 - 13.) Medical Alerts
 - 14.) Official withdrawal from school notification
- Section II:** Special Education Students only
- 4.) Evaluation Report/Eligibility
 - 5.) IEP/Section 504 Accommodation Form
 - 6.) Teacher IEP Review Form

Section III:

- 2.) Student Progress reports
 - e. Attendance
 - f. Grades
 - g. Assignments Progress
 - h. Effort
- 3.) Home School District Transcripts/Report Cards

K. **DSCYF Education Unit Support-** DSCYF acknowledges the arduous task of educating youth needing such services. The student population is transient and most youth participating in these programs have scattered school histories. As such the DEPARTMENT'S education unit will provide the following supports:

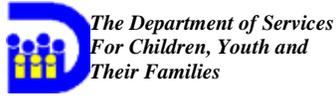
- 1.) Annual training and update of the most current regulations and guidelines found in Individual with Disabilities Education Act (IDEA) for CONTRACTOR education employees.
- 2.) Model forms and processes
- 3.) Focus review of each agency school site two times per year
- 4.) Additional support(s) upon request in the areas of :
 - a. Academic Instruction
 - b. IDEA – State and Federal regulations
 - c. Technical Assistance

VI. Compliance with Clinical and Administrative Standards

- A. The CONTRACTOR will comply with the requirements published in the DPBHS Treatment Provider Manual, herein incorporated by reference and available online at <http://kids.delaware.gov/pbhs/pbhs.shtml>
- B. The CONTRACTOR will comply with the data requirements as set forth in the DPBHS Nonresidential Services Forms and Directions, herein incorporated by reference and available online at <http://kids.delaware.gov/pbhs/pbhs.shtml>
- C. The CONTRACTOR will comply with the requirements as set forth in the DSCYF Operating Guidelines in the current contract year.
- D. Pursuant to 31 Del.C. section 309, and in compliance with Delacare regulations that require criminal background checks on "any person employed by the DEPARTMENT (or its contractors) in a position which involves supervisory or disciplinary authority over a child/youth or in a position which provides the opportunity to have direct access with a child/youth without the presence of other employees or adults," the CONTRACTOR will provide documentation that all present program employees have begun the criminal background check process and that all future hires will have begun the criminal background check process prior to beginning work at the program.

VII. Performance Expectations

- A. Length of stay is targeted at 1-3 months. This is a collaborative effort between the provider and the DPBHS Clinical Management Team involved with the case.
- B. Interface with DPBHS Team Working with Mental Health Court Clients
In addition to the regular progress reviews, the Mental Health Court team requires status reviews every three weeks that address clinical, case management and compliance with conditions of the court. Appearance in Court may be required if there is a specific purpose for the therapist's report.



Treatment Provider Manual
Description of Services
Day Treatment, Mental Health
Hospital-Based/Hospital Affiliated
Partial Hospitalization

I. SERVICE OVERVIEW

A. Definitions

CSMT	Clinical Services Management Team
DPBHS	Division of Prevention and Behavioral Health Services
DSCYF	Department of Services for Children, Youth and Their Families
IEP	Individualized Education Plan

B. Description

Day Treatment is a 5-full-day intensive program that provides developmentally appropriate intervention for seriously disturbed children or adolescents who are unable fulfill the functional requirements of his developmental stage without this level of intensive service.

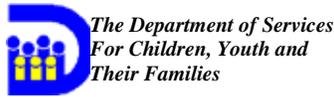
C. Dimensions

1. Staff-Secure - Unlocked facility in which movement inside the facility and egress from the facility is strictly limited by staff and/or by geographical circumstances, although doors can be opened without a key. Education is provided on-site.
2. Medium - Client attends for a full day (between 6-8 hours per day) 3 - 5 days per week. The program is available to meet with families after hours and in emergencies. The client receives multiple services each day which are included on a treatment/service plan and may include but are not limited to:
 - education
 - individual counseling
 - family counseling
 - supervised daily living
 - supervised recreational activities
 - medical/psychiatric services including nursing
3. Medium/High Team - Services provided with a team approach. The team must headed by a clinician with a graduate degree in a behavioral science and includes, at minimum:
 - One or more trained clinical staff, e.g. minimum of master’s level in some human service discipline, RN, etc., and
 - Trained, supervised staff specializing in some aspect of behavior change, e.g. residential childcare workers or non-residential community interventionists, and
 - Clinical staff available for consultation, and some intervention, e.g. physicians including psychiatrists and psychologists

II. TARGET POPULATION

A. Age - under eighteen.

B. Number to be Served - As referred and approved by the DPBHS CSMT.

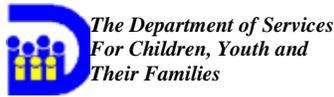


Treatment Provider Manual
Description of Services
Day Treatment, Mental Health
Hospital-Based/Hospital Affiliated
Partial Hospitalization

III. SERVICE COMPONENTS

The program will be available to clients for 12 months of the year and must be open a minimum of 225 days per year for the minimum number of hours of a standard school day for the developmental level of the client served. Activities must also be provided in afternoons and/or evening to assure that working parents are able to participate in treatment. Activities will occur both on-site at the program and in the client's natural environment. They will include but not be limited to:

