DIXON SETTLEMENT AGREEMENT QUARTERLY REPORT

Pursuant to the terms of Paragraph 74 of the Settlement Agreement ("SA"), the District reports the following information:

I. Child and Youth Services

a. Community Services Reviews

Requirement: 70% in overall system performance on CSR by September 30, 2013[1]

(1) Results of FY 2012 or FY2013 CSRs, as applicable (SA, ¶¶ 55 and 58). FY 2012 CSRs are scheduled for May 7 – May 25, 2012

(2) Status of Human Systems and Outcomes ("HSO") consultation (SA, ¶¶ 56 and 57), including:

i. HSO Contract Approval – HSO began work in November 2011 with DMH to provide technical assistance to DMH staff and identified providers. In addition, HSO and DMH have begun the work of organizing the FY 12 Child Community Service Reviews (CSRs). HSO's work from November 2011 to early February 2012 was funded through HSO's contract with the Court Monitor. For its work for the remainder of FY 12, HSO has a contract with DMH. Currently HSO is providing technical assistance to six providers (Fihankra Place, Hillcrest Center, LAUNCH, McClendon Center, Family Matters and Universal) through two-day provider training for each provider focused on defining and measuring quality practice. HSO will also provide 40% of the CSR reviewers, case judging, consultation and final report for the Child CSRs that will occur from May 7 – May 25, 2012.

ii. Scheduled trainings for the upcoming CSR:

a. New Reviewer Training occurred the week of January 24, 2012 for DMH staff and community stakeholders to lead child/youth CSRs; another occured the week of April 10, 2012.

b. Refresher Training will occur April 17th and April 19th.

[1] This is a summary of the Settlement Agreement requirements; for a full text of the requirements please refer to the referenced paragraphs of the Settlement Agreement.

c. "Conversion" training, to certify prior adult CSR leads as child/youth leads, will occur on April 18th.

iii. Practice Principles and additional technical assistance:

a. DMH has drafted practice principles that have been used as the basis for the technical assistance provided to providers. These principles are currently being drafted as a policy, and the policy is in the process of being vetted by the CSR Integration Workgroup.
b. The Child/Youth Services Division is working with the CSR unit to shape provider-specific technical assistance based on the needs of particular provider agencies.
c. The CSR unit has offered introductory trainings to two new providers who have not previously been involved in the CSR process, but whose consumers will constitute a substantial percentage (~10%) of those reviewed during the May CSR.

iv. Performance improvement plans for low-performing CSAs: CSAs that performed below expectations in the 2011 CSR were chosen as targeted CSAs mentioned above; they are required to participate in up to four days of technical assistance designed to facilitate practice improvement in the areas in which they most needed improvement. This technical assistance is being provided by HSO, the CSR unit, and staff from the CYSD.

v. Preparation for CSA-level CSR process: The CSR unit is working with Far Southeast Family Strengthening Collaborative (FSFSC) to prepare for the May CSR. The CSR unit has been coordinating the identifying information supplied by CSAs regarding each child and family in the sample, and FSFSC is obtaining consents and building schedules for the reviews. The CSR unit is also working with CFSA and the Court Monitor for the LaShawn v. Gray case to insure that all DMH consumers in the CSR sample who have CFSA involvement will be reviewed using both the DMH CSR protocol and the CFSA QSR protocol. This will provide a comprehensive view of the services received by this vulnerable population.

b. Psychiatric Residential Treatment Facilities ("PRTFs") (SA, ¶ 59)

Requirement: 30% Reduction in total bed-days from 5/1/11 – 4/30/12 (baseline) to 5/1/12 – 4/30/13[2]

PRTF Total Bed Days Baseline Data[3] Baseline Period: 05/01/11 –04/30/12 (as of 12/31/11)		
Placing Agency	**# Served with SED**	**Total # of Bed Days (from admission)**
Department of Youth Rehabilitation Services (DYRS)	123	32,861
Child and Family Services Agency (CFSA)	39	16,197
Department of Mental Health (DMH)	12	4,054
Office of the State Superintendent of Education (OSSE)	5	1,451
D.C. Public Schools (DCPS)	12	7,545
HSCSN	7	2,241
Total Bed Days Baseline Number	**198**	**64,349**

c. Reduction PRTF Usage (SA, ¶ 59)

PRTF Bed Days Comparison Period: 05/01/12 –04/30/13[4]		
Placing Agency	**# Served with SED**	**Total # of Bed Days**
Department of Youth Rehabilitation Services (DYRS)		
Child and Family Services Agency (CFSA)		
Department of Mental Health (DMH)		
Office of the State Superintendent of Education (OSSE)		
D.C. Public Schools (DCPS)		
Total Bed Days (05/01/11 – 04/30/12)		
Total Percentage Reduction from Baseline Number of Bed Days ((insert number))		

[2] This is a summary of the Settlement Agreement requirements; for a full text of the requirements please refer to the referenced paragraphs of the Settlement Agreement.

[3]The District will report a running total of number of children served with SED in a PRTF and bed days until the baseline period is complete. The date of the reporting period will also be included in the chart.

[4]The District will report a running total of number of children served with SED in a PRTF and bed days during the comparison period until it is complete. The date of the reporting will also be included in the chart underneath the line describing the baseline period. An example of the language is as follows "Data reported below is as of 12/31/11."

d. PRTF Discharges and Community Services (SA, ¶ 60)

There were 29 youth discharged from PRTFs during the first quarter of FY12. Three (3) youth were discharged from a PRTF but did not spend anytime in the community because they went directly into non-community placements (correctional facility or RTC) and remained for the duration of the 90-day period. There were 25 youth who were discharged to the community after completing treatment, and one (1) youth who was discharged due to abscondance for a total of 26 youth being monitored in the community (see paragraph e, below, for more information on this particular youth).

Quarter	Total Number of C/Y Discharged	Reasons for Discharge	Community-Based Services After Discharge for Youth in the Community
1QFY12	(29) Discharged	(25) Appropriately Completed Treatment (1) Abscondance (3) Discharged but went directly into non-community placements (correctional facility or RTC)	**Billed MHRS Services** CBI Level II CBI Level I – MST Med/Som Community Support Diagnostic Assessment Behavioral Health Screening Other[5] **Agency Self-Reported Non-MHRS Services** Mentoring Academic Support Tutoring Job/Work Program Workforce Development Substance Abuse Counseling
2QFY12			(Same for each successive quarter)
3QFY12			
4QFY12			
1QFY13			
2QFY13			
3QFY13			
4QFY13			

[5] The District will amend this report to reflect additional services as they are added to the service taxonomy.

e. PRTF Discharges and Outcomes (SA, ¶ 60)

(1) Narrative summary of outcomes for children/youth discharged from PRTFs during the most recent quarter and for the end of the fiscal year, if applicable.

The services youth received while in the community are listed above in Table d. and show both billed claims received for MHRS services, as well as non-MHRS services and supports self-reported by agency staff to DMH. Youth received therapeutic and clinical services as well as academic and professional assistance. All 26 youth who were discharged from PRTFs remained in the community throughout the reporting period (90 days) without disruptions. The youth who absconded from the PRTF and was subsequently discharged did so while at home for his second home visit from the facility. His initial home visit in the beginning of November, 2011 was successful; the second home visit was for the Thanksgiving holiday. The youth did not return to the facility following his Thanksgiving home visit. As a result a custody order was issued; on December 27, 2011, he was located and placed at the Youth Services Center (YSC). He has since been placed at another PRTF.

(2) Length of Community Tenure – Community tenure for children/youth is calculated beginning with the date of discharge and continuing up to and including the 180th day after discharge. For purposes of this report, a disruption in community tenure occurs when the child/youth is: incarcerated/detained for 14 days or more; hospitalized (in a psychiatric hospital) for 22 days or more; or re-admitted to a PRTF.

Summary of Community Tenure Data	1Q (10/1/11 – 12/31/11)
Total Youth Monitored in the Community at beginning of Quarter*	*0*
Total Youth Discharged from a PRTF to the Community during FY 12 1Q	*26*
Total Youth Completing Community Tenure*	*0*
Total Youth Being Monitored at end of Quarter*	*26*
Total Youth Without Disruptions in Community Tenure during FY 12 1Q	*26*
Total Youth With Disruptions in Community Tenure during FY 12 1Q	*0*

Maximum Number of Days Possible in Community (Total # of Days Between Date of Discharge for Each Youth to Last Day of Reporting Period)[6]	*719*
Actual Number of Days in Community*	*712*
% of Actual Days to Possible Days in Community*	*99%*

*These categories were added in order to inform the reader of the cumulative number of youth when more than one quarter of data is available.

Disruption in Community Tenure Data[7]							
Type of Disruption	**Total Applicable**	**<30 Days**	**31-60 Days**	**61-90 Days**	**91-120 Days**	**121-150 Days**	**151-180 Days**
Incarceration More than 14 Days	*0*						
Hospitalization More than 22 Days	*0*						
Readmitted to PRTF	*0*						

f. Evidenced-Based and Promising Practices (SA, ¶ 61)

[6] DMH will report the total number of days that the children discharged during a quarter could have been in the community. This accounts for the different discharge dates from a PRTF. For example: 20 children are discharged during the first quarter of FY 12 (October 1 – December 31, 2011). A child is discharged on October 3, 2011. The maximum days in the community for that child would be 89 (28 days in October + 30 days in November + 31 days in December). For another child discharged on December 25, 2011 the maximum days in the community would be 6.

[7] Data will be reported cumulatively and will identify each placement disruption throughout the course of the 180 day tracking period. For example, a child who is hospitalized during days 31 – 60 and hospitalized again during days 151 – 180 will be shown in both columns of the chart.

Requirement: FFT and MST to increase by 20% (both FY 12 and FY 13)
HFW to increase by 10% (FY 12) and 20% (FY 13)[8]

Annual Service Utilization					
Type of Service	**FY 2011 Unduplicated Number of C/Y Served FY 11**	**FY 2012 Unduplicated Number of C/Y Served FY 12 (through 12/31/11)**	**FY 2011 - 2012 Percent Increase**	**FY 2013 Unduplicated Number of C/Y Served FY13**	**FY 2012 - 2013 Percent Increase**
FFT	82	61			
MST	129	54			
HFW	211	180			

Service Utilization by Quarter (FY 12)				
Services	**# Served 1Q**	**# Served 2Q**	**# Served 3Q**	**# Served 4Q**
FFT	61			
MST	54			
HFW	180			
Total Served	295			

[8] This is a summary of the Settlement Agreement requirements; for a full text of the requirements please refer to the referenced paragraphs of the Settlement Agreement.

II. Supported Housing

g. Supported Housing Capacity (SA, ¶¶ 62, 63, and 64)

Requirement: 300 new vouchers/units (minimum 200 vouchers) by September 30, 2013
Housing Plan by September 30, 2012[9]

Supported Housing Capacity					
Program	**Baseline Capacity (As of 09/30/11)**	**Capacity Quarter 1**	**Capacity Quarter 2**	**Capacity Quarter 3**	**Capacity Quarter 4**
Home First Subsidy (HFS)	**653**	657			
Local Rent Subsidy Program (LRSP)	**93**	93			
Shelter Plus Care (SPC)	**159**	159			
Federal Vouchers (Project- and Tenant-Based)	**436**	436			
Capital-Funded Units	**55**	35			

[9] This is a summary of the Settlement Agreement requirements; for a full text of the requirements please refer to the referenced paragraphs of the Settlement Agreement.
[10] Twenty (20) capital units were completed and occupied by consumers. These consumers received Home First Subsidies for rental assistance. However due to other consumers who were receiving HFS moving onto vouchers or off of HFS for other reasons, the HFS number did not increase by 20. The new FY 12 subsidies are now being awarded and therefore the HFS number will be increasing in the future.

h. Supported Housing rules status (SA, ¶ 65)

To ensure that the Housing Rules are in alignment with the Housing Plan, finalization of the Housing Rules is on hold until the Housing Plan is completed. The Housing Rules will include language regarding priority populations where the Consumer is:

1. Pending discharge from Saint Elizabeths Hospital
2. In an emergency situation involving the health or safety of the consumer or the consumer's family
3. Moving to a less-restrictive environment

i. Enforcement of Supported Housing Rules (SA, ¶ 65)

(1) Demonstrate that the Supported Housing rules are communicated to providers and that they are being enforced.

Once the Housing Rules have been finalized, they will be disseminated to the providers. In the meantime, DMH has monthly meetings with its CSA Housing Liaisons, and housing issues are discussed on an on-going basis in the monthly Clinical Directors' meeting. Additionally, DMH is now offering quarterly training on DMH housing programs through the DMH Training Institute for all CSA employees. The next training is scheduled for April 24, 2012.

(2) Demonstrate that available housing is assigned according to the priority populations in accordance with the Supported Housing rules. (Use table below in addition to any relevant narrative).

Consumers on the Housing Waiting List are candidates for housing opportunities as they arise. Consumers in priority populations will be selected first for housing opportunities, followed by consumers on the Housing Waiting List with the longest wait time.

Priority Population Category	# Applied or Referred to SH	# Placed in SH 1Q	# Placed in SH 2Q	# Placed in SH 3Q	# Placed in SH 4Q
SEH Discharge	1	1			
Homeless w/SMI	74	12			
Consumer w/SMI Transfer to Less Restrictive Setting	2	6			
Other	20	1			
Total	**97**	**20**			

j. **Supported Housing Strategic Plan (SA, ¶ 66)**

Provide narrative of status of strategic plan, including efforts to consult with consumers and consumer advocates. Attach draft/final plan as applicable.

DMH issued a Request for Proposal (RFP) for a vendor to develop the Strategic Housing Plan on February 3, 2012. A vendor has been selected and the contract was awarded on April 4, 2012. We expect that the Plan will be completed by July 31, 2012.

III. Supported Employment Services

Requirement: Methodology for assessment to be used by all CSAs: March 31, 2012
60% of all adults with SMI interested in SE to be referred: April 1, 012 – September 13, 2013
Increase in consumers served: FY 12, 10%; FY 13, 15% over FY 12[11]

k. Methodology to Assess Need (SA, ¶ 67)

Provide narrative of status of the development of an objective methodology to assess the need for supported employment services. Describe how DMH is implementing this methodology and enforcing compliance.

DMH has revised its Supported Employment Policy (see Exhibit A, DMH Policy # 508.1A, Evidence Based Supported Employment Services, issued February 28, 2012) to require every CSA to assess all adult consumers with a Serious Mental Illness (SMI) or Axis II Personality Disorder for interest and eligibility in supported employment. If an interested person is eligible, the CSA is required to refer the individual to a Supported Employment Program. The CSA must complete an electronic performance event screen for each individual when completing the 180-day treatment plan (or more often when necessary) to confirm that consumers have been assessed, offered and referred for supported employment service authorization. DMH monitors the performance event screen data to insure that CSAs complete the process and offer the service. A centralized waitlist has been created at DMH for those individuals waiting for an available opening at a Supported Employment provider.

l. Assessment and Referral (SA, ¶¶ 67 and 68)

Assessment and Referral for Supported Employment Services ("SES") Measurement Period: April 1, 2012 through September 30, 2013						
	3QFY12	4QFY12	1QFY13	2QFY13	3QFY13	4QFY13
Total # w/SMI Assessed and Need SES						
Of those Assessed, Total # Referred to SES						
Percentage Referred to SES Services						

[11] This is a summary of the Settlement Agreement requirements; for a full text of the requirements please refer to the referenced paragraphs of the Settlement Agreement.

m. Service Delivery (SA, ¶ 69)

Delivery of Supported Employment Services					
	1QFY12	2QFY12	3QFY12	4QFY12	Total for FY 2012
Total Unduplicated Count of Adults with SMI who Received at Least One SES	**440**				
Percentage Increase Over FY 2011 Baseline - 761					

IV. Continuity of Care

Requirement: 70% of adults and children seen within 7 days of hospital discharge by September 30, 013

80% of adults and children seen within 30 days of hospital discharge by September 30, 2013

Continuity of Care performance standards in policy and Human Care Agreements[12]

[12] This is a summary of the Settlement Agreement requirements; for a full text of the requirements please refer to the referenced paragraphs of the Settlement Agreement.

n. Continuity of Care Delivery (SA, ¶¶ 70 and 71)

Continuity of Care – Adults					
	1QFY12	2QFY12	3QFY12	4QFY12	Total for FY 2012
Total Number of Adults Discharged	266				266
Number of Adults Receiving a Community Based Service within 7 days of Discharge	181				181
Percentage Receiving Service w/in 7 Days of Discharge	68.05 %	%	%	%	68.05 %
Number of Adults Receiving a Community Service within 30 days of Discharge	200				200
Percentage Receiving Service w/in30 Days of Discharge	75.19 %	%	%	%	75.19 %

Continuity of Care – Children and Youth					
	1QFY12	2QFY12	3QFY12	4QFY12	Total for FY 2012
Total Number of C/Y Discharged	159				159
Number of C/Y Receiving a Community Based Service within 7 days of Discharge	82				82
Percentage Receiving Service w/in 7 Days of Discharge	51.57 %	%	%	%	51.57 %
Number of C/Y Receiving a Community Service within 30 days of Discharge	105				105
Percentage Receiving Service w/in 30 Days of Discharge	66.04 %	%	%	%	66.04 %

o. Performance Standards (SA, ¶ 73)

Provide narrative describing the status of the development, monitoring, and enforcement of continuity of care performance standards. Attach applicable DMH policy and sample Human Care Agreement.

