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

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

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.

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

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)**