- A. Professional diagnostic and therapeutic services, e.g., psychological and psychiatric services, individual and family and family assessment, individual, group and family treatment, medication evaluation/monitoring and case management.
- B. Activities provided within a therapeutic milieu, e.g., individual and group therapeutic recreation, field trips, parent and school consultation, behavior management, and other psycho-social education activities.
- C. Crisis response for active clients:
 - 1. The client and/or family will be able to reach a day treatment staff person in an emergency.
 - 2. If the client's behavior appears to signal that he/she may be approaching a crisis, the day treatment staff will alert the DPBHS crisis unit, including instructions for how to contact the day treatment therapist if there is an emergency.
 - 3. If the DPBHS mobile crisis team is contacted at any time, a member of the day treatment staff will be available to make telephone recommendations about disposition.
 - 4. During the regular working day, if an emergency occurs, the day treatment staff will notify the DPBHS CSMT, respond in-person to the crisis if possible, with the DPBHS crisis team if they are dispatched.
- D. Transportation to and from program activities.
- E. An educational program appropriate to the level and individual educational needs of the client and which includes classroom education provided by a certified teacher, educational and cultural activities, and physical, occupational and speech therapy as specified on the IEP. Additional requirements of Educational programs follow:
 - 1. Some youth are placed (out of medical necessity or for legal reasons) in programs which inhibit or interfere with participation and attendance at the local sending school. In such cases the CONTRACTOR is responsible for ensuring that the youth continue to be educated at the appropriate level. To meet this need, CONTRACTORS must ensure compliance with the following processes:
 - a. Prior to enrollment, the CONTRACTOR will obtain written consent from each parent or legal guardian to obtain records and maintain communication with the sending district.



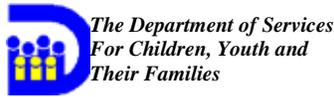
- b. Within three business days of admission to the day treatment program, the CONTRACTOR will contact the youth's home school to determine current standing with the school (e.g. enrolled attending; enrolled not attending; officially withdrawn.). Written confirmation of status will be obtained. If the youth is attending school, the CONTRACTOR will obtain course schedule, level of credits and current grades.
- c. Within five business days, the CONTRACTOR will establish a written agreement with the sending school for 'homebound' instruction to be provided by the school district or the CONTRACTOR.
- d. At the close of each week and at the conclusion of each month, written documentation will be provided by the CONTRACTOR to the school district regarding each student's participation and assignment completion during "homebound" instruction. This will include documented length of services per day/week and monthly. Course grades and/or actual assignments will be provided to the sending school at the close of each week and month.
- e. The services provided are in accordance with the student's
 - i. Grade Level
 - ii. Educational status as either a General or Special Education Student
 - iii. Parent/Guardian Permission(s)
- f. Students not participating in "homebound" instruction or pursuing a GED must be 16 years or older, have written consent by parent or legal guardian, AND be officially withdrawn from school. CONTRACTORS may receive written notification from the sending district that the youth has legally withdrawn from school. Parents and youth who are identified as needing special education services should receive the special education procedural safeguards prior to making this decision. Such decisions must be evidenced by written notification and parental signatures. (CONTRACTORS will receive training from DSCYF to ensure appropriate understanding of this requirement.)

2. Student Records File Folder

CONTRACTORS will maintain educational files in a separate, secure (locked) location Educational files shall include the following documents:

Section I

- 1.) Signed release of information for educational records and on- going communication
- 2.) Student Records Request form
- 3.) Record Review/Inspection Form
- 4.) Written "Homebound" instruction agreement
- 5.) Telephone/Mail Contact Log Form
 - a. Weekly/Monthly contact between Agency Teacher and School district
 - b. Assignment log with due dates
- 6.) Medical Alerts
- 7.) Official withdrawal from school notification



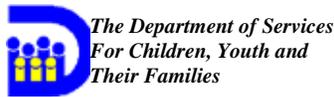
Treatment Provider Manual
Description of Services
Day Treatment, Mental Health
Hospital-Based/Hospital Affiliated
Partial Hospitalization

Section II- Special Education Students only

- b. Evaluation Report/Eligibility
- c. IEP/Section 504 Accommodation Form
- d. Teacher IEP Review Form

Section III-

- 1.) Student Progress reports
 - a. Attendance
 - b. Grades
 - c. Assignments Progress
 - d. Effort
- 2.) Home School District Transcripts/Report Cards
- 3. DSCYF Education Unit Support - The DEPARTMENT acknowledges the arduous task of educating youth needing such services. The student population is transient and most youth participating in these programs have scattered school histories. As such the DEPARTMENT'S education unit will provide the following supports:
 - a. Annual training and update of the most current regulations and guidelines found in Individual with Disabilities Education Act (IDEA) for CONTRACTOR education employees.
 - b. Model forms and processes
 - c. Focus review of each agency school site two times per year
 - d. Additional support(s) upon request in the areas of :
 - i. Academic Instruction
 - ii. IDEA – State and Federal regulations
 - iii. Technical Assistance



Service Overview

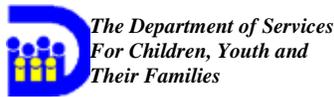
Definition –

IRT is a behavioral health residential treatment based on the use of highly trained treatment parents to implement individualized treatment in their own home on a continuous basis (24/7) under the clinical supervision of licensed professionals for a limited period or time to prepare the youth for a more permanent placement in his/her community.