The Integrated Care Division (ICD) continues to monitor and track continuity of care for eligible individuals discharged from hospitals. Continuity of Care Performance Standards have been revised and published (*see* Exhibit B, DMH Policy #200.2A, Continuity of Care Practice Guidelines for Adult Mental Health Providers, dated January 17, 2012; Exhibit C, DMH Policy # 200.5A, Continuity of Care Practice Guidelines for Children and Youth, dated January 27, 2012, both attached to this report). The Human Care Agreements (HCAs) that DMH enters into with each provider requires that the providers comply with the applicable policies, including these; however the Integrated Care Division (ICD) Director is working to get the HCAs modified to specifically include continuity of care requirements.

ICD will work with the Office of Accountability on monitoring corrective action plans from those providers whose performance is not acceptable.

Although the adult performance data is not far from the required benchmark performance standards, DMH recognizes that the children's results remain a concern. Although the child care manager has been in the position less than a year for the new protocol, there has been a 10 – 20% improvement already. With the continuity of care standards, use of corrective action plans, and the integrated Systems of Care in the Children and Youth Services Division, as well as the CSR interventions used with a number of the children's providers, we expect that the children's performance will continue to improve.

Department of Mental Health

TRANSMITTAL LETTER

SUBJECT **Evidence Based Supported Employment Services**		
POLICY NUMBER **DMH Policy 508.1A**	DATE FEB 2 8 2012	TL#162

Purpose. To update the policy to reflect recent changes in supported employment services, and provide the Supported Employment Fidelity Scale adopted by the Department of Mental Health (DMH).

Applicability. Applies to DMH enrolled eligible consumers eighteen (18) years of age and over; DMH-certified Core Services Agencies; certified Supported Employment Program providers; and the Mental Health Authority (MHA).

Policy Clearance. Reviewed by affected responsible staff and cleared through appropriate MHA offices.

Implementation Plans. **A plan of action to implement or adhere to this policy must be developed by designated responsible staff. If materials and/or training are required to implement this policy, these requirements must be part of the action plan. Specific staff should be designated to carry out the implementation and program managers are responsible for following through to ensure compliance. Action plans and completion dates should be sent to the appropriate authority. Contracting Officer Technical Representatives (COTRs) must also ensure that contractors are informed of this policy if it is applicable or pertinent to their scope of work.** ***Implementation of all DMH policies shall begin as soon as possible. Full implementation of this policy shall be completed by March 31, 2012.***

Policy Dissemination and Filing Instructions. Managers/supervisors of DMH and DMH contractors must ensure that staff are informed of this policy. Each staff person who maintains policy manuals must ensure that this policy is filed in the **DMH** Policy and Procedures Manual, and contractors must ensure that this policy is maintained in accordance with their internal procedures.

ACTION

REMOVE AND DESTROY	**INSERT**
DMH Policy 508.1	**DMH Policy 508.1A**

2/28/12

Stephen T. Baron
Director, DMH

EXHIBIT A

GOVERNMENT OF THE DISTRICT OF COLUMBIA	Policy No. 508.1A	Date FEB 2 8 2012	Page 1
DEPARTMENT OF MENTAL HEALTH	**Supersedes:** DMH Policy 508.1, same subject, dated 3/22/2005		

Subject: Evidence Based Supported Employment Services

1. **Purpose**. To set forth the Department of Mental Health (DMH) requirements for evidence-based supported employment services.

2. **Applicability**. Applies to DMH enrolled eligible consumers eighteen (18) years of age and over; DMH-certified Core Services Agencies (CSAs); certified Supported Employment Program providers; and the Mental Health Authority (MHA).

3. **Authority**. Department of Mental Health Establishment Act of 2001; Title 22 DCMR, Chapter A37, Mental Health Supported Employment Certification Standards.

4. **Background**. Evidence-based supported employment is designed for adult consumers with a serious mental illness (SMI) or a primary diagnosis on Axis II of a Personality Disorder, for whom competitive employment has not traditionally occurred, or for whom competitive employment has been interrupted or intermittent as a result of either.

Evidence-based supported employment involves community-based employment in integrated work settings that is consistent with the strengths, resources, priorities, concerns, abilities, capabilities, interests and informed choice of the consumer.

5. **Definitions**. For purposes of this policy:

5a. Supported Employment - A part-time or full-time job in which a consumer receives support in a competitive employment setting and in which the consumer earns the minimum wage or higher. Supports shall include intake, assessments, job club, treatment team coordination, job development, ongoing job coaching, and follow up for each consumer, including offering job options that are diverse and permanent.

5b. Supported Employment Program Provider – A DMH-certified MHRS provider who has also been certified by DMH to provide evidence-based supported employment services pursuant to Title 22 DCMR, Chapter A37, Mental Health Supported Employment Certification Standards.

5c. Employment Specialist – A person who works for a certified Supported Employment Program provider; must satisfy all requirements for unlicensed credentialed workers pursuant to Title 22 DCMR Chapter A37 and Chapter A34, Section 3410, and all training requirements established by DMH.

5d. SMI (Serious Mental Illness) - A primary mental health diagnosis of: Schizophrenia; Schizoaffective Disorder; Bipolar 1 Disorder; Major Depressive Disorder; Delusional Disorder; Psychotic Disorder, not otherwise specified (NOS); Dysthymic Disorder; Post Traumatic Stress Disorder; or Depressive Disorder, NOS.

5e. Department of Disability Services, Rehabilitation Services Agency (RSA) – The District government entity that provides employment services to those individuals with developmental and other disabilities.

5f. Individualized Work Plan (IWP) – A plan developed between the Supported Employment Program provider and the consumer that includes an employment goal and the support services required to reach the goal.

6. **Policy**.

6a. DMH is committed to promoting evidence-based supported employment services based on the interests and preferences, as well as career goals, of eligible consumers.

6b. CSAs must assess each consumer 18 years of age and older for eligibility for, and interest in, supported employment services. Consumers who are eligible and interested shall be referred for supported employment services.

6c. Certified Supported Employment Program providers must design and implement evidence-based supported employment services in accordance with Title 22 DCMR Chapter A37.

6d. Evidence-based supported employment services shall be authorized and provided in accordance with the consumer's treatment plan. The treatment plan shall document the consumer's employment interests and career goals.

6e. The consumer's employment and career planning process must be driven by the consumer's preferences, and not by provider expectations or decisions.

6f. Employment Specialists shall be part of the consumer's clinical home treatment team and participate in the development of the treatment plan with regard to supported employment services.

7. **Eligibility for Employment Services**. A consumer must meet the following requirements in order to be eligible for supported employment services:

- Be seriously mentally ill or have a primary diagnosis on Axis II of a Personality Disorder;
- Be at least (18) years of age;
- Indicate an interest in employment; and
- Have supported employment identified as a service on a current valid Individualized Recovery Plan (IRP).

8. **Referrals**. Requests for supported employment services may be made by consumers, family members, advocates, or other service providers. Eligible consumers shall be referred to Supported Employment Program providers by their CSA.

9. **Responsibilities**.

9a. CSAs shall:

(1) **Ask** every adult consumer 18 years of age and over with SMI or a primary diagnosis on Axis II of a Personality Disorder, if they want to be employed: (1) during the development of initial treatment plan; (2) at every treatment plan meeting thereafter; and (3) upon request of family members, advocates, or other services providers.

(2) **Assess** consumers for eligibility if they indicate an interest in employment prior to referral to a Supported Employment Program provider (see eligibility requirements in Section 7 above).

(3) **Inform** eligible consumers of all available certified Supported Employment Program providers, and **allow** the consumer to select the agency of their choice or to be placed on the DMH Supported Employment Wait list.

(4) **Complete and submit** an electronic Supported Employment Services (SES) authorization request.

(5) Once supported employment services are authorized in the electronic management system, **refer** eligible consumers to a certified Supported Employment Program provider within five (5) business days.

(6) **Accurately complete** performance event screen in the electronic management system for every consumer regarding supported employment at development of the initial treatment plan and at least every 180 days thereafter, or more often as needed.

9b. Supported Employment Program Providers shall:

(1) **Inform** the DMH, Office of Programs, Supported Employment Program Manager/designee of your program's capacity on a weekly basis.

(2) **Accept** consumer into services within thirty (30) days of the assessment/referral by a CSA, unless you have reached maximum capacity and are unable to accept new consumers.

- If unable to accept new consumers, **coordinate** with the DMH, Office of Programs, Supported Employment Program Manager/designee, for the consumer to be placed on the Supported Employment Wait list, and inform the CSA of same.

(3) **Provide** the following evidence-based services:

(a) Intake - Involves obtaining background, clinical, and employment information in order to enroll the consumer into the evidence-based supported employment program and initiate a referral to RSA.

(b) Vocational Assessment – Consists of conducting vocational assessments, and assessment of person-centered employment information in order to identify the individual's employment interests, preferences, and abilities.

(c) Individualized Work Plan (IWP) development - Includes the process of developing a plan with the consumer that includes an employment goal and the support services required to reach the goal, such as integrating employment goals into the IRP, strategies to address stressor situations, assistance with symptom self-monitoring and self management, and assistance in increasing social support skills and networks that ameliorate life stresses resulting from the consumer's mental illness or emotional disturbance and are necessary to enable and maintain the consumer's independent living.

(d) Supported Employment Job Club – Assists consumers in understanding how to complete job applications, effective interviewing techniques, resume writing, appropriate grooming, hygiene, and dress for work situations.

(e) Benefits Counseling - Helps consumers examine and understand how employment may impact benefits such as supplemental security income (SSI), social security disability income (SSDI), medical assistance, and other disability-related benefits. May also involve advocacy on behalf of consumers to resolve issues related to their benefits.

(f) Treatment Team Coordination – Involves coordination and contact with treatment team members regarding the provision of evidence-based supported employment services.

(g) Job Development – Involves contacting employers through various activities in order to obtain community-based employment for consumers.

(h) Time Limited Job Coaching – Helps consumers learn job duties once employed through on-the-job training, effective use of community resources, and consultation with the worker's employer, coworkers, family or supervisors as necessary for a maximum of ninety (90) days.

(i) Unlimited Ongoing Job Coaching – Involves the provision of on and off-the-job supports to help a consumer manage his or her illness to achieve personal recovery goals, including employment, and resolve challenges, disruptions, and conflicts in the person's life that negatively impact on the consumer's health and ability to work.

(j) Job Assistance – Involves assisting the consumer with management of mental illness, with requirements of employment, such as teaching and reinforcing previously learned strategies for controlling emotions, focusing on tasks, assertiveness, utilization of coping techniques, socialization, boundary issues, averting crises, and crisis intervention to help prevent symptom exacerbation and minimize disruptions to employment.

(k) Time Unlimited Follow-Along Supports for the consumer and employer which include:

(i) Consumer Follow-Along Supports - including crisis intervention, job coaching, treatment changes, travel training, job support groups, and career counseling.

(ii) Employer Supports – including working with the employer to make reasonable accommodations to enhance job performance, contacting the employer to monitor progress and resolve issues, and working with the employer and consumer to establish effective supervision and feedback strategies.

9c. Employment Specialists who work for DMH certified Supported Employment Program providers, shall:

(1) **Manage** a supported employment caseload of up to twenty (20) consumers.

(2) **Demonstrate** the ability to identify consumer interests, preferences, and abilities and then **help** the consumer obtain employment of their choice.

(3) **Demonstrate** the ability to advocate for consumers.

(4) **Possess** basic knowledge of community marketing and job development.

(5) **Demonstrate** the ability to identify as well as arrange/provide job coaching and long-term supports to help consumers maintain employment.

(6) **Demonstrate** the ability to liaison with the RSA counselors in order to assist consumers in obtaining community-based employment.

(7) **Be trained** by DMH on evidence-based supported employment principles and practices, and **attend** DMH supported employment meetings.

(8) **Carry out** all phases of evidence-based supported employment services as described in Section 9b (3) above.

(9) **Be part of** the consumer's clinical home treatment team and **attend** regular treatment team meetings.

(10) **Document** services on a service note in accordance with Title 22 DCMR Chapter A37; and **ensure** monthly progress note is forwarded to the consumer's clinical home for inclusion in the consumer's clinical record.

9d. The DMH Office of Accountability shall process applications for certification and certify qualified MHRS providers as Supported Employment Program providers in accordance with Title 22 DCMR Chapter A37.

9e. The DMH Office of Programs shall:

(1) **Provide** training, support, and tools for implementing evidence-based supported employment services.

(2) **Conduct** a baseline program evaluation using the Supported Employment Fidelity Scale adopted by DMH (Exhibit 1) within thirty (30) days of the provider's supported employment program start-up, with a second evaluation conducted six (6) months after program start-up. **Conduct** an annual fidelity evaluation thereafter.

(3) **Require** Supported Employment Program providers receiving a fidelity score below 55 to develop a plan of correction and receive technical assistance from DMH Supported Employment Program staff. If the certified Supported Employment Program provider's score does not improve to 55 or higher within six (6) months of the original fidelity score, the provider shall not be eligible for recertification, and may be decertified.

(4) **Collect** supported employment outcome information on a monthly basis from certified Supported Employment Program providers. Core outcome data to be collected includes:

- number of consumers referred and source of referral; number of consumers who were enrolled, served, employed, inactive, referred to RSA, participating in education programs, and receiving employer benefits (health, dental, and retirement);
- average number of hours that consumers worked and average hourly wage paid to consumers;
- locations of employers who have hired consumers;
- number of full—time Employment Specialists; and
- other information that DMH may require.

(5) **Utilize** quality improvement information from a variety of sources, including but not limited to, consumer satisfaction surveys, community services review results, and routine oversight and monitoring activities, in order to monitor consumer satisfaction with supported employment services.

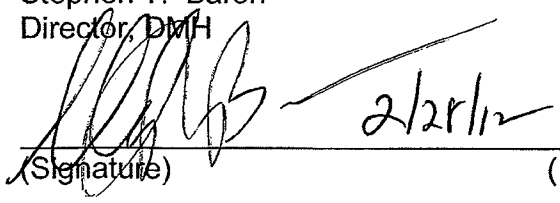
10. **Mandatory Monthly Meetings**. Managers of certified Supported Employment Programs and Employment Specialists must attend monthly mandatory meetings to be held by the DMH supported employment program staff.

11. **Records and Documentation**. Each certified Supported Employment Program provider shall establish and adhere to an Employment Record Policy for employment record documentation, security and confidentiality of consumer information in accordance with Title 22 DCMR Chapter A37, Section 3707.

12. **Inquiries**. Questions related to this policy should be addressed to the DMH, Office of Programs, Supported Employment Program Manager at (202) 673-7597.

Approved By:

Stephen T. Baron
Director, DMH



(Signature) (Date)

SUPPORTED EMPLOYMENT FIDELITY SCALE*

1/7/08

Rater: **Site:** **Date:** **Total Score:**

Directions: Circle one anchor number for each criterion.

Criterion	Data Source**	Anchor
Staffing		
1. Caseload size: Employment specialists have individual employment caseloads. The maximum caseload for any full-time employment specialist is 20 or fewer clients.	MIS, DOC, INT	1= Ratio of 41 or more clients per employment specialist. 2= Ratio of 31-40 clients per employment specialist. 3= Ratio of 26-30 clients per employment specialist. 4= Ratio of 21-25 clients per employment specialist. 5= Ratio of 20 or fewer clients per employment specialist.
2. Employment services staff: Employment specialists provide only employment services.	MIS, DOC INT	1= Employment specialists provide employment services less than 60% of the time. 2= Employment specialists provide employment services 60 - 74% of the time. 3= Employment specialists provide employment services 75 - 89% of the time. 4= Employment specialists provide employment services 90 - 95% of the time. 5= Employment specialists provide employment services 96% or more of the time.

*Formerly called IPS Model Fidelity Scale
**See end of document for key

3. Vocational generalists: Each employment specialist carries out all phases of employment service, including intake, engagement, assessment, job placement, job coaching, and follow-along supports before step down to less intensive employment support from another MH practitioner. (Note: It is not expected that each employment specialist will provide benefits counseling to their clients. Referrals to a highly trained benefits counselor are in keeping with high fidelity, see Item # 1 in "Services".)	MIS, DOC, INT, OBS	1= Employment specialist only provides vocational referral service to vendors and other programs. 2= Employment specialist maintains caseload but refers clients to other programs for vocational services. 3= Employment specialist provides one to four phases of the employment service (e.g. intake, engagement, assessment, job development, job placement, job coaching, and follow along supports). 4= Employment specialist provides five phases of employment service but not the entire service. 5= Employment specialist carries out all six phases of employment service (e.g. program intake, engagement, assessment, job development/job placement, job coaching, and follow-along supports).