- A Professional Parent Home Setting for youth with emotional or behavioral disorders or who may have sexual abuse and behavioral issues, substance use disorders, difficult to manage behaviors, and/or cognitive impairments.
- One client per home. The appropriateness and number of biological children of the professional parents who reside in the home during the client's admission for treatment will also be taken into consideration on a case-by-case basis. Preference is for only one additional child in the home. In special circumstances (e.g. siblings), the admission of two clients to a treatment home may be given consideration. The presence of more than one biological child in the home must also be given special consideration. Special consideration is defined as a treatment team meeting of all parties involved to discuss the appropriateness of this exception and the discussion and results of the meeting documented. The team must then secure the approval of the Program Administrator from DPBHS prior to the placement of the child.
- Professional treatment parents serve as primary therapeutic interventionists, responsible for providing services under the direction of a licensed mental health therapist. Services are based on a comprehensive evaluation conducted by the provider (an integrated assessment to cover the medical, psychological, social, behavioral and developmental areas) specifically developed to address the strengths, limitations, issues, and abilities of the individual clients. Services will include a therapeutic environment, general guidance, supervision, behavior management skills development and other mental health and rehabilitation services designed to improve the youth's condition. Services will modify in intensity depending on the requirements of the youth as documented in the treatment plan, without change in residential setting.

A. Program Dimensions (4-7-6)

1. **Foster Care (4): A residence in which the child is supervised. Egress from the residence is possible. Child activities outside the residence may or may not be directly supervised. Education or vocational training is usually provided in another setting.**
2. **Family-Like Supervision (7): Foster-care. This is twenty-four hour responsibility in which a parent or parents (staff) act as primary caretaker(s) for a child who is in the custody of the Department. Staff is expected to provide parent-like supervision pursuant to the developmental level of the foster child.**



3. **Medium/Low Team (6): Services provided with a team headed by a specialist in some aspect of behavioral management. The team includes trained, supervised staff specializing in some aspect of behavior change, and clinical staff available for consultation and some intervention, e.g. physicians including psychiatrists and psychologists**

II. Target Population

The primary target population for Individualized Residential Treatment consists of children and adolescents, aged 6 to 17 years, who manifest significant emotional or behavioral disorders or who may have sexual abuse and behavioral issues, substance use disorders, difficult to manage behaviors, and/or cognitive impairments, and who are, at the time of referral, recipients of residential treatment or psychiatric hospital treatment. Prior to referral, these clients will have been determined by the Division of Prevention and Behavioral Health Services to be safely treatable in a community based setting. Such youth will have derived maximum benefit from institutional residential treatment or psychiatric hospitalization, and will be stabilized in consequence of that treatment, but likely continue to display durable patterns of maladaptive or problematic behavior that will prove challenging to manage in a community-based setting. All clients to be served under this contract will be referred by the Division of Prevention and Behavioral Health Services.

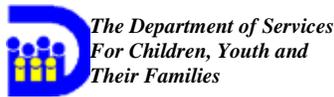
B. Client Criteria

1. **Clinical Eligibility is determined by DPBHS prior to referral.**
2. **Financial Eligibility is determined by DPBHS prior to referral.**

III. Service Components / Performance Expectations

In conformity with the purpose for which the Division of Prevention and Behavioral Health Services is contracting for this service, DPBHS will evaluate client success in this service primarily by the following key indicators:

- **Client Measures**
 - **Process Measures:**
 - § Number of school days child attends while in treatment (based on provider report). Target –95% of days of school attended monthly.
 - § Proportion of time client is successfully maintained in treatment (i.e. not requiring deeper end service such as institutional residential treatment psychiatric hospital or detention/secure care during course of treatment in IRT) Target – 95% per month.
 - § Client, IRT parent and natural/biological parent satisfaction surveys completed at periodic intervals. Target – 80% in the satisfied to highly satisfied range.
 - § PBHS will monitor feedback on the OHIO Scales Assessment.



Division Of Prevention And Behavioral Health Services
Treatment Provider Manual
Description of Services
Individualized Residential Treatment (IRT)
Therapeutic Respite Services

- § The average length of stay will not exceed 6 months.
- **Outcomes Measures:**
 - § 90% of IRT clients will exhibit improvement in Functional Stability Measures:
 - IRT clients will have a decrease in aggressive behaviors.
 - IRT clients will have no more than 3 suspensions in a school year.
 - IRT clients will exhibit improved academic success as evidenced by school reports.

The provider will complete quarterly reports on program performance related to all of the above measures and will provide this report for review by DPBHS upon request.

· **Provider Measures**

- Compliance with notifying appropriate PBH staff, in writing, of parents who have completed all of the requirements/training to be an IRT provider and the family's contact information prior to any child being placed in the home. Target – 100%
- Compliance with notifying appropriate PBH staff, in writing, of families that are no longer going to be an IRT home. Target- 100%
- Compliance with initial and ongoing IRT parent education. Target – 100% per month or acceptable exception.
- Compliance with behavioral therapist contacts with IRT client and family. Target – 100% per month or demonstrated due diligence.
- Compliance with behavioral aide contacts with IRT client and family. Target – 100% per month or demonstrated due diligence.
- Placement disruptions which are defined as any permanent change in a client's placement. Target – 0% annually.
- Individualized treatment plans that are updated on a regular basis to reflect the client's progress/lack of progress, Progress notes demonstrate progress/lack of progress on client's treatment goals and objectives, and Treatment Team meetings and Coordination of care is documented in the client's records. Target - 90%.
- Deliverables are submitted on time to appropriate PBHS staff.
- 70% of IRT clients will close successfully on an annual basis.
- Compliance with monitoring IRT homes. Target – 100% per quarter.

The provider will complete quarterly reports on program performance related to all of the above measures and will provide this report for review by DPBHS upon request.

IV. Clinical Program and Staff Credentials

Only those staff approved by DPBHS under this contract may provide services.

The professional treatment parents will:

- Be screened and selected using a specified set of standards in conjunction with the DELACARE Foster Standards as outlined by the agency in their proposal
- Agree to and pass a criminal and child abuse background check and agree to identify other family members and friends who visit the house on a regular basis so they can have a criminal and child abuse screen completed
- Be competent to serve as treatment parents by virtue of a combination of education (e.g. B.A./B.S.), training and experience.
- Participate in the development of and implement their roles in treatment/educational/vocational plans, arranging for appropriate ancillary services, including transportation as needed
- Provide other care and supervision ordinarily provided by a parent
- Maintain the appropriate level of safety for the child in the home at all times.
- Advocate for the child, making collateral contacts with schools, etc. as necessary to support the child
- Work directly, under clinical supervision, with biological/adoptive/foster families as indicated in the treatment plan to teach and model appropriate social interpersonal and parenting skills
- Have one of the trained parents free from other obligations at all times to be available as a treatment parent, to provide consistent, ongoing interventions and support to the child in treatment in home/school/community
- Will not be an active Foster Care parent with the Division of Family Services (DFS) while serving as an IRT parent.

The provider organization:

The provider organization provides recruitment, training, treatment and discharge planning, coordination of care, and supervision of the treatment parents, respite parents, behavioral health therapists, and behavioral healthcare aides. The provider organization is to use an evidence-based model for provision of services and is responsible for the quality, outcomes and satisfaction of these services. Specifically, the provider will provide:

- A minimum of 40 hours of evidence-based training prior to an IRT parent serving as a professional treatment parent
- Continuing education per parent (minimum of 30 hours of evidence-based training/year)
- Matching of clients with IRT parents who have the specific skills to treat the needs of the individual client
- Individualized treatment planning with all involved parties based on the individual's strengths, limitations, needs and abilities
- Assistance in the transition of the client from the Residential Treatment Center to the IRT setting
- A behavioral health therapist and/or behavioral analysts (licensed mental health professional) intervention with child/treatment parents (indicate the amount of time for each intervention per week in the proposal)
 - § Therapist intervention with child and /or family as indicated
 - § In-home clinical supervision of treatment parents

- § Family therapy with the biological/adoptive/foster parents.
- § Collateral/indirect contacts on child's behalf (e.g. with schools)
- A behavioral health aide to work with the child on the clinically appropriate, objectives in the treatment plan (Indicate amount of time per week for the behavioral health aide)
- Respite care for the treatment parents utilizing a plan that selects appropriate respite parents and informs them of the treatment plan during the respite periods to prevent interruptions in consistency of interventions
- 24/7 on-call mental health intervention, to include on-site crisis intervention as necessary. If the client's behavior appears to signal that he/she may be approaching a crisis, the provider will alert the DPBHS crisis unit, and have written instructions on how to contact the provider if there is an emergency.
- An evidence-based unifying theoretical model to guide active intervention for the client in treatment and extension of that intervention to school/community/home
- Coordination of treatment with DPBHS treating professionals, treatment parents, biological/adoptive/foster families and other involved parties
- Conduct treatment planning meetings within the first 10 days of admission and at a minimum of every 45 days thereafter
- Conduct discharge planning upon admission of the client and continue throughout the client's stay with an emphasis on the development of the skills needed for their permanent placement and identification and coordination of services needed after discharge in collaboration with the Clinical Services Management Team (CSMT)
- Utilize performance improvement, outcomes studies and satisfaction surveys to identify areas in the provision of services requiring specific attention and improvement
- Psychiatric services when indicated
- Certification of licensing as a child placement agency in Delaware is a required condition of contract execution
- The provider may work with Department of Family Services (DFS) to provide therapeutic foster care for dependent IRT youth once the IRT placement is completed. See Department Policy #209 on Services Coordination: http://kids.delaware.gov/pdfs/pol_dsc209_ServiceCoordination.pdf

The following trained personnel will provide NET's IRT Services:

- **Professional Treatment Parent(s):** An individual or couple, with multi-years experience working with adolescents and preferably in residential treatment. One of the Professional Treatment Parent(s) will be free from other obligations 24 hours a day, seven days a week. During respite periods this will transfer to the respite provider who provides the same coverage and has the same responsibilities for the care of the foster youth. NET will consider working single parent applicants who may not be free from other obligation 24 /7 if they identify a co-parent who can assist in meeting this obligation. The co-parent must live within close proximity and meet all training and supervision requirement. The Professional Treatment Parent assures that each youth's educational, medical, case

management, and psychiatric needs are adequately assessed and provided for in a timely manner.

- **Respite Resources:** An individual with equal experience as the Professional Treatment Parent(s), who will be equally trained (skills/knowledge) and informed (case specific) and prepared to provide substitute foster treatment in their home during the planned absence of the Professional Treatment Parent(s) or as needed to avert crisis. The Respite resource will be paid full rate and the Professional Treatment Parent will be paid half the rate during periods where respite is accessed. The Respite resource will be fully dedicated (24 hours per day, seven days per week) during respite provision, including treatment plan implementation and development. The Respite Specialist will be an important member of the treatment team, and not a baby sitter or drop-off, if only for short periods of time, and therefore will be trained and supervised with the same expectations as for the Professional Treatment Parent(s).
- **Behavioral Health Aide (BHA):** An individual with experience working with adolescents, preferably in residential treatment will serve as a BHA. The BHA will provide up to 5 hours of in-home, in school and/or in-community support for youth in NET's IRT Services. The level of intensity of hours/service will be determined by treatment team and can be adjusted as need fluctuates. The BHA will be a consistent support to the youth and Professional Treatment Parent(s), providing an additional adult role model and support. The Case Clinician and/or Program Director will directly supervise the BHA on a weekly basis. The BHA will not be used as a relief staff, but instead will work in tandem, not in place of the Professional Treatment Parent(s).
- **Case Clinician:** A Licensed Mental Health Professional with multi-years experience in foster care will be required for these positions. The Case Clinician will serve as the team leader, ultimately responsible for comprehensive assessment, treatment planning and review, case management, plan coordination, and weekly on-site supervision, weekly on-site individual and (as needed) family therapy and on-call responsibility as well as implementing performance improvement efforts. The Case Clinician will be directly supervised by the Program Director, a master's level administrator with many years of experience developing and managing behavioral health treatment services.