ORGANIZATION

1. Integration of rehabilitation with mental health treatment thru team assignment: Employment specialists are part of up to 2 mental health treatment teams from which at least 90% of the employment specialist's caseload is comprised.	MIS, DOC, INT, OBS	1= Employment specialists are part of a vocational program that functions separately from the mental health treatment. 2= Employment specialists are attached to three or more mental health treatment teams. OR Clients are served by individual mental health practitioners who are not organized into teams. OR Employment specialists are attached to one or two teams from which less than 50% of the employment specialist's caseload is comprised. 3= Employment specialists are attached to one or two mental health treatment teams, from which at least 50 - 74% of the employment specialist's caseload is comprised. 4= Employment specialists are attached to one or two mental health treatment teams, from which at least 75 - 89% of the employment specialist's caseload is comprised. 5= Employment specialists are attached to one or two mental health treatment teams, from which 90 - 100% of the employment specialist's caseload is comprised.

2. Integration of rehabilitation with mental health treatment thru frequent team member contact: Employment specialists actively participate in weekly mental health treatment team meetings (not replaced by administrative meetings) that discuss individual clients and their employment goals with shared decision-making. Employment specialist's office is in close proximity to (or shared with) their mental health treatment team members. Documentation of mental health treatment and employment services are integrated in a single client chart. Employment specialists help the team think about employment for people who haven't yet been referred to supported employment services.	MIS, DOC INT, OBS	1= One or none is present. 2= Two are present 3= Three are present. 4= Four are present. 5= Five are present. All five key components are present. • Employment specialist attends weekly mental health treatment team meetings. • Employment specialist participates actively in treatment team meetings with shared decision-making. • Employment services documentation (i.e., vocational assessment/profile, employment plan, progress notes) is integrated into client's mental health treatment record. • Employment specialist's office is in close proximity to (or shared with) their mental health treatment team members. • Employment specialist helps the team think about employment for people who haven't yet been referred to supported employment services.
3. Collaboration between employment specialists and Vocational Rehabilitation counselors: The employment specialists and VR counselors have frequent contact for the purpose of discussing shared clients and identifying potential referrals.	DOC, INT OBS, ISP	1= Employment specialists and VR counselors have client-related contacts (phone, e-mail, in person) less than quarterly to discuss shared clients and referrals. OR Employment specialists and VR counselors do not communicate. 2= Employment specialists and VR counselors have client-related contacts (phone, e-mail, in person) at least quarterly to discuss shared clients and referrals. 3= Employment specialists and VR counselors have client-related contacts (phone, e-mail, in-person) monthly to discuss shared clients and referrals. 4= Employment specialists and VR counselors have scheduled, face-to-face

		meetings at least quarterly, OR have client-related contacts (phone, e-mail, in person) weekly to discuss shared clients and referrals. 5= Employment specialists and VR counselors have scheduled, face-to-face meetings at least monthly and have client-related contacts (phone, e-mail, in person) weekly to discuss shared clients and referrals.
4. Vocational unit: At least 2 full-time employment specialists and a team leader comprise the employment unit. They have weekly client-based group supervision following the supported employment model in which strategies are identified and job leads are shared. They provide coverage for each other's caseload when needed.	MIS, INT, OBS	1= Employment specialists are not part of a vocational unit. 2= Employment specialists have the same supervisor but do not meet as a group. They do not provide back-up services for each other's caseload. 3= Employment specialists have the same supervisor and discuss clients between each other on a weekly basis. They provide back-up services for each other's caseloads as needed. OR, If a program is in a rural area where employment specialists are geographically separate with one employment specialist at each site, the employment specialists meet 2-3 times monthly with their supervisor by teleconference. 4= At least 2 employment specialists and a team leader form an employment unit with 2-3 regularly scheduled meetings per month for client-based group supervision in which strategies are identified and job leads are shared and discuss clients between each other. They provide coverage for each other's caseloads when needed. OR, If a program is in a rural area where employment specialists are geographically separate with one employment specialist at each site, the employment specialists meet 2-3 times per month with their supervisor in person or by teleconference and mental health practitioners are available to help the employment specialist with activities such as taking someone to work or picking up job applications. 5= At least 2 full-time employment specialists and a team leader form an employment unit with weekly client-based group supervision based on the supported employment model in which strategies are identified and job leads are shared. They provide coverage for each other's caseloads when needed.

5. Role of employment supervisor: Supported employment unit is led by a supported employment team leader. Employment specialists' skills are developed and improved through outcome-based supervision. All five key roles of the employment supervisor are present.	MIS, INT, DOC, OBS	1= One or none is present. 2= Two are present. 3= Three are present. 4= Four are present. 5= Five are present. Five key roles of the employment supervisor: • One full-time equivalent (FTE) supervisor is responsible for no more than 10 employment specialists. The supervisor does not have other supervisory responsibilities. (Program leaders supervising fewer than ten employment specialists may spend a percentage of time on other supervisory activities on a prorated basis. For example, an employment supervisor responsible for 4 employment specialists may be devoted to SE supervision half time.) • Supervisor conducts weekly supported employment supervision designed to review client situations and identify new strategies and ideas to help clients in their work lives. • Supervisor communicates with mental health treatment team leaders to ensure that services are integrated, to problem solve programmatic issues (such as referral process, or transfer of follow-along to mental health workers) and to be a champion for the value of work. Attends a meeting for each mental health treatment team on a quarterly basis. • Supervisor accompanies employment specialists, who are new or having difficulty with job development, in the field monthly to improve skills by observing, modeling, and giving feedback on skills, e.g., meeting employers for job development. • Supervisor reviews current client outcomes with employment specialists and sets goals to improve program performance at least quarterly.

6. Zero exclusion criteria: All clients interested in working have access to supported employment services regardless of job readiness factors, substance abuse, symptoms, history of violent behavior, cognition impairments, treatment non-adherence, and personal presentation. These apply during supported employment services too. Employment specialists offer to help with another job when one has ended, regardless of the reason that the job ended or number of jobs held. If VR has screening criteria, the mental health agency does not use them to exclude anybody. Clients are not screened out formally or informally.	DOC, INT OBS	1= There is a formal policy to exclude clients due to lack of job readiness (e.g., substance abuse, history of violence, low level of functioning, etc.) by employment staff, case managers, or other practitioners. 2= Most clients are unable to access supported employment services due to perceived lack of job readiness (e.g., substance abuse, history of violence, low level of functioning, etc.). 3= Some clients are unable to access supported employment services due to perceived lack of job readiness (e.g., substance abuse, history of violence, low level of functioning, etc.). 4= No evidence of exclusion, formal or informal. Referrals are not solicited by a wide variety of sources. Employment specialists offer to help with another job when one has ended, regardless of the reason that the job ended or number of jobs held. 5= All clients interested in working have access to supported employment services. Mental health practitioners encourage clients to consider employment, and referrals for supported employment are solicited by many sources. Employment specialists offer to help with another job when one has ended, regardless of the reason that the job ended or number of jobs held.
7. Agency focus on competitive employment: Agency promotes competitive work through multiple strategies. Agency intake includes questions about interest in employment. Agency displays written postings (e.g., brochures, bulletin boards, posters) about employment and supported employment services. The focus should be with the agency programs that provide services to adults with severe mental illness. Agency supports ways for clients to share work stories with other clients and staff. Agency measures rate of competitive employment and shares this information with agency leadership and staff.	DOC, INT, OBS	1= One or none is present. 2= Two are present. 3= Three are present. 4= Four are present. 5= Five are present. Agency promotes competitive work through multiple strategies: • Agency intake includes questions about interest in employment. • Agency includes questions about interest in employment on all annual (or semi-annual) assessment or treatment plan reviews.

• Agency displays written postings (e.g., brochures, bulletin boards, posters) about working and supported employment services, in lobby and other waiting areas.

• Agency supports ways for clients to share work stories with other clients and staff (e.g., agency-wide employment recognition events, in-service training, peer support groups, agency newsletter articles, invited speakers at client treatment groups, etc.) at least twice a year.

• Agency measures rate of competitive employment on at least a quarterly basis and shares outcomes with agency leadership and staff.

8. <u>Executive team support for SE</u>: Agency executive team members (e.g., CEO/Executive Director, Chief Operating Officer, QA Director, Chief Financial Officer, Clinical Director, Medical Director, Human Resource Director) assist with supported employment implementation and sustainability. All five key components of executive team support are present.	DOC, INT, OBS	1= One is present. 2= Two are present. 3= Three are present. 4= Four are present. 5= Five are present. • Executive Director and Clinical Director demonstrate knowledge regarding the principles of evidence-based supported employment. • Agency QA process includes an explicit review of the SE program, or components of the program, at least every 6 months through the use of the Supported Employment Fidelity Scale or until achieving high fidelity, and at least yearly thereafter. Agency QA process uses the results of the fidelity assessment to improve SE implementation and sustainability. • At least one member of the executive team actively participates at SE leadership team meetings (steering committee meetings) that occur at least every six months for high fidelity programs and at least quarterly for programs that have not yet achieved high fidelity. Steering committee is defined as a diverse group of stakeholders charged with reviewing fidelity, program implementation, and the service delivery system. Committee develops written action plans aimed at developing or sustaining high fidelity services.

• The agency CEO/Executive Director communicates how SE services support the mission of the agency and articulates clear and specific goals for SE and/or competitive employment to all agency staff during the first six months and at least annually (i.e., SE kickoff, all-agency meetings, agency newsletters, etc.). This item is not delegated to another administrator.

• SE program leader shares information about EBP barriers and facilitators with the executive team (including the CEO) at least twice each year. The executive team helps the program leader identify and implement solutions to barriers.

SERVICES

1. Work incentives planning: All clients are offered assistance in obtaining comprehensive, individualized work incentives planning before starting a new job and assistance accessing work incentives planning thereafter when making decisions about changes in work hours and pay. Work incentives planning includes SSA benefits, medical benefits, medication subsidies, housing subsidies, food stamps, spouse and dependent children benefits, past job retirement benefits and any other source of income. Clients are provided information and assistance about reporting earnings to SSA, housing programs, VA programs, etc., depending on the person's benefits.

DOC, INT OBS, ISP

1= Work incentives planning is not readily available or easily accessible to most clients served by the agency.

2= Employment specialist gives client contact information about where to access information about work incentives planning.

3= Employment specialist discusses with each client changes in benefits based on work status.

4= Employment specialist or other MH practitioner offer clients assistance in obtaining comprehensive, individualized work incentives planning by a person trained in work incentives planning prior to client starting a job.

5= Employment specialist or other MH practitioner offer clients assistance in obtaining comprehensive, individualized work incentives planning by a specially trained work incentives planner prior to starting a job. They also facilitate access to work incentives planning when clients need to make decisions about changes in work hours and pay. Clients are provided information and assistance about reporting earnings to SSA, housing programs, etc., depending on the person's benefits.

2. Disclosure: Employment specialists provide clients with accurate information and assist with evaluating their choices to make an informed decision regarding what is revealed to the employer about having a disability.	DOC, INT OBS	1= None is present. 2= One is present. 3= Two are present. 4= Three are present. 5= Four are present. • Employment specialists do not require all clients to disclose their psychiatric disability at the work site in order to receive services. • Employment specialists offer to discuss with clients the possible costs and benefits (pros and cons) of disclosure at the work site in advance of clients disclosing at the work site. Employment specialists describe how disclosure relates to requesting accommodations and the employment specialist's role communicating with the employer. • Employment specialists discuss specific information to be disclosed (e.g., disclose receiving mental health treatment, or presence of a psychiatric disability, or difficulty with anxiety, or unemployed for a period of time, etc.) and offers examples of what could be said to employers. • Employment specialists discuss disclosure on more than one occasion (e.g., if clients have not found employment after two months or if clients report difficulties on the job.)
3. Ongoing, work-based vocational assessment: Initial vocational assessment occurs over 2-3 sessions and is updated with information from work experiences in competitive jobs. A vocational profile form that includes information about preferences, experiences, skills, current adjustment, strengths, personal contacts, etc, is updated with each new job experience. Aims at problem solving using environmental assessments and consideration of reasonable accommodations. Sources of information include the client, treatment team, clinical records, and with	DOC, INT, OBS, ISP	1= Vocational evaluation is conducted prior to job placement with emphasis on office-based assessments, standardized tests, intelligence tests, work samples. 2= Vocational assessment may occur through a stepwise approach that includes: prevocational work experiences (e.g., work units in a day program), volunteer jobs, or set aside jobs (e.g., NISH jobs agency-run businesses, sheltered workshop jobs, affirmative businesses, enclaves). 3= Employment specialists assist clients in finding competitive jobs directly without systematically reviewing interests, experiences, strengths,

the client's permission, from family members and previous employers.		etc. and do not routinely analyze job loss (or job problems) for lessons learned. 4= Initial vocational assessment occurs over 2-3 sessions in which interests and strengths are explored. Employment specialists help clients learn from each job experience and also work with the treatment team to analyze job loss, job problems and job successes. They do not document these lessons learned in the vocational profile, OR The vocational profile is not updated on a regular basis. 5= Initial vocational assessment occurs over 2-3 sessions and information is documented on a vocational profile form that includes preferences, experiences, skills, current adjustment, strengths, personal contacts, etc. The vocational profile form is used to identify job types and work environments. It is updated with each new job experience. Aims at problem solving using environmental assessments and consideration of reasonable accommodations. Sources of information include the client, treatment team, clinical records, and with the client's permission, from family members and previous employers. Employment specialists help clients learn from each job experience and also work with the treatment team to analyze job loss, job problems and job successes.
4. Rapid job search for competitive job: Initial employment assessment and first face-to-face employer contact by the client or the employment specialist about a competitive job occurs within 30 days (one month) after program entry.	DOC, INT, OBS, ISP	1= First face-to-face contact with an employer by the client or the employment specialist about a competitive job is on average 271 days or more (> 9 mos.) after program entry. 2= First face-to-face contact with an employer by the client or the employment specialist about a competitive job is on average between 151 and 270 days (5-9 mos.) after program entry. 3= First face-to-face contact with an employer by the client or the employment specialist about a competitive job is on average between 61 and 150 days (2-5 mos.) after program entry. 4= First face-to-face contact with an employer by the client or the employment specialist about a competitive job is on average between 31 and 60 days (1-2 mos.) after program entry. 5= The program tracks employer contacts and the first face-to-face contact with an employer by the client or the employment specialist about a competitive job is on average within 30 days (one month) after program entry.

5. Individualized job search: Employment specialists make employer contacts aimed at making a good job match based on clients' preferences (relating to what each person enjoys and their personal goals) and needs (including experience, ability, symptomatology, health, etc.) rather than the job market (i.e., those jobs that are readily available). An individualized job search plan is developed and updated with information from the vocational assessment/profile form and new job/educational experiences.	DOC, INT OBS, ISP	1= Less than 25% of employer contacts by the employment specialist are based on job choices which reflect client's preferences, strengths, symptoms, etc. rather than the job market. 2= 25-49% of employer contacts by the employment specialist are based on job choices which reflect client's preferences, strengths, symptoms, etc., rather than the job market. 3= 50-74% of employer contacts by the employment specialist are based on job choices which reflect client's preferences, strengths, symptoms, etc., rather than the job market. 4= 75-89% of employer contacts by the employment specialist are based on job choices which reflect client's preferences, strengths, symptoms, etc., rather than the job market and are consistent with the current employment plan. 5= Employment specialist makes employer contacts based on job choices which reflect client's preferences, strengths, symptoms, lessons learned from previous jobs etc., 90-100% of the time rather than the job market and are consistent with the current employment/job search plan. When clients have limited work experience, employment specialists provide information about a range of job options in the community.
6. Job development - Frequent employer contact: Each employment specialist makes at least 6 face to-face employer contacts per week on behalf of clients looking for work. (Rate for each then calculate average and use the closest scale point.) An employer contact is counted even when an employment specialist meets the same employer more than one time in a week, and when the client is present or not present. Client-specific and generic contacts are included. Employment specialists use a weekly tracking form to document employer contacts.	DOC, INT	1= Employment specialist makes less than 2 face-to-face employer contacts that are client-specific per week. 2= Employment specialist makes 2 face-to-face employer contacts per week that are client-specific, OR Does not have a process for tracking. 3= Employment specialist makes 4 face-to-face employer contacts per week that are client-specific, and uses a tracking form that is reviewed by the SE supervisor on a monthly basis. 4= Employment specialist makes 5 face-to-face employer contacts per week that are client-specific, and uses a tracking form that is reviewed by the SE supervisor on a weekly basis.

		5= Employment specialist makes 6 or more face-to-face employer contacts per week that are client specific, or 2 employer contacts times the number of people looking for work when there are less than 3 people looking for work on their caseload (e.g., new program). In addition, employment specialist uses a tracking form that is reviewed by the SE supervisor on a weekly basis.
7. Job development - Quality of employer contact: Employment specialists build relationships with employers through multiple visits in person that are planned to learn the needs of the employer, convey what the SE program offers to the employer, describe client strengths that are a good match for the employer. (Rate for each employment specialist, then calculate average and use the closest scale point.)	DOC, INT, OBS	1= Employment specialist meets employer when helping client to turn in job applications, OR Employment specialist rarely makes employer contacts. 2= Employment specialist contacts employers to ask about job openings and then shares these "leads" with clients. 3= Employment specialist follows up on advertised job openings by introducing self, describing program, and asking employer to interview client. 4= Employment specialist meets with employers in person whether or not there is a job opening, advocates for clients by describing strengths and asks employers to interview clients. 5= Employment specialist builds relationships with employers through multiple visits in person that are planned to learn the needs of the employer, convey what the SE program offers to the employer, describe client strengths that are a good match for the employer.
8. Diversity of job types: Employment specialists assist clients in obtaining different types of jobs.	DOC, INT, OBS, ISP	1= Employment specialists assist clients obtain different types of jobs less than 50% of the time. 2= Employment specialists assist clients obtain different types of jobs 50-59% of the time. 3= Employment specialists assist clients obtain different types of jobs 60-69% of the time. 4= Employment specialists assist clients obtain different types of jobs70-84% of the time.