I. SERVICE OVERVIEW

A. Definitions

DFS	Division of Family Services
DPBHS	Division of Prevention and Behavioral Health Services
RFP	Request For Proposal

B. Description

The Joint Commission accredited residential treatment services purchased under this Contract comprise one element of the continuum of mental health treatment services provided by the DEPARTMENT’S DPBHS for children and adolescents. Services at this level are characterized by the provision of a 24-hour residential living environment, which is deliberately designed to create a structured therapeutic milieu, and which forms the basic foundation around which clinical treatment services are organized and integrated. Within the residential treatment level of the DPBHS continuum, programs and services are differentiated along several key dimensions:

- The restrictiveness of the milieu, in terms of both the physical characteristics of the environment and its proximity to the community;
- The nature and extent of clinical resources deployed in support of the milieu;
- The ratios of child care staff-to-clients, and the nature and extent of client supervision and care provided;
- The extent to which educational services are provided within the program, versus reliance upon the public school system.

II. TARGET POPULATION

Children and adolescents under the age of eighteen (18) years for whom the DPBHS Clinical Services Management Team has determined residential treatment services are clinically necessary.

III. ADMISSION, DISCHARGES, AND FUNDING AUTHORIZATION

A. Referrals, Initial Service Authorization and Expected Length of Stay/Service, Funding Approval and Admission

Refer to the DPBHS Provider Manual.

B. Medical Services Not Covered by the CONTRACTOR

1. DPBHS Only Funded Youth:

Medical care provided during the DPBHS authorized service period will not be funded by DPBHS. As part of the admission process, the provider shall discuss insurance coverage and fiscal liability for medical services with the parent. The provider is expected to make

arrangements with local medical care providers to capitalize on the child's insurance, including documented efforts to encourage the enrollment of local providers in the Delaware Medicaid program. Prior to the initiation of a medical service, the parent/legal custodian will be notified, provide consent for services and will assume responsibility for any financial charges incurred. Exception: If PBH only funded youth are in the legal custody of the DEPARTMENT'S DFS, fee-for-service medical services may be covered provided the CONTRACTOR complies with the following requirements:

2. DFS Medical Preauthorization Requirements:

Herein, the term "Medical Services" shall be understood to include all services related to the dental, optical, pharmacy & over-the-counter medication needs of Delaware youth, as well as services traditionally described as medical in nature such as X-rays, laboratory work, etc.

DFS desires to direct medical expenses to private insurance and/or Delaware Medicaid when possible. DFS expects all CONTRACTORS to assist in this effort by:

- i. Complying with DFS Preauthorization Requirements: All medical services, evaluations, treatments or diagnostic procedures not included in the per diem rate as described in the Budget Summary of this Contract require written preauthorization by the DFS Contract Manager or designee. The CONTRACTOR shall send a completed Medical Service Preauthorization Request form (Attachment C-1 of this contract) to the DFS Contract Manager prior to the scheduling/delivery of all such services. The DFS Contract Manager shall then fax or mail the signed preauthorization form back to the CONTRACTOR. Preauthorization may not be practical or possible for Emergency medical needs. On the next business day however, the CONTRACTOR shall fax a completed Medical Service Preauthorization Request form to the DFS Contract Manager for signature and return.
- ii. Adhering to the Requirements of Known Private Insurance Coverage for any Delaware Youth: The CONTRACTOR shall exhaust all private insurance benefits before submitting medical bills to DFS for payment. This may include and require preauthorizing services, obtaining exemptions from preferred provider networks, contacting insurers, providers, DFS Case Managers and/or parents/guardians for clarifications, etc. Documentation of claim denials will be expected to accompany any services billed to DFS for youth covered under any Private Insurance. An Explanation of Benefits (EOB) is the preferred verification or invoice from medical provider.
- iii. Assisting Local Health Care Providers with Delaware Medicaid: The CONTRACTOR agrees to contact their local medical providers of choice and request that they enroll with Delaware Medicaid. When Delaware youth in the CONTRACTOR'S program need medical services beyond the scope of the Program, the CONTRACTOR shall make every effort to use providers who agree to participate with Delaware Medicaid. Medical providers enrolled in the Delaware Medicaid Assistance Program (DMAP) agree to accept Delaware Medicaid's final payment disposition as payment in full for Medicaid covered services.

Additional information is available at the Delaware Medicaid website:
www.dmap.state.de.us

Medicaid claims denied for billing errors will not be reimbursed by DFS. Medical providers should address these issues directly with EDS at:

- **Pharmacy line: 1- 800-999-3371**
- **Non-pharmacy issues with Provider Relations: 302-454-7154**
or
1-800-999-3371

- iv. Billing DFS for Medical Services: DFS youth may be covered by a variety of private insurances, Delaware Medicaid, both or none of these health care payment sources. Before submitting any health care service billing directly to DFS for payment, the CONTRACTOR must ensure that efforts to seek payment from these other sources have been unsuccessful.