		5= Employment specialists assist clients obtain different types of jobs 85-100% of the time.
9. Diversity of employers: Employment specialists assist clients in obtaining jobs with different employers.	DOC, INT, OBS, ISP	1= Employment specialists assist clients obtain jobs with the different employers less than 50% of the time. 2= Employment specialists assist clients obtain jobs with the same employers 50-59% of the time. 3= Employment specialists assist clients obtain jobs with different employers 60-69% of the time. 4= Employment specialists assist clients obtain jobs with different employers 70-84% of the time. 5= Employment specialists assist clients obtain jobs with different employers 85-100% of the time.
10. Competitive jobs: Employment specialists provide competitive job options that have permanent status rather than temporary or time-limited status, e.g., TE (transitional employment positions). Competitive jobs pay at least minimum wage, are jobs that anyone can apply for and are not set aside for people with disabilities. (Seasonal jobs and jobs from temporary agencies that other community members use are counted as competitive jobs.)	DOC, INT, OBS, ISP	1= Employment specialists provide options for permanent, competitive jobs less than 64% of the time, OR There are fewer than 10 current jobs. 2= Employment specialists provide options for permanent, competitive jobs about 65- 74% of the time. 3= Employment specialists provide options for permanent competitive jobs about 75-84%% of the time. 4= Employment specialists provide options for permanent competitive jobs about 85-94% of the time. 5= 95% or more competitive jobs held by clients are permanent.

11. <u>Individualized follow-along supports</u>: Clients receive different types of support for working a job that are based on the job, client preferences, work history, needs, etc. Supports are provided by a variety of people, including treatment team members (e.g., medication changes, social skills training, encouragement), family, friends, co-workers (i.e., natural supports), and employment specialist. Employment specialist also provides employer support (e.g., educational information, job, accommodations) at client's request. Employment specialist offers help with career development, i.e., assistance with education, a more desirable job, or more preferred job duties.	DOC, INT, OBS, ISP	1= Most clients do not receive supports after starting a job. 2= About half of the working clients receive a narrow range of supports provided primarily by the employment specialist. 3= Most working clients receive a narrow range of supports that are provided primarily by the employment specialist. 4= Clients receive different types of support for working a job that are based on the job, client preferences, work history, needs, etc. Employment specialists provide employer supports at the client's request. 5= Clients receive different types of support for working a job that are based on the job, client preferences, work history, needs, etc. Employment specialist also provides employer support (e.g., educational information, job accommodations) at client's request. The employment specialist helps people move onto more preferable jobs and also helps people with school or certified training programs. The site provides examples of different types of support including enhanced supports by treatment team members.
12. <u>Time-unlimited follow-along supports</u>: Employment specialists have face-to-face contact within 1 week before starting a job, within 3 days after starting a job, weekly for the first month, and at least monthly for a year or more, on average, after working steadily, and desired by clients. Clients are transitioned to step down job supports from a mental health worker following steady employment. Employment specialists contact clients within 3 days of learning about the job loss.	DOC, INT, OBS, ISP	1= Employment specialist does not meet face-to-face with the client after the first month of starting a job. 2= Employment specialist has face-to-face contact with less than half of the working clients for at least 4 months after starting a job. 3= Employment specialist has face-to-face contact with at least half of the working clients for at least 4 months after starting a job. 4= Employment specialist has face-to-face contact with working clients weekly for the first month after starting a job, and at least monthly for a year or more, on average, after working steadily, and desired by clients. 5= Employment specialist has face-to-face contact within 1 week before starting a job, within 3 days after starting a job, weekly for the first month, and at least monthly for a year or more, on average, after working steadily and desired by clients. Clients are transitioned to step down job supports, from a mental health worker following steady employment clients. Clients are transitioned to step down job supports from a mental health worker following steady employment.

		Employment specialist contacts clients within 3 days of hearing about the job loss.
13. Community-based services: Employment services such as engagement, job finding and follow-along supports are provided in natural community settings by all employment specialists. (Rate each employment specialist based upon their total weekly scheduled work hours then, calculate the average and use the closest scale point.)	DOC, INT OBS	1= Employment specialist spends 30% time or less in the scheduled work hours in the community. 2= Employment specialist spends 30 - 39% time of total scheduled work hours in the community. 3= Employment specialist spends 40 -49% of total scheduled work hours in the then community. 4= Employment specialist spends 50 - 64% of total scheduled work hours in the community. 5= Employment specialist spends 65% or more of total scheduled work hours in the community.
14. Assertive engagement and outreach by integrated treatment team: Service termination is not based on missed appointments or fixed time limits. Systematic documentation of outreach attempts. Engagement and outreach attempts made by integrated team members. Multiple home/community visits. Coordinated visits by employment specialist with integrated team member. Connect with family, when applicable. Once it is clear that the client no longer wants to work or continue SE services, the team stops outreach.	MIS, DOC, INT, OBS	1= Evidence that 2 or less strategies for engagement and outreach are used. 2= Evidence that 3 strategies for engagement and outreach are used. 3= Evidence that 4 strategies for engagement and outreach are used. 4= Evidence that 5 strategies for engagement and outreach are used. 5= Evidence that all 6 strategies for engagement and outreach are used: i) Service termination is not based on missed appointments or fixed time limits. ii) Systematic documentation of outreach attempts. iii) Engagement and outreach attempts made by integrated team members. iv) Multiple home/community visits. v) Coordinated visits by employment specialist with integrated team member. vi) Connect with family, when applicable.

*Data sources:

MIS	Management Information System
DOC	Document review: clinical records, agency policy and procedures
INT	Interviews with clients, employment specialists, mental health staff, VR counselors, families, employers
OBS	Observation (e.g., team meeting, shadowing employment specialists)
ISP	Individualized Service Plan

2/14/96
6/20/01, Updated
1/7/08, Revised

Supported Employment Fidelity Scale Score Sheet

Staffing		
1.	Caseload size	Score:
2.	Employment services staff	Score:
3.	Vocational generalists	Score:
Organization		
1.	Integration of rehabilitation with mental health thru team assignment	Score:
2.	Integration of rehabilitation with mental health thru frequent team member contact	Score:
3.	Collaboration between employment specialists and Vocational Rehabilitation counselors	Score:
4.	Vocational unit	Score:
5.	Role of employment supervisor	Score:
6.	Zero exclusion criteria	Score:
7.	Agency focus on competitive employment	Score:
8.	Executive team support for SE	Score:
Services		
1.	Work incentives planning	Score:
2.	Disclosure	Score:
3.	Ongoing, work-based vocational assessment	Score:
4.	Rapid search for competitive job	Score:
5.	Individualized job search	Score:
6.	Job development—Frequent employer contact	Score:
7.	Job development—Quality of employer contact	Score:
8.	Diversity of job types	Score:
9.	Diversity of employers	Score:
10.	Competitive jobs	Score:
11.	Individualized follow-along supports	Score:
12.	Time-unlimited follow-along supports	Score:
13.	Community-based services	Score:
14.	Assertive engagement and outreach by integrated treatment team	Score:
	Total:	

115 – 125	= Exemplary Fidelity
100 - 114	= Good Fidelity
74 – 99	= Fair Fidelity
73 and below	= Not Supported Employment

Department of Mental Health

TRANSMITTAL LETTER

SUBJECT Continuity of Care Practice Guidelines for Adult Mental Health Providers		
POLICY NUMBER **DMH Policy 200.2A**	DATE JAN 17 2012	TL# 159

Purpose. To update the guidelines for the continuity of care between providers of mental health services and supports to Department of Mental Health (DMH) adult consumers.

Applicability. Applies to Core Services Agencies (CSAs), Assertive Community Treatment (ACT) providers, Saint Elizabeths Hospital, community hospitals, Crisis Emergency Providers, the Mental Health Authority; and all other providers who have an agreement or contract with DMH or with certified providers regarding provision of services for DMH adult consumers.

Policy Clearance. Reviewed by affected responsible staff and cleared through appropriate MHA offices.

Implementation Plans. **A plan of action to implement or adhere to this policy must be developed by designated responsible staff. If materials and/or training are required to implement this policy, these requirements must be part of the action plan. Specific staff should be designated to carry out the implementation and program managers are responsible for following through to ensure compliance. Action plans and completion dates should be sent to the appropriate authority. Contracting Officer Technical Representatives (COTRs) must also ensure that contractors are informed of this policy if it is applicable or pertinent to their scope of work. *Implementation of all DMH policies shall begin as soon as possible. Full implementation of this policy shall be completed within sixty (60) days after the date of this policy.***

Policy Dissemination and Filing Instructions. Managers/supervisors of DMH and DMH contractors must ensure that staff are informed of this policy. Each staff person who maintains policy manuals must ensure that this policy is filed in the **DMH** Policy and Procedures Manual, and contractors must ensure that this policy is maintained in accordance with their internal procedures.

ACTION

REMOVE AND DESTROY	INSERT
DMH Policy 200.2	DMH Policy 200.2A

1/17/12

Stephen T. Baron
Director, DMH

EXHIBIT B

GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF MENTAL HEALTH	Policy No. 200.2A	Date JAN 17 2012	Page 1
	Supersedes: DMH Policy 200.2 Continuity of Care, dated July 25, 2002		

Subject: Continuity of Care Practice Guidelines for Adult Mental Health Providers

1. **Purpose**. To establish specific guidelines to ensure continuity of care between providers of mental health services and supports to Department of Mental Health (DMH) adult consumers.

2. **Applicability**. Applies to Core Services Agencies (CSAs), Assertive Community Treatment (ACT) providers, Saint Elizabeths Hospital, community hospitals, Crisis Emergency Providers, the Mental Health Authority; and all other providers who have an agreement or contract with DMH or certified providers regarding provision of services for DMH adult consumers.

3. **Authority**. Department of Mental Health Establishment Amendment Act of 2001.

4. **Definitions/Abbreviations**. For purposes of this policy:

4a. DMH Continuity of Care Practice Guidelines for Adult Providers in the Mental Health System of Care - guidelines that describe the responsibilities and actions of providers and DMH in response to adult consumers who seek or receive urgent or emergency mental health treatment and supports and/or transfer, or who are discharged to different levels of care within the mental health system.

4b. Mental Health Provider- referred to in this policy as provider, is: (a) any individual or entity, public or private, that is licensed or certified by the District of Columbia to provide mental health services or mental health supports; (b) any individual or entity, public or private, that has entered into an agreement with DMH to provide mental health services or mental health supports; or (c) Saint Elizabeths Hospital.

4c. Community Hospitals - private hospitals in the District of Columbia that have arrangements with the DMH for provision of services to DMH consumers.

4d. Crisis Emergency Provider – A provider certified by DMH to provide crisis emergency services or who has contracted with DMH to provide same. This provider may be part of a CSA or may be a separate entity. The provider is accessible twenty-four hours per day, seven days per week (24/7) to offer crisis intervention to callers who are in crisis to dispatch mobile crisis services, and to assist all persons in the District who may need emergency mental health care.

5. **Policy**. To ensure continuity of care, all providers will follow the DMH adult continuity of care practice guidelines in the provision of services to adult consumers of mental health treatment in the District of Columbia.

6. **Responsibilities for DMH**. DMH shall:

6a. **Issue** the continuity of care practice guidelines to all newly certified providers who provide services and supports to adults;

6b. **Notify** providers of all changes to the continuity of care practice guidelines as soon as the changes become effective; and

6c. **Monitor** treatment and care in compliance with the adult continuity of care practice guidelines, and take appropriate action where necessary.

7. **Specific Guidance for All Adult Mental Health Providers**.

7a. **Utilize** the DMH Continuity of Care Practice Guidelines for Adult Providers in the Mental Health System of Care (Exhibit 1) for urgent, emergency, transfer, and admission and discharge situations when an adult consumer:

(2) is assigned to the provider via the Access Helpline;

(3) presents for treatment at a crisis emergency provider;

(4) presents for treatment at a CSA or ACT Provider;

(5) is referred to a crisis bed;

(6) is admitted to or discharged from a community hospital;

(7) is admitted to or discharged from Saint Elizabeths Hospital;

(8) transfers to another CSA; and

(9) is incarcerated in the D.C. Jail.

7b. **Link** the adult consumer to resources that are most relevant to the consumer's identified needs. The provider shall link the consumer to these services, rather than having the consumer locate their own services; and

7c. **Be Familiar** with the adult continuity of care practice guidelines to ensure continuity of care.

Approved By:

Stephen T. Baron
Director, DMH

(Signature) **(Date)**

District of Columbia Department of Mental Health
Continuity of Care Practice Guidelines for
ADULT Providers in the Mental Health System of Care

These guidelines outline the responsibilities of the District of Columbia Department of Mental Health (hereafter called DMH) system of care providers for adult consumers.

The following sections describe the responsibilities and actions of providers and the DMH Division of Care Coordination Access Helpline in response to adult consumers who seek or receive urgent or emergency mental health treatment and supports and/or transfer to different levels of care within the mental health system of care. The outline below describes the structure of these guidelines:

1. Crisis Response, Urgent and Emergency Care
   - 1A. Contacting the DMH Access Helpline (AHL)
   - 1B. Presentation to Providers who are a CEP
   - 1C. Presentation at Providers who are a CSA or ACT Provider

2. Continuity of Care Upon Involuntary Admission to a Community Acute Care Facility
   - 2A. If the Consumer has a CSA/ACT Provider
   - 2B. If the Consumer has no CSA and is Eligible for CSA Enrollment
   - 2C. Responsibilities of the Community Acute Care Facility
   - 2D. Transfer from a Community Acute Care Facility to Saint Elizabeths Hospital

3. Continuity of Care for Forensic and Criminal Justice involved Consumers (including those who are pre-trial, serving a sentence either in a correctional institution or psychiatric facility).
   - 3A. Inmates who are Enrolled in a CSA/ACT Provider
   - 3B. Inmates who are not Enrolled in a CSA

4. Continuity of Care Upon Admission to Saint Elizabeths Hospital
   - 4A. If the Consumer is not Enrolled in a CSA
   - 4B. If the Consumer has a CSA/ACT Provider
   - 4C. Responsibilities of Saint Elizabeths Hospital

5. Continuity of Care Upon Admission to a Crisis Bed
   - 5A. Referral to a Crisis Bed
   - 5B. If the Crisis is not Resolved within 48 Hours
   - 5C. If Medical Necessity is Met
   - 5D. If Medical Necessity is not Met or Resolved
   - 5E. Notice of Unplanned Discharge

6. Continuity of Care for any CSA Transfer/Change
   - 6A. Right to Change a CSA
   - 6B. Responsibilities upon Knowledge of Consumer's Intent to Transfer or Change CSA.

7. Monitoring

8. Definitions

District of Columbia Department of Mental Health
Continuity of Care Practice Guidelines for
***ADULT* Providers in the Mental Health System of Care**

The provider shall adhere to DMH clinical policies, including DMH Policy 311.1, D.C. Medication Access Project (DCMAP); DMH Policy 300.1C, Level of Care Utilization System (LOCUS/CALOCUS) Evaluations; and DMH Policy 645.1, DMH Privacy Policies and Procedures. All consumer information is subject to the Health Insurance Portability and Accountability Act (HIPAA) and the Mental Health Information Act (MHIA) protections.

District of Columbia Department of Mental Health
Continuity of Care Practice Guidelines for
ADULT Providers in the Mental Health System of Care

1. Crisis Response, Urgent and Emergency Care.

Consumers in crisis may seek or be presented for treatment at several different locations. The provider's crisis response shall be consistent with the provider's role for that consumer, based on that consumer's need at that time, as described below:

1A. Contacting the DMH Access HelpLine (AHL):

When a consumer, family member, or other individual or entity contacts the AHL for a person in crisis, the AHL staff will complete a telephonic risk assessment.

1. When the consumer's needs are identified as urgent or emergency, AHL will respond as follows:

   a. If consumer has a CSA/ACT Provider, AHL staff will contact the CSA/ACT Provider, unless immediately calling 911 or crisis emergency provider is indicated upon determination that the consumer is likely to injure self or others due to his/her mental illness.

      i. If no response from CSA/ACT Provider within thirty (30) minutes, contact CSA/ACT Provider again.

      ii. If no response from CSA/ACT Provider within two (2) hours from first contact (or sooner based on assessed need), contact the CSA/ACT Provider senior administrator or designee or on call staff.

      iii. In the absence of a CSA/ACT Provider response, AHL staff may deploy a Crisis Emergency Provider.

   b. If consumer does not have a CSA/ACT Provider, AHL will contact a Crisis Emergency Provider, unless immediately calling 911 is indicated upon determination that the consumer is likely to injure self or others.