ALL HEALTH CARE SERVICES BILLED DIRECTLY TO DFS MUST INCLUDE:

- Original invoice from medical provider;
- Signed/approved DFS Medical Services Preauthorization form (Attachment C-1);
- Documentation (EOB preferred) of Private Health Insurance denial, or invoice from medical provider with denial detail, if applicable;
- Medicaid denial if applicable – The assigned DFS Contract Manager will work with the CONTRACTOR and/or directly with their local medical service providers to assist with Delaware Medicaid claim processing and claim denials when necessary. CONTRACTORS and service providers must promptly alert the DFS Contract Manager of problems involving Delaware Medicaid claims. Claims submitted to DFS for payment without the documentation listed above are subject to denial by DFS.

IV. PROGRAM AND SERVICE COMPONENTS

- A. Residential treatment exists as one component of a continuum of care. The concept of establishing a therapeutic milieu with a strong clinical base is central to effective residential treatment. Therapeutic interventions, activities, milieu, clinical and educational components must be carefully engineered to create a total ecological treatment environment within which the development and growth of the child or adolescent in specific areas can be systematically fostered. Individual characteristics of such an integrated treatment environment include:

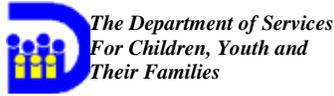
- Evaluation of psychiatric, psychological, social, familial, behavioral and developmental dimensions of the client's situation within the context of the client's precipitating symptomatology.
- Counseling and psychotherapy, including individual, family and group therapies and problem-specific approaches (e.g., drug/alcohol counseling, etc.).
- Programmed opportunities for the amelioration of presenting problems including the acquisition of skills and competencies. Specific program features include skill

building with an emphasis upon interpersonal and problem solving skills; self-care and social skills; and activity and recreational programming.

- Monitoring and management of the environmental stimuli to which the child or adolescent is subject.
 - A high degree of structure, order, and predictability with regard to the routines of daily living, the management of behavior and the provision for basic needs.
 - Careful monitoring and management of peer group interaction to promote social learning and minimize the negative effects of peer influence.
 - Provisions for educational opportunities. Educational programming appropriate to the level and individual educational needs of the client.
 - Treatment focus is designed to achieve the ultimate goal of returning the client to the least restrictive clinically appropriate setting within the shortest clinically appropriate timeframe.
- B. This contract was awarded in FY06 in response to the successful submission of a proposal to provide Services. This proposal was submitted by the CONTRACTOR in response to a Request for Proposals (RFP) issued by the DEPARTMENT. The DEPARTMENT is purchasing those services as described in the proposal submitted by the CONTRACTOR. The CONTRACTOR is responsible for immediate notification of the DEPARTMENT in the event of any substantive changes or modifications to the services as described in the original CONTRACTOR's proposal.

V. PERFORMANCE EXPECTATIONS

- A. Treatment Outcome Expectations: DPBHS expects contracted services for children and youth to support the DEPARTMENT'S overall goals of safety and positive outcomes for children and youth in provider services. Provider child outcomes may be evaluated in one or more of the following ways:
1. Percent of children requiring another service of the same or greater level of intensity/restrictiveness or the same provider service within six months of service discharge.
 2. Child safety incidents related to service delivery process errors/failures.
 3. Percent of children moving to a more intensive/restrictive service for more than four days while receiving services from a contracted provider.
- B. Process Expectations: DPBHS expects providers to be responsive to contractual stipulations related to the timeliness of service activities and reporting requirements and to the manner in which services are provided. Provider service delivery process performance may be evaluated in one or more of the following ways:
1. Services are delivered in conformance with the standards of the agency's accrediting body.
 2. Timeliness of expected/required activities.
 3. Timeliness, accuracy and completeness of required reports.
 4. Child and family satisfaction rates.



I. SERVICE OVERVIEW

A. Definitions

DPBHS	Division of Prevention and Behavioral Health Services
DSCYF	Department of Services for Children, Youth and Their Families

B. Description

Inpatient treatment services provide an out-of-home, twenty-four hour psychiatric treatment milieu under the direction of a physician. Within the medical context of an inpatient facility, clients can be safely evaluated, medications can be prescribed and monitored, and treatment interventions can be intensively implemented. Inpatient treatment services represent the most restrictive and intensive intervention available within the DPBHS continuum of services.

C. Dimensions

1. Medical/Psychiatric Hospital - Locked medical facility for youth who are dangerous to self or others because of behavioral health problems. Movement inside the facility and egress from the facility are strictly limited. External doors and some internal doors cannot be opened from the inside without a key. Education is provided on-site. Use of this facility is limited and is to protect the client and/or the community from his/her dangerous behaviors.
2. High - This is a site-based twenty-four hour, seven day per week program with three shifts of awake staff. The client receives multiple services which appear on a treatment/service plan and may include but are not limited to:
 - education
 - individual counseling
 - family counseling
 - supervised daily living
 - supervised recreational activities
 - medical/psychiatric services including nursing
3. High Team - Services provided with a team approach. The team must be headed by a licensed mental health professional and includes, at minimum:
 - One or more trained clinical staff, e.g. minimum of master’s level in some human service discipline, RN, etc.
 - Clinical staff available for consultation and some intervention, e.g. physicians including psychiatrists and psychologists
 - Trained, supervised staff may be added to the team. These individuals specialize in some aspect of behavior change, e.g. residential childcare workers or non-residential community interventionists

II. TARGET POPULATION

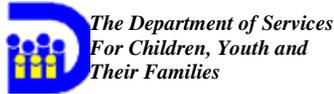
Inpatient treatment services will be provided to children and adolescents under the age of eighteen (18) years.

III. SERVICE COMPONENTS

Inpatient treatment exists as one component of a continuum of care. Therefore, inpatient treatment is used primarily for short term acute care to address symptoms which cannot be addressed at other less restrictive levels of care. When the acute crisis is resolved, the client can continue treatment in a less restrictive program.

A therapeutic milieu with strong psychiatric medical support is central to effective inpatient treatment. Therapeutic interventions, activities, milieu and educational components must be carefully integrated to create a total ecological treatment regime. Individual characteristics of such an integrated treatment regime include:

- Thorough evaluation of medical, psychological, social, familial, behavioral and developmental dimensions of the client's situation within the context of the client's precipitating symptoms.
- Management of the environmental stimuli to which the child or adolescent is subject.
- Careful monitoring of psychotropic medications and their effects on the client's behavior.
- A high degree of structure, order, and predictability with regard to the routines of daily living, the management of behavior and the provision for basic needs.
- Careful monitoring and management of peer group interaction to promote social learning and minimize the negative effects of peer influence.
- Programmed activities for the amelioration of presenting problems, including skill building, with an emphasis upon interpersonal and problem solving skills; self-care/life skills; activity and recreational programming.
- Counseling and psychotherapy, including individual and group approaches and problem-specific approaches.
- Family therapy with focus upon reintegration into the community within the shortest clinically appropriate time frame.
- Provisions for educational opportunities.



I. SERVICE OVERVIEW

D. Definitions

DPBHS	Division of Prevention and Behavioral Health Services
DSCYF	Department of Services for Children, Youth and Their Families
DYRS	Division of Youth Rehabilitative Services

E. Description

Inpatient treatment services provide an out-of-home, twenty-four hour psychiatric treatment milieu under the direction of a physician. Within the medical context of an inpatient facility, clients can be safely evaluated, medications can be prescribed and monitored, and treatment interventions can be intensively implemented. Inpatient treatment services represent the most restrictive and intensive intervention available within the DPBHS continuum of services.

The CONTRACTOR, through this contract and in accordance with 16 Del. C. sections 5001(2) and 5135, is hereby designated by the DEPARTMENT Secretary as an appropriate facility for the diagnosis, care and treatment of mentally ill minors who are involuntarily admitted to the custody of the CONTRACTOR'S psychiatric hospital pursuant to 16 Del. C. section 5122 or section 5001 et. seq.

It is the intent of this contract to purchase from the CONTRACTOR involuntary psychiatric hospital services for minors only insofar as said services are required by and in compliance with pertinent provisions of 16 Del. C. Chapters 50 and 51, herein incorporated by reference. The CONTRACTOR will be familiar with pertinent provisions of 16 Del. C. Chapters 50 and 51 and associated legal and professional procedures governing involuntary hospitalization of juveniles. It is expected that the CONTRACTOR will seek clarification from the DEPARTMENT should questions or problems arise in the implementation of services under this contract.

F. Dimensions

1. Medical/Psychiatric Hospital - Locked medical facility for youth who are dangerous to self or others because of behavioral health problems. Movement inside the facility and egress from the facility are strictly limited. External doors and some internal doors cannot be opened from the inside without a key. Education is provided on-site. Use of this facility is limited and is to protect the client and/or the community from his/her dangerous behaviors.
2. High - This is a site-based twenty-four hour, seven day per week program with three shifts of awake staff. The client receives multiple services which appear on a treatment/service plan and may include but are not limited to:
 - education
 - individual counseling
 - family counseling
 - supervised daily living
 - supervised recreational activities
 - medical/psychiatric services including nursing



3. High Team - Services provided with a team approach. The team must be headed by a licensed mental health professional and includes, at minimum:
 - One or more trained clinical staff, e.g. minimum of master's level in some human service discipline, RN, etc.
 - Clinical staff available for consultation and some intervention, e.g. physicians including psychiatrists and psychologists
 - Trained, supervised staff may be added to the team. These individuals specialize in some aspect of behavior change, e.g. residential childcare workers or non-residential community interventionists

II. TARGET POPULATION

Inpatient treatment services will be provided to children and adolescents under the age of eighteen (18) years.

III. SERVICE COMPONENTS

Involuntary inpatient treatment should be used only in extraordinary circumstances where a minor meets the legal definition for involuntary admission, and a parent or legal guardian's signature for voluntary inpatient treatment is unavailable. Treatment is used primarily for acute crisis resolution to address behavior and symptoms which cannot be addressed at other less restrictive levels of care. When the acute crisis is resolved, the client should continue treatment in a less restrictive context.

A therapeutic milieu with strong psychiatric medical support is central to effective inpatient treatment. Therapeutic interventions, activities, milieu and educational components must be carefully integrated to create a total ecological treatment regime. Specifically, the CONTRACTOR agrees to provide:

- Independent psychiatric evaluation within 24 hours of admission.
- A thorough assessment of the medical, psychological, social, familial, behavioral and developmental dimensions of the client's situation within the context of the client's precipitating symptoms.
- Focused brief treatment and stabilization as medically necessary, including individual and group approaches and problem-specific approaches.
- Therapeutic stabilization of youth in crisis, including physically aggressive minors, and minors who are a danger to self or others.
- A safe and secure environment for all minors who are involuntarily admitted, including those who are violent and dangerous to themselves and/or others and those who have been adjudicated or are otherwise in the custody of the DYRS.
- Careful monitoring of psychotropic medications and their effects on the client's behavior.
- A high degree of structure, order, and predictability with regard to the routines of daily living, the management of behavior and the provision for basic needs.
- Monitoring and management of peer group interaction to promote social learning and minimize the negative effects of peer influence.