2. AHL staff will document the planned action in the electronic management system.

District of Columbia Department of Mental Health
Continuity of Care Practice Guidelines for
ADULT Providers in the Mental Health System of Care

1B. Presentation to Providers who are a Crisis Emergency Provider:
(See Section 8 for definition of Crisis Emergency Provider)

A consumer may present directly to a Crisis Emergency Provider or may be linked by Access Helpline (AHL). If the consumer presents directly to a Crisis Emergency Provider, the Crisis Emergency Provider **MUST** contact AHL.

1. Whenever a consumer is treated at any Crisis Emergency Provider, the consumer will receive the following services before any disposition or outcome:

a. If consumer has a CSA/ACT Provider, the Crisis Emergency Provider will contact the CSA/ACT Provider to notify them that one of their consumers is presenting for services, obtain previous treatment history, and notify AHL. The AHL or Crisis Emergency Provider will request CSA/ACT Provider face to face response, unless immediately calling 911 is indicated upon determination that the consumer is likely to injure self or others.

i. If no response within thirty (30) minutes, contact the CSA/ACT Provider again.

ii. If no response within two (2) hours (or sooner based on assessed need), the Crisis Emergency Provider should notify the AHL for follow-up with CSA/ACT Provider.

iii. Crisis Emergency Provider should provide services in accordance with subsections 2 and 3 below, as applicable.

b. If consumer has no CSA/ACT Provider:

- Crisis Emergency Provider should provide services in accordance with subsections 2 and 3 below, as applicable.
- The Crisis Emergency Provider will also offer the consumer linkage to a CSA through the consumer choice process and if agreeable, assist the eligible consumer with calling AHL to enroll in a CSA. The Crisis Emergency Provider will also assist with arranging a CSA emergency or urgent need intake appointment as part of the Crisis Emergency Provider treatment discharge planning.

2. Consumers who meet criteria for emergency need or who have an FD-12, Application for Emergency Hospitalization, for involuntary treatment assessment must be seen by the Crisis Emergency Provider within one (1) hour. An assessment must be conducted and include a mental status examination, screening for suicide or homicidal ideations, and assessment of inpatient treatment need. This contact will be required for admission to a facility. Admission to an acute care facility may proceed if a Crisis Emergency Provider physician or qualified psychologist recommends admission based on medical necessity.

3. Consumers who meet criteria for urgent need for mental health services will have an assessment including mental status examination, and screening for suicide or homicidal ideation. The Crisis Emergency Provider will complete a crisis plan to address the current situation and provide it to the consumer and assigned CSA/ACT provider. If the consumer is not linked to a CSA/ACT Provider and is eligible for MHRS, the Crisis Emergency Provider will contact AHL to assist the consumer with enrollment to a CSA for ongoing services and supports.

If the consumer is a resident of the District of Columbia, the consumer shall be referred to a private mental health provider or enrolled in a CSA of their choice, as applicable. If the consumer is not a resident of the District of Columbia, contact must be made (or attempted) with the mental health authority representatives in the consumer's home jurisdiction and/or the consumer's designated family/friend.

1C. Presentation at Providers who are Core Services Agency (CSA)/Assertive Community Treatment (ACT) Provider:

When a consumer presents in crisis at a CSA/ACT Provider, that provider will:

1. Provide any needed emergency care to stabilize immediate life threatening situations, which may include but is not limited to calling 911, and then refer consumer for further treatment based on their knowledge of that consumer's status.

2. Use these practice guidelines and/or LOCUS screening to indicate level of acuity and service needs.

3. If the consumer is enrolled with the CSA/ACT Provider and the consumer meets the guidelines for urgent or emergency need, initiate appropriate clinical intervention based on the assessed needs of the consumer.

4. If the consumer is not in active treatment with that CSA/ACT Provider, the CSA/ACT Provider may call AHL to request crisis emergency services.

2. Continuity of Care Upon Involuntary Admission to a Community Acute Care Facility.

AHL will authorize involuntary admission, inform the acute care facility of the consumer's assigned CSA/ACT Provider, and immediately notify the assigned CSA/ACT Provider of the admission. Upon admission to an acute care facility (referred to as facility) the protocol below will be followed.

A DMH Care Manager will be assigned to coordinate the continuity of care between the CSA/ACT Provider and the acute care facility.

2A. If the Consumer has a Core Services Agency (CSA)/Assertive Community Treatment (ACT) Provider:

1. The acute care facility will communicate with the consumer's CSA/ACT Provider within one (1) day of admission. Communication will include discussion of the consumer's psychosocial history, IRP, treatment course history, and medication history.

2. The CSA/ACT Provider will have face to face contact with the consumer and designated acute care facility staff within two (2) days of notification of admission. That contact will include the initial treatment team meeting to establish discharge planning with the consumer and the facility treatment team.

3. During the time of treatment in the acute care facility, the CSA/ACT Provider shall:

   a. Ensure LOCUS screenings are performed at appropriate intervals to indicate level of acuity and appropriate service needs;

   b. Have face to face contact with consumer and facility treatment team at least once a week during the entire length of stay at the facility; and

   c. Notify significant others as noted on the IRP and in the advanced instructions the same day of notification of admission if possible, but no later than the following day or as directed in the consumer's IRP/advanced instructions.

4. CSA/ACT Provider will maintain progress notes in the consumer's clinical record, reflecting all meetings and communications with facility staff, the consumer, and all significant others. If appropriate the CSA/ACT Provider treating psychiatrist will consult telephonically or in person with the acute care facility treating psychiatrist.

5. The CSA/ACT Provider will participate in the development of an appropriate discharge plan with the consumer and acute care facility staff. Discharge planning must be documented in the consumer's clinical record and include:

   a. A face to face appointment between the CSA/ACT Provider and the consumer, within seven (7) days of the consumer's discharge from facility to the community;

   b. A scheduled medication somatic appointment for all consumers on psychotropic medications with the CSA/ACT Provider within ten (10) days of discharge; and

   c. Evidence of an attempt to address the consumer's individual needs including benefits acquisition, and housing, as applicable.

2B. If Consumer has no Core Services Agency (CSA) and is Eligible for CSA Enrollment:

1. If the consumer is not a resident of the District of Columbia, contact must be made (or attempted) with the mental health authority representatives in the consumer's home jurisdiction and/or the consumer's designated family/friend to gain collateral information including psychosocial history, treatment course history, and medication history.

2. If eligible for CSA enrollment, the AHL staff will enroll the consumer with a CSA if the consumer is able and willing to have a telephone conversation. This will be done through the consumer choice process. If the consumer is unable or unwilling to have this telephone contact, a CSA will be randomly assigned.

- If random CSA assignment occurs, the CSA will be responsible for ensuring that the choice menu form is completed when the consumer is more stable, and filed in the consumer's clinical record.

3. The AHL will notify the assigned CSA of admission of the consumer and their enrollment to the CSA.

4. The CSA will have face-to-face contact at the acute care facility with the consumer within two (2) days of the consumer being assigned to that CSA to work with the acute care facility to develop an appropriate discharge plan.

5. Discharge planning/documentation must include:

a. A face to face appointment between the CSA and the consumer, within seven (7) days of the consumer's discharge from facility to the community;

b. A scheduled medication somatic appointment for all consumers on psychotropic medications with the CSA within ten (10) days of discharge;

c. LOCUS screening to indicate level of acuity and appropriate service needs; and

d. Evidence of an attempt to address the consumer's individual needs including benefits acquisition, and housing, as applicable.

2C. Responsibilities of the Community Acute Care Facility:

Upon admission, the acute care facility will communicate with the consumer's CSA/ACT Provider within one (1) day of admission and will perform the following responsibilities for the consumer's continuity of care. Acute care facilities have additional responsibilities, such as those imposed by District and federal laws including the Ervin Act, to include coordination with the Office of the Attorney General (OAG) Mental Health Section, and

completion of necessary legal forms (such as Form 522, 541, and 5-day letter for the return of committed patients).

1. The acute care facility will schedule an initial treatment team meeting to be held within two (2) days of admission to the facility, and document invitation of a CSA/ACT Provider representative.

2. The acute care facility staff will ensure the consumer is invited to all treatment team meetings, and every discharge planning meeting. The acute care facility staff must document in the consumer's clinical record each time an attempt was made to include the consumer for every date where a consumer did not attend.

3. The acute care facility shall notify the CSA/ACT Provider, the assigned DMH Care Manager, and the OAG Mental Health Section immediately of any transfer, request for discharge against medical advice, or unplanned discharge.

4. Prior to converting an involuntary consumer to a voluntary status, the acute care facility must ensure they are in compliance with DMH Policy 303.3, Converting Civilly Committed Consumers to Voluntary.

5. At discharge, the acute care facility will provide a prescription or enough medication for the consumer until the next scheduled medication somatic appointment scheduled at their CSA/ACT Provider, or as determined in the discharge planning process.

6. The acute care facility will provide the CSA/ACT provider a discharge summary upon discharge.

2D. Transfer from a Community Acute Care Facility to Saint Elizabeths Hospital:

1. If an involuntary adult consumer needs to be transferred to Saint Elizabeths Hospital, the assigned DMH Care Manager will authorize the transfer.

2. If the consumer is authorized to be transferred from a community acute care facility to Saint Elizabeths Hospital, the CSA/ACT Provider will communicate with the Saint Elizabeths Hospital staff within one (1) day after transfer.

3. Once transferred, the CSA/ACT Provider will have face to face contact with the consumer and the Saint Elizabeths Hospital staff within two (2) days after transfer.

- Communication with the Saint Elizabeths Hospital staff will include discussion of the consumer's psychosocial history, IRP, treatment course history, medication history, and scheduling of initial treatment team meeting with staff to include appropriate discharge planning.

3. Continuity of Care for Forensic and Criminal Justice Involved Consumers.

Consumers on Pre-Trial Status. CSA/ACT Providers with consumers on pre-trial status will be expected to communicate with the DMH Court Liaison or the appropriate supervision agency.

CSA/ACT Providers with Consumers Ordered to Competency Restoration (on an in or outpatient basis) will be required to provide information and coordinate care with the competency restoration staff either at the DMH Mental Health Services Division (MHSD) or at Saint Elizabeths Hospital.

Consumers who are not linked to CSA/ACT Providers may request to be enrolled with a CSA through AHL with support from a variety of court personnel or supervision staff.

Consumers Incarcerated in Jail or Prison. The DMH Jail Liaison shall be responsible for linking all referred mental health or mentally ill adult jail inmates to a CSA. There are no restrictions for referrals to the DMH Jail Liaison. The DMH Jail Liaison shall be responsible for facilitating the continuity of care process with the CSA.

3A. Inmates who are Enrolled in a Core Services Agency (CSA)/ACT Provider:

1. The DMH Forensic Services staff shall notify the CSA/ACT Provider of the consumer's incarceration.

2. The CSA/ACT Provider shall schedule a tentative appointment with the DMH Jail Liaison to see the consumer and shall provide information to the mental health staff of the Department of Corrections (DOC) related to the inmate's diagnosis, medication and treatment.

3. The DMH Jail Liaison prepares a list on a regular basis of staff from DMH CSAs and ACT teams for the DOC who are approved to enter the D.C. Jail. For those CSA/ACT Provider staff not already on the list, the DMH Jail Liaison shall prepare a written request to the Jail Deputy Warden for Programs for the CSA/ACT Provider staff to visit the inmate.

   a. The CSA/ACT Provider staff shall report to the D.C. Jail main entrance for an escort.

   b. All visitors shall be required to go through the D.C. Jail security check.

4. The CSA/ACT Provider, with input from the D.C. Jail mental health staff, shall complete a LOCUS evaluation upon initial assessment of the inmate and prior to release if notified. The CSA/ACT Provider shall conduct an assessment of the inmate's needs to determine the status of support and services required or in place for the consumer when they are released from jail.

5. The CSA/ACT Provider shall develop a discharge plan to meet the psychosocial needs upon release to the community that will address housing, benefits, and other follow-up requirements, and as necessary, complete applications for benefits and housing.

- The discharge plan shall include criminal justice staff and family members (as applicable and available) involved in the consumer's care, treatment, and services.

6. The DMH Jail Liaison shall notify the CSA/ACT Provider of the court hearing date as soon as possible. The CSA/ACT Provider shall participate in the court hearing process.

7. The DMH Jail Liaison shall notify the CSA/ACT Provider of the consumer's release date and obtain an appointment date for the inmate to see the CSA/ACT Provider within seven (7) days of release from jail.

8. The Department of Corrections shall at the time of release provide written discharge instructions in a form that the consumer can understand. Information shall include the name of the CSA/ACT contact, telephone number, address of the CSA/ACT Provider, and appointment date.

3B. Inmates who are not Enrolled in a Core Services Agency (CSA):

The DMH Jail Liaison shall facilitate the referral of mentally ill inmates who are not enrolled in a CSA who are in need of and/or request services.

1. The DMH Jail Liaison shall screen and provide information regarding the various CSAs.

a. The DMH Jail Liaison shall contact the DMH Access Helpline (AHL) and the CSA to enroll the inmate in a CSA. For situations where the inmate has had multiple jail admissions without connection to a CSA, the DMH Jail Liaison may refer to the D.C. Linkage program.

b. In all situations, a CSA contact person shall be assigned to the inmate.

c. The CSA contact person shall schedule a tentative appointment with the DMH Jail Liaison to see the consumer at the D.C. Jail.

2. The DMH Jail Liaison shall prepare a written request to the Jail Deputy Warden for Programs for the CSA contact person to visit the inmate.

3. After the tentative appointment has been scheduled, the DMH Jail liaison and CSA contact person should follow the same procedures outlined in Section 3A2 – 3A7.

4. Continuity of Care Upon Admission to Saint Elizabeths Hospital.

All individuals admitted to Saint Elizabeths Hospital under a civil admission will be assigned to a CSA if not already enrolled. Saint Elizabeths Hospital will be responsible for finding out if the individual is currently assigned to a CSA/ACT Provider.

4A. **If the consumer is not already enrolled,** the AHL staff will enroll a consumer with a CSA.

- If the consumer is able and willing to have a telephone conversation, this will be done through the consumer choice process.
- If the consumer is unable or unwilling to have this telephone contact, a CSA will be assigned randomly to the consumer, first by home location, then by location of consumer at time of crisis (e.g., shelter, street).
- If random CSA assignment occurs, the CSA will be responsible for ensuring that the choice menu form is completed when consumer is more stable, and filed in the consumer's clinical record.
- The AHL will notify the assigned CSA of admission of consumer and their enrollment to CSA.

4B. **If the Consumer has a CSA/ACT Provider:**

1. Saint Elizabeths Hospital shall be responsible for communicating with the consumer's CSA/ACT Provider within one (1) day of admission.

2. The CSA/ACT Provider shall arrange for a face to face contact with the consumer and designated Saint Elizabeths Hospital staff. Face to face contact should occur within two (2) days of admission.

- Communication with designated Saint Elizabeths Hospital staff will include discussion of the consumer's psychosocial history and IRP, treatment course history, medication history, and scheduling of initial treatment team meeting with Saint Elizabeths Hospital staff, to be held within five (5) days of admission.

3. During the time of treatment in Saint Elizabeths Hospital, the CSA/ACT Provider shall:

a. Have face to face contact with consumer and staff at a minimum of once a week for the first thirty (30) days of stay at Saint Elizabeths Hospital.

b. Have face to face contact with the consumer and staff at least once a month for subsequent lengths of stay at Saint Elizabeths Hospital and attend all treatment team meetings.

c. Make contact with significant others as noted on the IRP and in the advanced instructions to notify of admission the same day of admission, if possible, and no later than the following day or as directed in the consumer's IRP advanced instructions.

d. The CSA/ACT Provider, in conjunction with the Saint Elizabeths Hospital treatment team, shall also complete LOCUS evaluations at appropriate intervals.

4. The CSA/ACT Provider will develop discharge planning with consumer and staff.

5. CSA/ACT Provider will maintain progress notes in the Saint Elizabeths Hospital clinical records and at the CSA/ACT Provider, reflecting all meetings and communications with staff, the consumer, and all significant others. If necessary the CSA/ACT provider treating psychiatrist will consult telephonically or in person with the Saint Elizabeths Hospital treating psychiatrist.

6. CSA/ACT Provider will participate in the Saint Elizabeths Hospital discharge planning process in order to affect a discharge that encourages successful community tenure. In addition, discharge planning and documentation must include:

a. A scheduled medication somatic appointment for all consumers on psychotropic medications with the CSA/ACT Provider within ten (10) days of discharge.

b. A face to face meeting between the CSA/ACT Provider, and the consumer, within seven (7) days of the consumer's discharge from Saint Elizabeths Hospital to the community.

c. Evidence of plans to address the consumer's individual needs including benefits acquisition and housing, and if applicable, discussion of legal status and hearing schedule to determine contingency plans based on possible court decisions and plans on coordinating care with the forensic outpatient division during community tenure, as applicable.

d. For consumers who have a forensic legal status, the court date must be treated as a discharge date from the hospital, and the CSA/ACT Provider is expected to attend each scheduled court date.

e. For consumers who are Not Guilty by Reason of Insanity (NGRI), linkage to appropriate providers will be in accordance with their court order.