- Programmed activities for the amelioration of presenting problems, including skill building, with an emphasis upon interpersonal and problem solving skills; self-care/life skills; activity and recreational programming.
- Brief family therapy with focus upon reintegration into the community within the shortest clinically appropriate time frame.
- Provisions for educational opportunities.

IV. INVOLUNTARY HOSPITALIZATION PROCEDURES

The CONTRACTOR agrees to comply with all legal and DPBHS requirements governing admission, continued stay and discharge. In addition, the CONTRACTOR agrees to the following:

A. Admission

1. Accept All Admissions - The CONTRACTOR must accept for admission all minors who are presented to the hospital for involuntary admission in accordance with Delaware law.
2. Confirmation with the DEPARTMENT - The CONTRACTOR will inform the DEPARTMENT of the actual date and time of any involuntary admission as soon as possible, and no later than 2 hours following the actual admission of a youth to the facility; unless the involuntary admission occurs at a time when State offices are closed, in which case the CONTRACTOR will notify the DEPARTMENT within the first two (2) hours of the next working day. In the event that said notification is not received within the specified time frames, the DEPARTMENT reserves the right to deny payment for all or part of the minor's course of hospital treatment.
3. Due Process - In accord with 16 Del. C. Ch. 50 and 51 concerning involuntary and provisional admissions, the CONTRACTOR will ensure that all applicable legal safeguards and procedures governing involuntary provisional hospitalization are implemented promptly for all involuntarily admitted patients and their families.

B. Continued Stay

1. Treatment. The CONTRACTOR will provide treatment to the involuntary minor as is medically appropriate.
2. Involuntary Treatment Pursuant to Court Ordered Commitment. If a patient is committed for continued treatment to the CONTRACTOR'S hospital pursuant to a Court order, the hospital shall provide treatment to the involuntary patient in accordance with the order, applicable Delaware law, this Contract and generally recognized professional standards.
3. Emergency Procedure Authorization. In the event that an emergency procedure must be performed at the facility or elsewhere, DPBHS must be informed on the next working day, or payment for the procedure may not be authorized. DPBHS will only consider funding for medical procedures that are directly related to the diagnosis and/or treatment of a client's psychiatric condition.
4. Ancillary Procedures Authorization. Psychological or other specialized evaluations, treatment or diagnostic procedures not included in the comprehensive per diem will be funded only as authorized by DPBHS.



C. Discharge

1. Emergency Apprehension. If a youth is admitted pursuant to 16 Del. C. section 5122, the youth will be discharged from involuntary status within 72 hours unless admitted or committed under some other provision of Delaware law. The CONTRACTOR must provide discharge recommendations in consultation with DPBHS.
2. Provisional Hospitalization. If a youth is admitted pursuant to 16 Del. C. section 5003, the youth must be discharged from involuntary status within two (2) working days unless judicial commitment proceedings are undertaken pursuant to 16 Del. C. section 5007 et. seq., in order to obtain legal authorization for continued hospitalization under a judicial commitment order. The CONTRACTOR must provide discharge recommendations in consultation with DPBHS.

V. **PROGRAM DELIVERABLES**

In addition to the specifications in the DPBHS Provider Manual and Involuntary Procedures Manual, the CONTRACTOR agrees to the following:

- A. The following must be delivered to DPBHS within 48 hours of admission:
 1. Admission Summary - including psychiatric evaluation with DSM IV diagnosis, initial treatment plan and signed by attending physician.
 2. Provider Certificate of Need.
- B. Monthly - The hospital will provide to the DPBHS Program Manager, at the close of every month a report which specifies how many minors were involuntarily admitted in the previous month, and for each patient, the level of care from which each patient was admitted, the level of care the patient was discharged to, the number of previous psychiatric hospitalizations, and whether the patient was involuntarily admitted or referred by an agent or employee of the hospital, or by a psychiatrist with admitting privileges at the hospital.



I. SERVICE OVERVIEW

A. Definitions

DPBHS	Division of Prevention and Behavioral Health Services
DSCYF	Department of Services for Children, Youth and Their Families
DYRS	Division of Youth Rehabilitative Services

B. Description

1. Supplemental Supervision - As an adjunct to the inpatient hospital and day/part day hospital programs operated under the contract, the CONTRACTOR, with authorization from DPBHS, may assign additional staff to provide one-to-one supervision for clients who are deemed to require that added service in order to make it possible to treat them safely and effectively at this level of care. When authorized, the additional staff member will be assigned solely and exclusively to the client, for whom the service was authorized, during agreed upon daily time periods, and for the duration of the authorization period.
2. Translation Service (subcontracted) - As an adjunct to the inpatient hospital and day hospital programs operated under the contract, the CONTRACTOR has the capacity to arrange for the provision of interpretation and translation services for clients who are not fluent in English or who are hearing impaired and require this service in order to participate in treatment.

II. TARGET POPULATION

Adjunctive services will be provided, when authorized and funded, to specific named clients who are DPBHS clients admitted to either the inpatient hospital program or the day hospital program within the CONTRACTOR’S system.

III. AUTHORIZATION AND FUNDING

A. Authorization

Adjunctive services must be specifically authorized for a named client by the DPBHS’ Clinical Services Management Team assigned to that client. The authorization will be for a designated and time limited period, subject to periodic renewal as client needs dictate.

B. Funding

The CONTRACTOR will bill separately for the cost of authorized adjunctive services at the rates specified in Attachment B-4.