4C. Responsibilities of Saint Elizabeths Hospital:

1. Saint Elizabeths Hospital will schedule the initial treatment planning meeting to be held within five (5) days of admission, and document invitation of CSA/ACT Provider representative. The initial treatment planning meeting will also include discharge planning as reflected in the Saint Elizabeths Hospital discharge planning process.

2. Saint Elizabeths Hospital will request the consumer's and CSA/ACT Provider's attendance at all treatment planning meetings, and discharge-planning meeting, if applicable.

- Saint Elizabeths Hospital must document in the consumer's clinical record each time an attempt was made to include the consumer, for every date where a consumer did not attend.

3. Saint Elizabeths Hospital shall notify the CSA/ACT Provider immediately of any transfer or unplanned discharge.

4. Upon conditional release of a forensic consumer or discharge of civil consumer, Saint Elizabeths Hospital will provide a prescription for medication for the consumer until the next scheduled medication somatic appointment scheduled at their CSA/ACT Provider, or as determined in the discharge planning process. In addition, the consumer will be provided with instructions regarding follow-up monitoring procedures in the community.

5. Continuity of Care Upon Admission to a Crisis Bed.

5A. Referral to a Crisis Bed. A consumer, natural support, CSA/ACT Provider, community acute care facility, or a crisis emergency provider may refer a consumer to a crisis bed.

1. The Crisis Bed Provider will:

- Gather information from the referring party, and admit if appropriate based on the clinical presentation (consumer has an Axis I diagnosis that is not primary substance abuse only or Axis II serious mental illness and a demonstrated need for 24-hour supervision and assistance while stabilization of symptoms in the community occurs).

- If admitted, notify AHL of the admission, and obtain collateral information as needed.

- The Crisis Bed Provider will notify the CSA/ACT Provider immediately, but no later than within 24 hours of admission. A treatment plan meeting will be held within 72 hours of admission if the consumer remains in the crisis bed.

2. If the consumer does not have a CSA/ACT Provider and is eligible for CSA enrollment, AHL will enroll the consumer with a CSA upon admission to the crisis bed.

- The AHL will document the admission to a crisis bed in the electronic management system.

5B. If the crisis is not resolved within 48 hours,

1. The crisis bed provider staff will provide AHL a written clinical presentation for a continued stay, LOCUS worksheet, and psychiatric evaluation.

2. AHL will review the documentation provided by the crisis bed provider and determine medical necessity.

5C. If medical necessity is met,

1. AHL will provide continued stay authorization at the crisis bed (not to exceed 14 calendar days).

2. If the crisis has not been resolved by Day 14, the consumer will be assessed for a more appropriate level of care.

5D. If medical necessity is not met or resolved, the CSA/ACT Provider will ensure the following crisis bed discharge planning is addressed/arranged:

1. face to face appointment between the clinical manager, or clinician designated in the consumer's IRP and the consumer, within seven (7) days of the consumer's discharge from the crisis bed to the community;

2. medication somatic appointment if the consumer is on psychotropic medications with the CSA/ACT Provider within ten (10) days of discharge; and

3. attempt to address the consumer's individual's needs including benefits acquisition, and housing, as applicable.

5E. Notice of Unplanned Discharge. The crisis bed provider is responsible of notifying AHL and the CSA/ACT Provider of any unplanned discharge (e.g., elopement or request for discharge against medical advice (AMA).

6. Continuity of Care For any CSA Transfer/Change.

6A. Right to Change a CSA. Consumers have the right to change their CSA at any time for any reason. This change can be made by telephone call only to the DMH Access HelpLine (AHL). Three (3) changes of CSA by a consumer within a benefit year may trigger a Care Coordination utilization review.

6B. Responsibilities upon Knowledge of Consumer's Intent to Transfer or Change CSA:

1. When a consumer notifies the AHL of their intent to transfer, the AHL staff will:

   a. Educate the consumer as to all available CSAs and their services, but may neither recommend nor suggest a CSA.

   b. If the consumer makes a choice of a new CSA he/she wants to receive services from, AHL will:
   - close the consumer's enrollment with the current CSA,
   - enroll the consumer with the new CSA,
   - assist the consumer with arranging an intake appointment at the new CSA, and
   - send an email notification to the old and new CSA.

2. If the consumer completed and signed a DMH-HIPAA Form 2 Consent for the Use and Disclosure of Protected Health Information Among Participating Network Providers, the old CSA will send the following documentation to the new CSA within one (1) week of the transfer and communicate to the new CSA any additional collateral information as needed:

   a. Diagnostic assessment;

   b. IRP;

   c. Clinical manager/approving practitioner's progress notes for past six (6) months;

   d. Psychiatrist's progress notes for past six (6) months; and

   e. Current medication records including lab reports, and physical.

3. If the consumer refuses to sign a DMH-HIPAA Form 2, Consent for the Use and Disclosure of Protected Health Information Among Participating Network Providers, for sharing records, the new CSA clinical manager/approving practitioner will discuss with the consumer the importance of the sharing of information and present options to the consumer to sign a limited authorization of disclosure (DMH-HIPAA Form 3, Authorization to Use or Disclose Protected Health Information). This may mean educating the consumer as to what portions of the record would be acceptable to transfer to the new CSA.

4. If the consumer transfers to a new CSA without first notifying the previous CSA, both agencies will learn of this via the DMH electronic management system. When this occurs, the previous CSA will:

- Ensure the consumer signed an authorization for disclosure form and then follow the same procedures in 6B2above. If the consumer refuses to sign an authorization for disclosure, the new CSA will follow 6B3 above.

7. Monitoring.

DMH will monitor provider responsiveness regarding a crisis/emergency situation and will monitor compliance with the Continuity of Care Practice Guidelines including continuity of care responsibilities regarding consumers change in level of care. Appropriate actions will be taken as necessary.

8. Definitions. For purposes of these adult continuity of care guidelines:

ACT – Assertive Community Treatment (ACT) is an intensive, integrated, rehabilitative, crisis, treatment, and mental health rehabilitative community support service provided by an interdisciplinary team to adults with serious and persistent mental illness with dedicated staff time and specific staff to consumer ratios.

ACT Provider – Assertive Community Treatment (ACT) Provider is an agency certified by DMH to provide ACT services, consistent with the MHRS Standards and the Department of Mental Health Establishment Amendment Act of 2001, and the Mental Health Consumers' Rights Protection Act.

Acute Care Facility – Private community hospitals and Saint Elizabeths Hospital at which acute or crisis mental health services are provided, also referred to as "facility" in this document.

Advanced Instructions – A written document prepared in accordance with D.C. Official Code § 7-1231.06 and Chapter 1 of Title 22A, DCMR, that details a consumer's mental health treatment preferences including his/her informed choice to accept or forego particular mental health services and mental health supports. Advance instructions become effective when the consumer is certified as incapacitated.

Approving Qualified Practitioner – The qualified practitioner responsible for overseeing the development and approval of the IRP. The approving qualified practitioner serves on the diagnostic/assessment team and may also serve as the clinical manager. Only a psychiatrist, psychologist, LICSW, APRN, or LPC may act as an AQP.

Authorization Plan – Items from the IRP that are entered into the DMH electronic management system and result in authorization plan numbers.

Clinical Manager – The qualified practitioner who coordinates service delivery. The clinical manager shall participate in the development and review of the consumer's IRP, along with the approving practitioner. The clinical manager may also serve as the approving practitioner. The clinical manager shall be employed by the CSA/ACT Provider, except that a psychiatrist serving as a clinical manager may be under contract to the CSA/ACT Provider.

Conditional Release – A person who is confined to a hospital under D.C. Official Code 24-501(d), who is granted release to the community under conditions of the court.

Consumer – A person who seeks or receives mental health services or mental health supports funded or regulated by DMH.

Continuity of Care (COC) - Coordination of services towards the stability of consumer-provider relationships over time. The relationship is typically established with a team rather than a single provider. Care provided by different professionals is coordinated through a common goal. A unique feature is continuity of contact, where the providers maintain contact with consumers, monitor their progress, and facilitate access to needed services.

Court Personnel - Attorneys for the prosecution or defense and staff of the Court.

Core Services Agency (CSA) – A DMH-certified community-based MHRS provider that has entered into a Human Care Agreement with DMH to provide specified MHRS. A CSA shall provide at least one core service directly and may provide up to three core services via contract with a sub-provider or subcontractor. A CSA may provide specialty services directly if certified by DMH as a specialty provider. However, a CSA shall also offer specialty services via an affiliation agreement with all specialty providers.

Crisis Emergency Provider (CEP) - A provider certified by DMH to provide crisis emergency services or who has contracted with DMH to provide same. This provider may be part of a CSA or may be a separate entity. The provider is accessible twenty-four hours per day, seven days per week (24/7) to offer crisis intervention to callers who are in crisis, to dispatch mobile crisis services, and to assist all persons in the District who may need emergency mental health care.

D.C. Jail – Provides Central Detention Facility and Central Treatment Facility.

Department of Corrections (DOC) – Provides incarceration services at the D.C. Jail and the halfway houses in the District.

DMH Access Helpline (AHL) – A telephone-based service center operated by DMH twenty-four hours per day, seven days per week (24/7). The DMH Access Helpline, 888-7WE-HELP (888-793-4357), provides crisis intervention, information and referral, service authorization and eligibility, and enrollment in the DMH system of care.

DMH Care Manager – A clinically licensed staff member that reports to the DMH Division of Integrated Care to provide care management and discharge support to eligible consumers.

District of Columbia Department of Mental Health
Continuity of Care Practice Guidelines for
ADULT Providers in the Mental Health System of Care

Eligibility – Eligibility for MHRS services requires that a person have a Axis I diagnosis that is not primary substance abuse only, or a primary diagnosis on Axis II; and is certified as requiring MHRS by an approving qualified practitioner; and is a resident of the District, except for emergency psychiatric care.

Emergency Need – For consumers who are involved in active crisis where the safety of the consumer or others is at risk within the next twenty-four (24) hours. Safety may be at risk due to suicide, homicide, and/or severe decompensation of functioning. Face to face services must be provided within one (1) hour of presentation at a CSA/ACT Provider. Crisis emergency services by a CEP must be provided within one (1) hour of the request or referral.

Individualized Recovery Plan (IRP) - The individualized recovery plan for adult consumers, which is the result of the diagnostic/assessment. The IRP is maintained by the consumer's CSA/ACT Provider. The IRP includes the consumer's treatment goals, strengths, challenges, objectives, and interventions. The IRP is the authorization of treatment, based upon certification that MHRS are medically necessary by an approving practitioner.

LOCUS – Level of Care Utilization System for psychiatric and addiction services, adult version assessment tool.

Mental Health Provider – (a) Any individual or entity, public or private, that is licensed or certified by the District of Columbia to provide mental health services or mental health supports; (b) any individual or entity, public or private, that has entered into an agreement with DMH to provide mental health services or mental health supports; or (c) Saint Elizabeths Hospital, also referred to in these guidelines as "provider."

Mental Health Rehabilitation Services (MHRS) – Those mental health services performed by DMH certified providers, according to the Mental Health Rehabilitation Services Provider Certification Standards; Chapter 34 of Title 22A District of Columbia Municipal Regulations.

Natural Settings – The consumer's residence, workplace, or other locations in the community the consumer frequents, such as the consumer's home, school, workplace, community centers, homeless shelters, street locations, or other public facilities. Natural settings do not include inpatient hospitals or community residential facilities.

Natural Supports – People who are informal supports and are acquainted or are related to the consumer, but do not provide a paid service. Natural supports can also be found in the consumer's community, such as the faith community, school, or community organizations, or workplace.

Resident of the District – A person who voluntarily lives in the District of Columbia and has no intention of presently removing them self from the District. The term "resident of the District" shall not include a person who lives in the District solely for a temporary purpose.

District of Columbia Department of Mental Health
Continuity of Care Practice Guidelines for
ADULT Providers in the Mental Health System of Care

Routine Need – CSAs response time of seven (7) business days for individuals seeking services who are not in urgent or emergency need.

Supervision Agency - In the District of Columbia the agencies supervising defendants or offenders is Pre-Trial Services or Court Supervision Offender Services Agency, or U.S. Parole Commission.

System of Care for Adults – A community support system for persons with mental illness that is developed through collaboration in the administration, financing, resource allocation, training, and delivery of services across all appropriate public systems. Each person's mental health services and mental health supports are based on an individual recovery plan (IRP), designed to promote recovery and develop social, community and personal living skills, and to meet essential human needs. It includes the appropriate integrated, community-based outpatient services and inpatient care, outreach, emergency services, crisis intervention and stabilization, age-appropriate educational and vocational readiness and support, housing and residential treatment and support services, family and caregiver supports and education, and services to meet special needs, which may be delivered by both public and private entities.

Urgent Need - Consumers experiencing distress that will develop into a crisis state without intervention, but where there is not yet a likely risk of injury to the consumer or others. Distress may be defined as at risk behavior such as suicide, homicide, a recent major loss, or a severe decompensation of functioning. Services must be provided within the same day of consumer presentation.

Approved By:

Stephen T. Baron
Director, DMH

1/17/12

(Signature) **(Date)**

Department of Mental Health

TRANSMITTAL LETTER

SUBJECT Continuity of Care Practice Guidelines for Children and Youth		
POLICY NUMBER **DMH Policy 200.5A**	DATE JAN 2 7 2012	TL# 160

Purpose. To update specific guidelines for the continuity of care between providers of mental health services and supports to Department of Mental Health (DMH) child/youth consumers.

Applicability. Applies to Core Services Agencies (CSAs), Community Based Intervention (CBI) Providers, acute care facilities, Psychiatric Residential Treatment Facilities, and the Mental Health Authority; and all other providers who have an agreement or contract with DMH or with certified providers regarding provision of services for DMH child/youth consumers.

Policy Clearance. Reviewed by affected responsible staff and cleared through appropriate MHA offices.

Implementation Plans. A plan of action to implement or adhere to this policy must be developed by designated responsible staff. If materials and/or training are required to implement this policy, these requirements must be part of the action plan. Specific staff should be designated to carry out the implementation and program managers are responsible for following through to ensure compliance. Action plans and completion dates should be sent to the appropriate authority. Contracting Officer Technical Representatives (COTRs) must also ensure that contractors are informed of this policy if it is applicable or pertinent to their scope of work. *Implementation of all DMH policies shall begin as soon as possible. Full implementation of this policy shall be completed within sixty (60) days after the date of this policy.*

Policy Dissemination and Filing Instructions. Managers/supervisors of DMH and DMH contractors must ensure that staff are informed of this policy. Each staff person who maintains policy manuals must ensure that this policy is filed in the **DMH** Policy and Procedures Manual, and contractors must ensure that this policy is maintained in accordance with their internal procedures.

ACTION

REMOVE AND DESTROY	INSERT
DMH Policy 200.5	DMH Policy 200.5A

1/27/12

Stephen T. Baron
Director, DMH

EXHIBIT C

GOVERNMENT OF THE DISTRICT OF COLUMBIA	Policy No. 200.5A	Date JAN 2 7 2012	Page 1
DEPARTMENT OF MENTAL HEALTH	**Supersedes:** dated 5/11/07	**DMH Policy 200.5, same subject,**	

Subject: Continuity of Care Practice Guidelines for Children and Youth

1. **Purpose**. To establish specific guidelines for the continuity of care between providers of mental health services and supports to Department of Mental Health (DMH) child/youth consumers.

2. **Applicability**. Applies to Core Services Agencies (CSAs), Community Based Intervention (CBI) Providers, acute care facilities, Psychiatric Residential Treatment Facilities, and the Mental Health Authority; and all other providers who have an agreement or contract with DMH or with certified providers regarding provision of services for DMH child/youth consumers.

3. **Authority**. Department of Mental Health Establishment Amendment Act of 2001.

4. **Definitions/Abbreviations**. For purposes of this policy:

4a. DMH Continuity of Care Practice Guidelines for Child/Youth Providers in the Mental Health System of Care - guidelines that describe the responsibilities and actions of providers and DMH in response to child/youth consumers who seek or receive urgent or emergency mental health treatment and supports; who are transferred or discharged to different levels of care within the mental health system; or who are admitted to a Psychiatric Residential Treatment Facility (PRTF).

4b. Mental Health Provider - referred to in this policy as provider, is: (a) any individual or entity, public or private, that is licensed or certified by the District of Columbia to provide mental health services or mental health supports; or (b) any individual or entity, public or private, that has entered into an agreement with DMH to provide mental health services or mental health supports.

4c. Acute Care Facilities - private hospitals at which acute or crisis mental health services are provided to children and youth.

4d. Mobile Crisis Services - Mobile crisis services respond within one (1) hour of the request or referral, and provide crisis/emergency services as appropriate. Crisis/emergency services consist of immediate response to screen the presenting mental health situation, de-escalation, and resolution of the immediate crisis situation.

5. **Policy**. To ensure continuity of care, all providers who serve children and youth will follow the DMH Continuity of Care Practice Guidelines for Child/Youth Providers in the Mental Health System of Care for the provision of urgent or emergency mental health services and/or transfer to different levels of care within the system of care.

6. **Responsibilities for DMH**. DMH shall:

6a. **Issue** continuity of care practice guidelines to all newly certified child/youth providers and to other organizations who are involved in their care (e.g., Child and Family Services Agency);

6b. **Notify** providers of all changes to the continuity of care practice guidelines as soon as the changes become effective; and

6c. **Monitor** treatment and care in compliance with the continuity of care practice guidelines, and take appropriate action where necessary.

7. **Specific Guidance for All Child/Youth Providers**.

7a. **Utilize** the DMH Continuity of Care Practice Guidelines for Child/Youth Providers in the Mental Health System of Care (Exhibit 1) for urgent, emergency, admission, discharge, and transfer situations when a child/youth consumer:

(1) needs mobile crisis services or an assessment by an acute care facility;

(2) presents for treatment at a CSA or CBI Provider;

(3) is assigned to the provider via the Access Helpline;

(4) is admitted to or discharged from an acute care facility;

(5) transfers to another CSA; and

(6) is admitted to or discharged from a PRTF.

7b. **Link** the child/youth to resources that are most relevant to the consumer's identified needs. The provider shall link the consumer to these services, rather than having the consumer locate their own services; and

7c. **Be Familiar** with the continuity of care practice guidelines for children and youth and all subsequent revisions as they become available to ensure continuity of care.

Approved By:

Stephen T. Baron
Director, DMH

1/27/12
(Signature) **(Date)**

District of Columbia Department of Mental Health
Continuity of Care Practice Guidelines
for *CHILD/YOUTH* Providers in the Mental Health System of Care

These guidelines outline the responsibilities of the District of Columbia Department of Mental Health (hereafter called DMH) system of care providers for children/youth and their families.

The following sections describe the responsibilities and actions of providers and the DMH Division of Care Coordination Access Helpline in response to child/youth consumers who seek or receive urgent or emergency mental health treatment and supports and/or transfer to different levels of care within the system of care. The outline below describes the structure of these guidelines.

1. Crisis Response, Urgent and Emergency Care
   - 1A. Contacting the DMH Access Helpline (AHL)
   - 1B. Presentation at a Provider who is a CSA/CBI Provider
   - 1C. Response by Mobile Crisis Services
   - 1D. Assessment by an Acute Care Facility

2. Continuity of Care Upon Admission to an Acute Care Facility
   - 2A. If the Consumer has a CSA/CBI Provider
   - 2B. If the Consumer has no CSA and is Eligible for CSA Enrollment
   - 2C. Expectations of the Acute Care Facility

3. Continuity of Care for Admission/Treatment/Discharge from a Psychiatric Residential Treatment Facility (PRTF)
   - 3A. PRTF Placement
     1. If the Child/Youth has a CSA/CBI Provider (and is under the custodial care of CFSA)
     2. If the Child/Youth has no CSA (and is under the custodial care of CFSA)
   - 3B. If the Child/Youth has no connection to CFSA
     1. If the Child/Youth has a CSA/CBI Provider
     2. If the Child/Youth has no CSA/CBI Provider
   - 3C. If DMH did not Certify Medical Necessity for Placement of a Child/Youth in a PRTF or the Child's Placement is Court Ordered
   - 3D. Responsibilities of the PRTF

4. Continuity of Care for any CSA Transfer/Change
   - 4A. Right to Change a CSA
   - 4B. Responsibilities upon Knowledge of Child/Youth's Intent to Transfer or Change CSA

5. Monitoring

6. Definitions

District of Columbia Department of Mental Health
Continuity of Care Practice Guidelines
for *CHILD/YOUTH* Providers in the Mental Health System of Care

The provider shall adhere to DMH clinical policies, including DMH Policy 300.1C, Level of Care Utilization System (LOCUS/CALOCUS) Evaluations; and DMH Policy 645.1, DMH Privacy Policies and Procedures. All consumer information is subject to the Health Insurance Portability and Accountability Act (HIPAA) and the Mental Health Information Act (MHIA) protections.

District of Columbia Department of Mental Health
Continuity of Care Practice Guidelines
for *CHILD/YOUTH* Providers in the Mental Health System of Care

1. Crisis Response, Urgent and Emergency Care.

Consumers in crisis may seek or be presented for treatment at several different locations. The provider's crisis response shall be consistent with the provider's role for that consumer, based on that consumer's need at that time, as described below:

1A. Contacting the DMH Access HelpLine (AHL):

When a consumer, family member, or other individual or entity contacts the AHL for a child/youth in crisis, the AHL staff will complete a telephonic risk assessment and determine if there is Child and Family Services Agency (CFSA) involvement.

When the consumer's needs are identified as urgent or emergency, AHL will respond as follows:

1. If consumer has a CSA/Community Based Intervention (CBI) Provider, AHL staff will contact the CSA/CBI Provider unless immediately calling 911 is indicated upon determination that the consumer is likely to injure self or others, or a referral for mobile crisis services is more appropriate.

    a. If no response from CSA/CBI Provider within thirty (30) minutes, contact the CSA/CBI Provider again.

    b. If no response from CSA/CBI Provider within two (2) hours from first contact (or sooner based on assessed need), contact the CSA/CBI Provider senior administrator or designee or on call staff.

    c. AHL staff may deploy mobile crisis services in the absence of a CSA/CBI Provider response.

2. If consumer does not have a CSA/CBI Provider, AHL will request response by mobile crisis services, unless immediately calling 911 is indicated upon determination that the consumer is likely to injure self or others.

3. AHL staff will document the planned action in the electronic management system.

1B. Presentation at a Provider who is a Core Services Agency (CSA)/Community Based Intervention (CBI) Provider:

When a consumer presents in crisis at a CSA/CBI Provider, that provider will:

1. Provide any needed emergency care to stabilize immediate life threatening situations, which may include but is not limited to calling 911, and then refer consumer for further treatment based on their knowledge of that consumer's status.

2. Use these practice guidelines and/or utilize the CALOCUS/LOCUS screening to indicate level of acuity and appropriate service needs.

3. If the consumer is enrolled with the CSA/CBI Provider and the consumer meets the guidelines for urgent or emergency need, initiate appropriate clinical intervention based on the assessed needs of the consumer.

4. If the consumer is not in active treatment with that CSA/CBI Provider, the CSA/CBI Provider may call AHL to request emergency services.

1C. Response by Mobile Crisis Services:

1. Upon request, mobile crisis services will respond within one (1) hour of the request or referral, and provide crisis/emergency services as appropriate. Crisis/emergency services consist of immediate response to screen the presenting mental health situation, de-escalation, and resolution of the immediate crisis situation.

- The crisis response period for children and youth may extend up to 72 hours. During that time, mobile crisis services will continue to monitor the situation to de-escalate as required.
- Mobile crisis services will determine through AHL if the consumer has a CSA/CBI Provider and, if so, communicate with the CSA/CBI Provider regarding history and collaborate on a crisis plan.

2. Once mobile crisis services are completed, mobile crisis will also ensure the consumer is connected to the appropriate level of care by: (a) notifying the consumer's CSA/CBI Provider and ensuring follow-up services; or (b) through AHL, assist the legal guardian with enrolling the consumer to a CSA, and ensuring follow-up services; or (c) notifying the CSA/CBI Provider if the consumer will be transported to a hospital.

3. If the consumer is discharged from crisis/emergency services for follow-up with a CSA/CBI Provider, mobile crisis services will maintain contact with the consumer until the consumer's CSA/CBI Provider has fully assumed responsibility for carrying out the treatment plan for the consumer.

4. If the child/youth needs an assessment for involuntary hospitalization, a mobile crisis services team member (who must be a physician, psychologist, or duly accredited officer agent) will complete an FD-12, Application for Emergency Hospitalization, and either transport, or arrange for transport of the child/youth for an assessment by an acute care facility.

1D. Assessment by an Acute Care Facility:

1. A consumer may present directly or be transported by mobile crisis services for an assessment.

2. If the consumer presents directly, the acute care facility will notify DMH of the admission of any child/youth that is enrolled/eligible for Medicaid (including Managed Care Organizations [MCOs]).

3. Admission to an acute care facility may proceed if the facility's psychiatrist authorizes admission based on medical necessity.

2. Continuity of Care Upon Admission to an Acute Care Facility (See Section 3 below for Psychiatric Residential Treatment Facilities).

A DMH Care Manager will be assigned to coordinate the continuity of care between the CSA/CBI Provider and the acute care facility.

2A. If the Consumer has a Core Services Agency (CSA)/Community Based Intervention (CBI) Provider:

The acute care facility will notify the DMH Division of Integrated Care of all Medicaid consumer admissions on a daily basis. The DMH Division of Integrated Care designee will inform the acute care facility of the consumer's assigned CSA/CBI Provider, and notify the CSA/CBI Provider of hospitalization.

1. The CSA/CBI Provider will communicate with the acute care facility within one (1) day of notification of admission. Contact will include discussion of the consumer's psychosocial history, Individualized Plan of Care (IPC), treatment course history, and medication history.

2. The CSA/CBI Provider will have face to face contact with the consumer and designated acute care facility staff within two (2) days of notification of admission. That contact will include the initial treatment team meeting to establish discharge planning with the consumer and the facility treatment team.

3. During the time of treatment in the acute care facility, the CSA/CBI Provider shall:

a. Inform the Child and Family Team (CFT) leader of the admission on the same day of notification of the admission; and

b. Have face to face contact with consumer at least twice a week for the entire length of stay at the facility.

4. The CSA/CBI Provider will maintain progress notes in the consumer's clinical record reflecting all meetings and communications with facility staff, the consumer, and CFT members. If appropriate, the community treating psychiatrist will consult by telephone or in person with the acute care facility treating psychiatrist.

5. The CSA/CBI Provider will participate in the development of an appropriate discharge plan with the consumer and acute care facility staff. Discharge planning must be documented in the consumer's clinical record and include:

a. A face to face appointment between the CSA/CBI Provider and the child/youth within seven (7) days of the child/youth's discharge from the facility to the community.

b. A scheduled medication somatic appointment for each child/youth on psychotropic medications with the CSA within ten (10) days of discharge; and

c. CALOCUS/LOCUS screening to indicate level of acuity and appropriate service needs.

d. Plans to have CBI authorized and in place within two (2) days of discharge, if appropriate.

2B. If Consumer has no Core Services Agency (CSA) and is Eligible for CSA Enrollment:

1. The acute care facility will notify the DMH Division of Integrated Care of all Medicaid consumer admissions on a daily basis. The DMH Division of Integrated Care designee will inform the acute care facility that the child/youth does not have a CSA, and ask the acute care facility to discuss enrollment in a CSA with the family.

2. If the parent/legal guardian is interested in mental health services and supports from DMH, the AHL staff will enroll the consumer with a CSA if the consumer/consumer's parent/legal guardian is able and willing to have a telephone conversation. This will be done through the consumer choice process.

- The acute care facility staff may assist the consumer/parent/legal guardian with calling AHL to enroll the consumer.
- If the child/youth is under the custodial care of CFSA, enrollment must be requested through the CFSA Office of Clinical Practice.

3. The CSA will become responsible for fulfilling the CSA responsibilities as detailed in Section 2, Continuity of Care Upon Admission to Acute Care Facility, 2A, 3b-5 above, as appropriate.

2C. Expectations of the Acute Care Facility:

Upon admission, the acute care facility will communicate with the consumer's CSA/CBI Provider and perform the following responsibilities for the consumer's continuity of care. Acute care facilities have additional responsibilities, such as those imposed by District and federal laws including the Ervin Act.

1. The acute care facility staff will invite the child/youth, CSA/CBI Provider, and parent/legal guardian to all treatment team and discharge planning meetings.

2. The acute care facility staff must document in the clinical record each time an attempt was made to include the child/youth whenever a child/youth does not attend a meeting, and include the reason the child/youth did not attend.

3. The acute care facility shall notify the CSA/CBI Provider and the assigned DMH Care Manager immediately of any transfer or unplanned discharge.

4. Prior to discharge, the acute care facility shall assist the consumer/parent/legal guardian with scheduling a follow-up appointment with the CSA/CBI Provider to be held within seven (7) days of discharge.

5. The acute care facility shall provide any documentation necessary, including the acute care facility's psychiatric evaluation, to assist the CSA/CBI Provider with obtaining authorization for outpatient services which require prior authorization.

6. At discharge, the acute care facility will provide a prescription or enough medication for the consumer until the next scheduled medication somatic

appointment which must be scheduled with their CSA/CBI Provider prior to discharge.

7. The acute care facility will provide the CSA/CBI Provider a discharge summary upon discharge.

3. Continuity of Care for Admission/Treatment/Discharge from a Psychiatric Residential Treatment Facility (PRTF).

3A. **PRTF Placement**. In order for the placement to be Medicaid eligible (if the child/youth is not placed through a managed care organization), DMH must certify the medical necessity of admission to a PRTF. A goal of the system of care is to ensure that every opportunity to place a child/youth in the community is exercised before a PRTF placement recommendation is made.

- Community-based alternatives to residential placement must be explored through a teaming process absent exceptional circumstances, prior to submitting a referral to the PRTF Review Committee for a medical necessity determination.

1. **If the Child/Youth has a CSA or CBI Provider** (and is under the custodial care of the Child and Family Services Agency [CFSA]):

a. If the Child and Family Team (CFT) determines that PRTF placement would most appropriately meet the needs of the child/youth, then CFSA will submit a referral for review of medical necessity to the PRTF Review Committee.

b. If the PRTF Review Committee certifies medical necessity for PRTF placement,

- The CSA/CBI Provider shall collaborate with CFSA and the DMH Residential Treatment Center Reinvestment Program (RTCRP) to identify the PRTF.
- The CSA/CBI Provider will communicate the following information to RTCRP and to CFSA (who will forward to the PRTF): summary of the child/youth's course of treatment, medication history, and IPC.
- CFSA will notify RTCRP of the final PRTF selection upon admission.

c. The RTCRP staff will coordinate with the CSA/CBI Provider to ensure that communication between CFSA, CSA/CBI Provider, and PRTF is complete, and to ensure that the PRTF has all relevant information to initiate treatment planning for the child/youth.

d. CFSA will be responsible for transportation of the child to the PRTF, including a face to face meeting with the child/youth and their family with the PRTF staff.

e. During the course of the placement, RTCRP will ensure that all relevant information with respect to the treatment plan and progress of the child/youth is communicated to the CSA at least every 180 days or as otherwise appropriate.

f. RTCRP and CFSA are responsible for monitoring the appropriateness of the clinical program/treatment during each CFSA child/youth's PRTF placement. RTCRP and CFSA will participate in the initial treatment team meeting at the PRTF within seven (7) calendar days of admission.

- RTCRP and CFSA will participate in the initial treatment team meeting telephonically if face to face participation is not feasible. RTCRP will invite the CSA/CBI Provider to participate telephonically in the initial treatment team meeting for clinical information sharing.

g. RTCRP and CFSA will conduct concurrent on-site reviews whenever feasible and share information throughout the placement, working jointly to coordinate timely discharge planning that assures appropriate services and supports are in place to assist the youth with reintegration into the community.

i. The initial treatment team meeting will include establishment of a tentative discharge plan and such plan will be monitored and updated as appropriate at subsequent treatment team meetings.

ii. RTCRP and CFSA shall participate in monthly treatment team meetings telephonically if face to face participation is not feasible.

iii. No less than ninety (90) days prior to the child/youth's discharge, RTCRP and CFSA will begin planning with the PRTF and the CSA to effect the smooth transition and coordination of care for the returning child/youth. Such planning will include: community service and support needs; parent/caregiver's access to services, as appropriate; benefits acquisition; education, placement and housing resources as appropriate; and other mental health services and supports that are identified in the discharge plan to include CBI services, if appropriate.

iv. RTCRP and the CSA will document all participation in treatment planning and care coordination activities in the clinical record, and coordinate discharge planning.

h. Discharge planning and documentation must include:

i. Plans to have CBI authorized and in place within two (2) days of discharge, if applicable.

ii. A face to face appointment between the CSA/CBI Provider and the child/youth within seven (7) days of the child/youth's discharge from the PRTF to the community. This appointment will include a Diagnostic Assessment.

iii. A scheduled medication somatic appointment for each child/youth on psychotropic medications with the CSA within ten (10) days of discharge.

iv. CALOCUS/LOCUS screening to indicate level of acuity and appropriate service needs.

2. **If Child/Youth has no CSA** (and is under the custodial care of CFSA):

a If the Child and Family Team (CFT) demonstrates that PRTF placement would most appropriately meet the needs of this child/youth, then CFSA must submit a referral for review of medical necessity to DMH.

b. If the PRTF Review Committee certifies medical necessity for PRTF placement, CFSA will collaborate with the DMH Residential Treatment Center Reinvestment Program (RTCRP) to identify the PRTF, and CFSA will provide the PRTF and RTCRP with a summary of the child/youth's care and treatment and medical history.

c. The RTCRP staff will ensure that communication between CFSA and PRTF is complete, and ensure that the PRTF has all relevant information to initiate treatment planning for the child/youth.

d. CFSA will be responsible for transportation of the child to the PRTF, including a face to face meeting with the child/youth and their family with the PRTF staff.

e. CFSA and RTCRP will conduct monitoring as stated in 3A1(f) and (g) above, except that the child/youth will not be linked to a CSA until 30 days prior to discharge since the child/youth did not have a CSA prior to admission to a PRTF.

f. CFSA will ensure the child/youth is linked to a CSA 30 days prior to the child/youth's discharge. The CFSA Behavioral Services Unit will work with the CFSA social worker regarding choice of a CSA and work with AHL to enroll the child or youth in a CSA.

g. Based on the consumer choice process, the AHL staff will assign a CSA and notify the CSA of the enrollment within twenty-four (24) hours.

h. CFSA, RTCRP, and the CSA will participate in discharge planning/coordination of care activities as stated in Section 3A1(h) above.

3B. The following applies if the child/youth has no connection to CFSA:

1. **<u>If the Child/Youth has a CSA/CBI Provider</u>:**

a. The DMH Residential Treatment Center Reinvestment Program (RTCRP) will ensure that the child/youth's CSA/CBI Provider coordinates and facilitates a Child and Family Team (CFT) process.

b. If the CFT determines that PRTF placement would most appropriately meet the needs of the child/youth, then the CSA/CBI Provider must submit a referral for review of medical necessity to the PRTF Review Committee.

c. If the PRTF Review Committee certifies medical necessity for PRTF placement, the CSA/CBI provider will facilitate collaboration with RTCRP and the consumer's parent/caregiver to identify the PRTF. The CSA/CBI Provider will provide the PRTF and RTCRP with a summary of the child/youth's course of treatment, medication history, IPC, and goals for PRTF placement.

d. The RTCRP staff will coordinate with the CSA/CBI Provider to ensure that the PRTF has all relevant information to initiate treatment planning for the child/youth.

e. The CSA/CBI Provider will help the parent/caregiver in making transportation arrangements to the PRTF. The parent/caregiver will transport the child/youth to the PRTF for admission.

f. During the course of the placement, RTCRP will ensure that all relevant information with respect to the treatment plan and progress of the child/youth is communicated to the CSA at least every 180 days or as otherwise appropriate.

g. RTCRP is responsible for monitoring the appropriateness of the clinical program/treatment during the child/youth's PRTF placement. RTCRP will participate in the initial treatment team meeting at the PRTF within seven (7) calendar days of admission. RTCRP will participate telephonically if face to face participation is not feasible. RTCRP will invite the CSA/CBI Provider to participate telephonically in the initial treatment team meeting for clinical information sharing.

i. The initial treatment team meeting will include establishment of a tentative discharge plan and such plan will be monitored and updated as appropriate at subsequent treatment team meetings.

ii. RTCRP shall participate in monthly treatment team meetings telephonically if face to face participation is not feasible.

iii. No less than ninety (90) days prior to the child/youth's discharge, RTCRP and the CSA will begin planning with the PRTF to effect the smooth transition and coordination of care for the returning child/youth. Such planning will include: community service and support needs; parent/caregiver's access to services, as appropriate; benefits acquisition; education, placement and housing resources, as appropriate; and other mental health services and supports that are identified in the discharge plan to include CBI services, if appropriate.

iv. RTCRP and the CSA will document all participation in treatment planning and care coordination activities in the clinical record.

h. Discharge planning and documentation must include:

i. Plans to have CBI authorized and in place within two (2) days of discharge, if applicable.

ii. A face to face appointment between the CSA/CBI Provider and the child/youth within seven (7) days of the child/youth's discharge from the PRTF to the community. This appointment will include a Diagnostic Assessment.

iii. A scheduled medication somatic appointment for each child/youth on psychotropic medications with the CSA within ten (10) days of discharge.

iv. CALOCUS/LOCUS screening to indicate level of acuity and appropriate service needs.

2. **<u>If Child/Youth has no CSA/CBI Provider</u>** (and has no connection to CFSA):

a. The referring entity must submit a PRTF Diversion package to the DMH PRTF Diversion Technical Assistance Coordinator to initiate the Child and Family Team (CFT) process.

b. If the CFT determines that PRTF placement would most appropriately meet the needs of this child/youth, then the referring entity must submit a referral for review of medical necessity to the PRTF Review Committee.

c. If the PRTF Review Committee certifies medical necessity for PRTF placement, the CFT will facilitate collaboration with the DMH Residential Treatment Center Reinvestment Program (RTCRP) and the child/youth's

parent/caregiver to identify the PRTF. The CFT will provide the PRTF and RTCRP with a summary of the child/youth's course of treatment and medication history to initiate treatment planning for the child/youth.

d. The CFT will help the parent/caregiver in making transportation arrangements, to the PRTF. The parent/caregiver will transport the child/youth to the PRTF for admission.

e. RTCRP will be responsible for monitoring the appropriateness of the clinical program/treatment during the child/youth's PRTF placement as stated in 3B1g, and will ensure the child/youth is linked to a CSA through AHL thirty (30) days prior to the child/youth's discharge.

f. The CSA will participate with RTCRP and the PRTF in discharge planning/coordination of care activities as stated in 3B1h above.

3C. If DMH did not Certify Medical Necessity for Placement of a Child/Youth in a PRTF or the Child's Placement is Court Ordered, that placing agency is responsible for placement, monitoring, and discharge planning.

- RTCRP may perform the clinical oversight for a District placing agency and help support discharge planning through a memorandum of understanding (MOU).

3D. Responsibilities of the Psychiatric Residential Treatment Facility (PRTF):

Responsibilities of the PRTF are covered in federal and District regulatory mandates and contractual agreements.

4. Continuity of Care for any CSA Transfer/Change.

4A. Right to Change a CSA: A child or youth/parent/legal guardian has the right to change the child/youth's CSA at any time for any reason. This change may be made by telephone call to the DMH Access HelpLine (AHL), or a referral to the CFSA Office of Clinical Practice for a CFSA involved child or youth. Three (3) changes of CSA by a consumer within a benefit year may trigger a Care Coordination utilization review.

4B. Responsibilities upon Knowledge of Child/Youth's Intent to Transfer or Change CSA:

1. When a child or youth/parent/legal guardian notifies AHL of their intent to transfer, AHL will:

a. Educate the child or youth/parent/legal guardian as to all available CSAs and their services, but may neither recommend nor suggest a CSA; and

b. If the child or youth/parent/legal guardian makes a choice of a new CSA, to receive services from, AHL will:

- close enrollment with the current CSA,
- enroll the child/youth with a new CSA,
- assist the parent/legal guardian with arranging an intake appointment at the new CSA (for CFSA children and youth, the CFSA social worker is responsible for making the intake appointment after the child/youth is enrolled with a CSA), and
- send an email notification to the old and new CSA.

2. If the child or youth/parent/legal guardian completed and signed a DMH-HIPAA Form 2 Consent for the Use and Disclosure of Protected Health Information Among Participating Network Providers, the old CSA will send the following documentation to the new CSA within one (1) week of the transfer:

a. Diagnostic assessment;

b. IPC;

c. Clinical manager/approving practitioner's progress notes for past six (6) months;

d. Psychiatrist's progress notes for past six (6) months; and

e. Current medication records including lab reports, and physical.

The old CSA will also communicate to the new CSA any additional collateral information as needed.

3. If the child or youth/parent/legal guardian refuses to sign a DMH-HIPAA Form 2, Consent for the Use and Disclosure of Protected Health Information Among Participating Network Providers, for sharing records, the new CSA clinical manager/approving practitioner will discuss with the child or youth/parent/legal guardian the importance of the sharing of information and present options to sign a limited authorization of disclosure (DMH-HIPAA Form 3, Authorization to Use or Disclose Protected Health Information). This may mean educating the child or youth/parent/legal guardian as to what portions of the record would be acceptable to transfer to the new CSA.

4. If the child or youth transfers to a new CSA without first notifying the previous CSA, both agencies will learn of this via the DMH electronic management system. When this occurs, the previous CSA will:

a. Ensure the child or youth/parent/legal guardian signed an authorization for disclosure form and then follow the same procedures in 4B 2 above.

b. If the child or youth/parent/legal guardian refuses to sign an authorization for disclosure, the new CSA will follow 4B 3 above.

5. **Monitoring**. DMH will monitor provider responsiveness regarding a crisis/emergency situation and will monitor compliance with the continuity of care practice guidelines including regarding consumer's change in level of care. Appropriate actions will be taken as necessary.

6. **Definitions**. For purposes of these child and youth continuity of care practice guidelines:

Acute Care Facility – Private hospitals at which acute or crisis mental health services are provided, also referred to as "facility" in this document.

Approving Qualified Practitioner – The qualified practitioner responsible for overseeing the development of and approval of the IPC. The approving qualified practitioner serves on the diagnostic/assessment team and may also serve as the clinical manager. Only a psychiatrist, psychologist, LICSW, APRN, or LPC may act as an AQP.

Authorization Plan – Items from the IPC that are entered into the DMH electronic management system and result in authorization plan numbers.

Child and Family Services Agency (CFSA) – The District agency responsible for the coordination of foster care, adoption and child welfare services, and services to protect children against abuse or neglect.

Child and Family Team (CFT) - A group of individuals who the family believes can help them develop and implement a plan that will assist the child and family in realizing and achieving their vision of the future. The team should include the child and his/her family, a mental health representative, court involved partners, and any individuals important in the child's life and who are identified and invited to participate by the child and family. This may include, for example, teachers, extended family members, friends, community support workers, healthcare providers, relevant experts, coaches, representatives from churches, synagogues or mosques, and representatives from other child-serving systems like Child and Family Services Agency (CFSA), Department of Youth Rehabilitation Services (DYRS), DC Public Schools (DCPS), and Court Social Services (CSS). The

size, scope and intensity of involvement of the team members is determined by level and complexity of need.

CALOCUS - Child and Adolescent Level of Care Utilization System assessment tool.

Child(ren)/Youth - Children or youth with mental health problems includes persons under 18 years of age, or persons under 22 years of age and receiving special education, youth or child welfare services, who:

(1) Have, or are at risk of having, a diagnosable mental, behavioral, or emotional disorder (including those of biological etiology) which substantially impairs the mental health of the person or is of sufficient duration to meet diagnostic criteria specified within the DSM-IV or the ICD-9-CM equivalent (and subsequent revisions), with the exception of substance abuse disorders, mental retardation, and other developmental disorders, or seizure disorders, unless those exceptions co-occur with another diagnosable serious emotional disturbance; and

(2) Demonstrate either functional impairments or symptoms that significantly disrupt their academic or developmental progress or family and interpersonal relationships; or

(3) Have an emotional disturbance causing problems so severe as to require significant mental health intervention.

Clinical Manager – The qualified practitioner who coordinates service delivery. The clinical manager shall participate in the development and review of the consumer's IPC, along with the approving practitioner. The clinical manager may also serve as the approving practitioner. The clinical manager shall be employed by the CSA/CBI Provider, except that a psychiatrist serving as a clinical manager may be under contract to the CSA/CBI Provider.

Consumer – A person who seeks or receives mental health services or mental health supports funded or regulated by DMH.

Continuity of Care (COC) - Coordination of services towards the stability of consumer-provider relationships over time. The relationship is typically established with a team rather than a single provider. Care provided by different professionals is coordinated through a common goal. A unique feature is continuity of contact, where the providers maintain contact with consumers, monitor their progress, and facilitate access to needed services.

Core Services Agency (CSA) – A DMH certified community-based MHRS provider that has entered into a Human Care Agreement with DMH to provide specified MHRS. A CSA shall provide at least one core service directly and may provide up to three core services via contract with a sub-provider or subcontractor. A CSA may provide specialty

services directly if certified by DMH as a specialty provider. However, a CSA shall also offer specialty services via an affiliation agreement with all specialty providers.

DMH Access HelpLine (AHL) – A telephone-based service center operated by DMH twenty-four hours per day, seven days per week (24/7). The DMH Access HelpLine, 888-7WE-HELP (888-793-4357), provides crisis intervention, information and referral, service authorization and eligibility, and enrollment in the DMH system of care.

DMH Care Manager – A clinically licensed staff member that reports to the DMH Division of Integrated Care to provide care management and discharge support to eligible consumers.

Eligibility – Eligibility for MHRS services requires that a person have a Axis I diagnosis that is not primary substance abuse only, or a primary diagnosis on Axis II; and is certified as requiring MHRS by an approving qualified practitioner; and is a resident of the District, except for emergency psychiatric care.

Emergency Need – For consumers who are involved in active crisis where the safety of the consumer or others is at risk within the next twenty-four (24) hours. Safety may be at risk due to suicide, homicide, and/or severe decompensation of functioning. Face to face services must be provided within one (1) hour of presentation at a CSA/CBI Provider. Mobile crisis services must be provided within one (1) hour of the request or referral.

Individualized Plan of Care (IPC) - The individualized plan of care for child/youth consumers, which is the result of the diagnostic/assessment. The IPC is maintained by the consumer's CSA (or CBI provider when a child is receiving CBI services). The IPC includes the consumer's treatment goals, strengths, challenges, objectives, and interventions. The IPC is the authorization of treatment, based on certification that the MHRS are medically necessary by the approving practitioner.

Legal Representative - Parent or court appointed legal guardian, or District agency (CFSA or DYRS) which has legal authority to consent to ordinary mental health treatment.

LOCUS – Level of Care Utilization System for psychiatric and addiction services, adult version assessment tool.

Managed Care Organization – referred to as MCO.

Mental Health Provider – (a) Any individual or entity, public or private, that is licensed or certified by the District of Columbia to provide mental health services or mental health supports; or (b) any individual or entity, public or private, that has entered into an agreement with DMH to provide mental health services or mental health supports, also referred to in these guidelines as "provider."

Mental Health Rehabilitation Services (MHRS) – Those mental health services performed by DMH certified providers, according to the Mental Health Rehabilitation Services Provider Certification Standards; Chapter 34 of Title 22A District of Columbia Municipal Regulations.

Mobile Crisis Services – Mobile crisis services will respond within one (1) hour of the request or referral, and provide crisis/emergency services as appropriate. Crisis/emergency services consist of immediate response to screen the presenting mental health situation, de-escalation, and resolution of the immediate crisis situation.

Natural Settings – The consumer's residence, workplace, or other locations in the community the consumer frequents, such as the consumer's home, school, workplace, community centers, homeless shelters, street locations, or other public facilities. Natural settings do not include inpatient hospitals or community residential facilities.

Natural Supports – People who are informal supports and know or are related to the youth/family, but do not provide a paid service (such as a grandparent or neighbor who is connected to the youth/family). Natural supports can also be found in the youth/family's community, such as the faith community, neighborhood, school, or community organizations.

Psychiatric Residential Treatment Facility (PRTF) - A psychiatric facility that (1) is not a hospital and (2) is accredited by the Joint Commission on Accreditation of Healthcare Organizations, the Commission on Accreditation of Rehabilitation Facilities, the Council on Accreditation of Services for Families and Children, or by any other accrediting organization with comparable standards that is recognized by the state in which it is located and (3) provides inpatient psychiatric services for individuals under the age of twenty-two (22) and meets the requirements set forth in §§ 441.151 through 441.182 of Title 42 of the Code of Federal Regulations, and is enrolled by the District of Columbia Department of Health Care Finance (DHCF) to participate in the Medicaid program.

PRTF Review Committee - An independent interagency team that ensures that referrals for admission to a PRTF and continued stays meet federal guidelines in accordance with 42 CFR § 441.152 in order to issue a medical necessity determination for PRTF placement, D.C. Municipal Regulation 29 DCMR § 948, and the requirements of the PRTF medical necessity determination process.

DMH Residential Treatment Center Reinvestment Program (RTCRP) - RTCRP is organizationally located within the DMH Child and Youth Services Division (CYSD). RTCRP collaborates with referring entities on the placement of children/youth in PRTFs; monitors the appropriateness and effectiveness of clinical services provided, given the child/youth's needs; assures appropriate and adequate lengths of stay; participates in discharge planning; and follows discharged youth for at least six (6) months after discharge to support the child/youth's successful reintegration into the community.

District of Columbia Department of Mental Health
Continuity of Care Practice Guidelines
for *CHILD/YOUTH* Providers in the Mental Health System of Care

Routine Need – CSAs response time of seven (7) business days for individuals seeking services who are not in urgent or emergency need.

System of Care for Children, Youth, and their Families – A community support system for children or youth with mental health problems and their families, which is developed through collaboration in the administration, financing, resource allocation, training, and delivery of services across all appropriate public systems. Each child's or youth's mental health services and mental health supports are based on a single, child and youth-centered, and family-focused individual plan of care (IPC), encompassing all necessary and appropriate services and supports, which may be delivered by both public and private entities. Prevention, early intervention, and mental health services and mental health supports to meet individual and special needs are delivered in natural, nurturing, and integrated environments, recognizing the importance of and support for the maintenance of enduring family relationships, and are planned and developed within the District and as close to the child's or youth's home as possible so that families need not relinquish custody to secure treatment for their children and youth.

Urgent Need – Consumers experiencing distress that will develop into a crisis state without intervention, but where there is not yet a likely risk of injury to the consumer or others. Distress may be defined as at risk behavior such as suicide, homicide, a recent major loss, or a severe decompensation of functioning. Services must be provided within the same day of consumer presentation.

Approved by:

Stephen T. Baron
Director, DMH

1/27/12

(Signature) **(Date)**